The Nation's Voice on Mental Illness

STATEMENT OF MIKE FITZPATRICK
EXECUTIVE DIRECTOR
NATIONAL ALLIANCE ON MENTAL ILLNESS
BEFORE THE HEALTH SUBCOMMITTEE
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
MARCH 27, 2007

Chairman Stark, Representative Camp and members of the Subcommittee, on behalf of the 210,000 members and 1,200 affiliates of the National Alliance on Mental Illness (NAMI), I want to thank you for convening this important hearing on the need for parity for mental illness and substance abuse parity in the Medicare program and private sector health plans. As the nation's largest organization representing people living with serious mental illness and their families, NAMI would like to offer strong support for equitable coverage for mental illness treatment across all public and private sector programs.

Since NAMI's inception in 1979, we have always supported enactment of standards that ensure non-discriminatory coverage of treatments for illnesses such as schizophrenia, schizo-affective disorder, bipolar disorder, major depression and severe anxiety disorders. This demand for parity level coverage is rooted in basic principles in the founding of NAMI as a consumer and family organization. NAMI believes strongly that:

1. mental illnesses are real,
2. treatment for mental illness works – if you can access it, and
3. there is simply no medical or economic justification for public sector programs or private health insurance plans to cover treatment for mental illness on different terms or conditions than any other illness.

The Cost of Untreated Mental Illness Are Overwhelming for Our Nation

- Mental disorders are the leading cause of disability in the US for ages 15-44.
- Suicide is the eleventh leading cause of death in the US, but is the third leading cause of death for people 10 to 24 years old. More than 90 percent of people who die by suicide have a history of mental illness.
- Adults with serious mental illness die 25 years younger than other Americans. A man with serious mental illness is likely to die by age 53, compared with the average male life expectancy of 78 years.
- Approximately 50 percent of students with a mental disorder age 14 and older drop out of high school; this is the highest dropout rate of any disability group.

- Twenty-four percent of state prison and 21 percent of local jail inmates have a recent history of a mental health disorder. An alarming 65 percent of boys and 75 percent of girls in juvenile detention have at least one mental disorder.
- Between 2000 and 2003, emergency department (ED) visits with a primary diagnosis of mental illness increased at four times the rate of other ED visits.
- The annual economic, indirect cost of mental illnesses is estimated to be $79 billion. Most of that amount—approximately $63 billion—reflects the loss of productivity as a result of illnesses.

NAMI Strongly Supports HR 1663

Chairman Stark, NAMI would like to congratulate you and your colleagues for bringing the Medicare Mental Health Modernization of 2007 (HR 1663) forward. For many years you have been the leader in Congress in pushing for equitable coverage for mental illness treatment in the Medicare program. As you know, Medicare has perhaps the out of date and discriminatory benefit for mental illness and substance abuse treatment of any public or private sector program. The most widely recognized restrictions are the discriminatory limit of 190 lifetime days on inpatient care under Part A and the 50% cost sharing requirement for outpatient services under Part B.

These restrictions – which apply only to mental illness treatment – were unacceptable intolerable in 1965, and are even more troubling in 2007. Over the past 40 years we have witnessed enormous advances in treatment for mental illness. Treatment for disorders such as schizophrenia, bipolar disorder and major depression rival those for heart disease and hypertension in terms efficacy and effectiveness. More importantly, the public health burden associated with major mental illnesses far exceeds that for many other medical disorders. It is simply unacceptable for the Medicare program – a critical public sector program that serves the most vulnerable and disabled individuals in our nation – to impose discriminatory limits on mental illness treatment.

Mr. Chairman, HR 1663 contains a number of important provisions that you have championed for years:

- Reduction of the discriminatory 50% co-payment for outpatient mental health services to 20%, and
- Elimination of the arbitrary 190-day lifetime limit on inpatient psychiatric care.

As in the past, NAMI strongly supports your leadership in moving to eliminate these outdated and unfair limits on treatment coverage. In addition, NAMI would also like to express support for long overdue improvements to the Medicare program in HR 1663 designed to update the program and make it consistent with evidence-based practice for treatment of mental illness. Among these critical improvements is the addition of new community-based residential and intensive outpatient mental health services.

