



January 13, 2010

The Honorable Nancy Pelosi
Speaker
U.S. House of Representatives
Washington, DC 20515

The Honorable Harry Reid
Majority Leader
U.S. Senate
Washington, DC 20510

Dear Leader Reid and Madam Speaker:

We applaud your leadership in securing passage by the House and Senate of comprehensive health care reform bills (H.R. 3962 and H.R. 3590, respectively) that include far-reaching initiatives to cover the uninsured as well as meaningful provisions to improve the quality of care and increase the availability of preventive services and programs that promote public health. As you know, mental health and substance use conditions are some of the most disabling and costly conditions.

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.¹ And, severe mental illnesses cost the U.S. \$193 billion in lost wages in 2002.²

We have been gratified to see that many provisions in the health care reform legislation moving through Congress address mental health and substance use concerns and would like to point out the proposals that will be most helpful for improving the availability of, access to, and quality of mental health and substance use services.

Parity Requirements

Mental health care 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. Thus, we are pleased that both the House and Senate bills include requirements that plans offered through the health insurance exchanges would have to comply with the Wellstone-Domenici Mental Health and Addiction Equity Act of 2008. **We urge you to include a provision in the final bill that ensures the application of this law to all qualified health insurance plans, regardless of plan size, in both the individual and small group market.**

No Annual or Lifetime Limits on Coverage

¹ 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.

² 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.

The stricter limits traditionally placed on mental health and substance use treatment often included lower annual and lifetime limits on coverage for these conditions. This discriminatory practice was prohibited in the initial mental health parity law of 1996. Thus we were troubled by the provision in the Senate bill to allow “reasonable” annual limits which would seem to roll back progress made over ten years ago with the first parity law. We appreciate that the Manager’s Amendment modified this provision and urge you to outlaw annual and lifetime limits altogether and immediately in the final health care reform bill.

Require Coverage of Mental Health and Substance Use Disorder Services

It will be important to **maintain the requirement included in both bills that the essential benefits package for qualified health plans must include mental health and substance use disorder services**, as well as rehabilitative and preventive services. 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.³

Full Medicaid Benefits

We also strongly support the proposals to expand Medicaid and prefer the House provision that would extend full Medicaid benefits to individuals up to 150 percent of poverty. While we greatly appreciate the strong parity requirement that would apply to the Medicaid benefits that would be available to individuals up to 133 percent of poverty **under the Senate bill, we are concerned that the benefits modeled after private insurance benchmarks under this provision would likely not adequately address the needs of people with serious mental health conditions.** If this approach is adopted, it will be critical to exempt individuals with serious mental health or substance use conditions from the population of beneficiaries scheduled to receive the scaled down benefits package. We also support the provision in the Senate bill to remove benzodiazepines and barbiturates from the list of medications states may exclude from Medicaid coverage.

Therapeutic Foster Care

An important provision to clarify that therapeutic foster care may be covered by state Medicaid programs was initially in both bills but it was removed from the Senate bill due to a misunderstanding that it was no longer needed. Although the Centers for Medicare and Medicaid Services did repeal a regulation that would have prohibited coverage of this critical service, there is still confusion among the states as to whether this service can be covered. To reassure and encourage states to provide this critical service to youth with very serious mental health conditions, it will be important to send a clear message that this service is covered by Medicaid **by accepting the House provision on therapeutic foster care into the final bill.**

³ Kaiser Commission on Medicaid and the Uninsured, Policy Brief entitled “Low-Income Adults Under Age 65 – Many are Poor, Sick, and Uninsured”, June 2009.

Youth in Public Institutions

We also strongly support the provision in the House bill to **require states to suspend rather than terminate Medicaid eligibility for youth incarcerated in a public institution**. Most of the young people in these facilities suffer from mental health and substance use conditions. Requiring these youth to reenroll in Medicaid upon release creates problematic gaps in coverage and harmful obstacles to them receiving needed treatment.

Mental Health and Substance Use Disorder Coverage in CHIP

In addition, we are concerned about likely disruptions in health care coverage for children enrolled in Children's Health Insurance Plans (CHIP) plans if CHIP were repealed as provided in the House bill. Nonetheless, we also continue to be concerned that children enrolled in the existing CHIP plans are not assured access to mental health and substance use disorder services. If the program is maintained as in the Senate bill, **we urge the inclusion of mental health and substance use services in the list of benefits that must be covered by CHIP plans**. Since both the House and Senate bills would require this of plans in the health insurance exchanges, it would be hard to justify not providing lower income children this protection.

Improved Care Coordination and Integration of Behavioral Health into General Health Care

Behavioral health consumers have some of the greatest unmet needs for improved care coordination. 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.⁴

Thus, we support provisions in both bills to encourage development of medical homes and community health teams to improve care coordination. We urge you to adopt in particular the **Senate provision to create a Medicaid state plan option to establish medical or health homes while specifying that individuals with serious mental health conditions qualify** to receive services through this option and community mental health centers are on the list of eligible providers. We also support the requirement in this provision of the Senate bill directing states to consult with SAMHSA regarding prevention and treatment of mental illness and substance abuse among the eligible individuals with chronic conditions. In addition, we support the provision supporting co-locating primary care providers in community-based mental health settings.

We also strongly support the provision in the House bill to require the Secretary to establish a program to **fund mental health and substance use disorder screening, brief intervention, referral, and recovery** services in primary care settings. In addition, we support the provision in the House bill to **redefine community mental health centers as Federally Qualified**

⁴ 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.

Behavioral Health Centers as a building block to assist community mental health centers to provide more comprehensive, integrated behavioral health care.

Prevention

We are encouraged by the many provisions in both bills to improve access to preventive services and urge you to ensure the mental health and substance use conditions are prioritized in these initiatives. One key provision in the House bill would **require that SAMHSA be consulted in the development of a national strategy on prevention and wellness** and we urge you to adopt this requirement into the final bill.

We support provisions in both bills to cover screening services without cost-sharing through the health insurance exchange plans, Medicare, and Medicaid. In addition, we strongly support the provision in the House bill to **include a behavioral health specialist on the “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.

A recent report by the Institute of Medicine on “Preventing Mental, Emotional, and Behavioral Disorders among Young People” described numerous interventions that can result in long term reductions in behavioral health disorders as well as other positive outcomes such as improved academic achievement.⁵ **Home visitation programs were among those highly recommended and thus we strongly support the provisions in both bills to fund these programs and would encourage you not to restrict eligibility to only nurse home visitation but to allow coverage of other types of home visitation programs** as well.

Finally, we strongly support provisions in **both bills establishing a grant program for school-based health clinics** and especially the **provisions explicitly directing these clinics to include mental health and substance use disorder assessments, treatment and referrals.**

Workforce Development

Both bills include a number of helpful workforce development provisions specifically addressing widespread shortages of mental health and addiction treatment providers. For example, we support the **provisions in both bills establishing a mental and behavioral health education and training grant program and a pediatric loan repayment program in the Senate bill that includes child and adolescent behavioral health providers.** We also applaud the Senate provision to **enhance training for primary care providers regarding mental and behavioral health conditions** as well as chronic care management and preventive medicine. In addition, we

⁵ 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.bocyp.org/prevention_policymakers_brief.pdf]

also strongly support **the provisions in the House bill to increase reimbursement for primary care under Medicaid.**

Medicare Part D Coverage of Behavioral Health Medications

Prescription medication is often a key component of effective behavioral health care and thus we **support the provision in the Senate bill to strengthen the requirement that Medicare Part D plans provide full coverage of six classes of clinically sensitive medications**, including anti-depressants, anti-psychotics, and anti-convulsants. 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. **We recommend that the final bill ensure coverage of the current protected classes at least through 2015 and maintain the requirement established in the Medicare Improvements for Patients and Providers Act that any restriction on access to a medication in one of the protected classes, including through prior authorization or other utilization management, must be approved through the exceptions process and be based on scientific evidence and medical standards of practice.** We also strongly support the provisions in both bills to begin closing the gap in coverage in the Part D benefit.

Research on Depression

We strongly support the provisions in the House and Senate bills to **increase funding for research on postpartum disorders, including depression, and urge you to include in the final bill the additional Senate provision to provide support services to women with this condition.** We also strongly support the provision in the **Senate bill to direct the Substance Abuse and Mental Health Services Administration to award grants to centers of excellence in the treatment of depressive disorders.**

Quality Measure Development

Both bills would establish national priorities for quality improvement taking into account those chronic conditions that impose a high burden of disease and health disparities. **We urge you to ensure that mental health and substance use conditions are explicitly prioritized under this initiative.**

Comparative Effectiveness Research

Both bills would establish new programs to fund and oversee comparative effectiveness research (CER). We urge you to ensure that the final program requires **inclusion of multiple consumer/patient representatives at all levels of the new entity established to carry out this initiative** including any board or governing body and any expert advisory panels. In addition, it

will be important to adopt the Senate provision **requiring that these consumer/patient representatives are adequately supported to facilitate their participation and enable them to engage most effectively on complex research topics.**

Thank you very much for your consideration of our views.

Sincerely,



David L. Shern, Ph D
President and CEO

Cc: The Honorable Max Baucus
The Honorable Chris Dodd
The Honorable Dick Durbin
The Honorable Tom Harkin
The Honorable Steny Hoyer
The Honorable George Miller
The Honorable Frank Pallone
The Honorable Charlie Rangel
The Honorable Pete Stark
The Honorable Henry Waxman