These important community-based services are part of the most widely recognized evidence-based, recovery-oriented service delivery model, programs of Assertive Community Treatment (ACT). Many states are currently using the Medicaid program to finance ACT services for the most disabled individuals living with mental illness.

Unfortunately, changes to the Medicaid Rehabilitation Option now actively under consideration at the Centers for Medicare and Medicaid Services (CMS) would devastate the ability of states to fund these critical services. These changes have not been endorsed by Congress and NAMI would urge you and your colleagues to continue oversight efforts to hold CMS accountable for enacting these unauthorized and destructive changes. In the meantime, passage of HR 1663 will go a long way toward broadening access to intensive community-based services for Medicare beneficiaries – both elderly and non-elderly people with disabilities receiving SSDI – living with severe mental illness. Finally, NAMI also applauds the efforts of this legislation to address the shortage of mental health professionals in rural and medically underserved regions.

Parity for Private Sector Health Insurance Plans Should Be a Top Priority for the 110th Congress

Mr. Chairman, as you know Congress has been debating enactment of a federal standard for equitable coverage of mental illness treatment in group health insurance plans since ht early 1990s. This has included enactment of the Mental Health Parity Act in 1996 that required parity, but only for annual and lifetime dollar limits. Since 1996, various bills have been introduced – some of which made progress – to require full parity, i.e. by adding durational treatment limitations (limits on inpatient days and outpatient visits that apply only to mental illness) and financial limits (higher cost sharing, deductibles and out-of-pocket limits that apply only to mental illness).

Mr. Chairman, as you know there are separate House and Senate parity bills (S 558 and HR 1424) that have broad bipartisan support. While there are differences between the bills, they are remarkably similar.

The separate House and Senate bills contain a number of major similarities. Both bills:

1) Expand on the limited 1996 Mental Health Parity Act that requires equitable coverage for mental illness only with respect annual and lifetime dollar limits. Both expand on these requirements by requiring parity for treatment limitations (limits on inpatient days and outpatient visits that apply only to mental illness and substance abuse) and financial limitations (higher cost sharing, co-payments or deductibles that applied to mental illness or substance abuse treatment).
2) Impose a parity standard as a coverage condition, i.e. neither bill mandates coverage of mental health or substance abuse treatment, but instead requires that if mental health and substance abuse benefits are offered, they must be on equal terms with medical surgical benefits. In other words, both bills allow employers and health plans to avoid the parity requirement by simply dropping mental health and substance abuse coverage altogether.
3) Amend the laws governing self-insured ERISA plans and fully insured plans regulated by the states. This means that parity would reach the 82 million covered lives in self-insured plans that are beyond the reach of state parity laws. Likewise, both bills amend the federal Public Health Services Act (PHSA) to reach fully insured plans in states that have not passed parity laws. By amending both ERISA and the PHSA will ensure that parity reaches an estimated 130

million Americans (82 million covered lives in ERISA plans and 45 million in state regulated plans under the PHSA, 25 million of whom are in the 42 states with parity laws).

4) Achieve parity for both mental illness and substance abuse disorders, a major step forward for individuals with co-occurring mental illness and substance abuse disorders.
5) Exempt group health plans sponsored by small employers, those with 50 or fewer workers, from the requirements of parity coverage.
6) Allow for employers or group health plans to seek an exemption if cost rise more than 2% as a result of compliance with the parity requirement. Both require health plans to first comply with the law for 6 months before seeking this cost increase exemption, and both would require plans getting an exemption to come back into compliance the following year.

At the same time, there are differences between the House and Senate bills on a number of important issues. These differences include:

- Scope of Benefits – Whether or not to define a list of required mental health and substance abuse diagnoses that must be covered by all health plans, or whether to defer to health plans and employers to define mental health and substance abuse benefits as under current law.
- State Preemption – How a new federal standard for mental health and substance abuse parity should interact with the existing 42 state parity law, i.e. whether or not a new federal standard should displace all or part of a state law.
- Out-of-Network Coverage – Both bills require parity for out-of-network benefits (i.e., equal treatment limits and equal cost sharing). However, the House bill goes further and requires plans to have an out-of-network benefit for mental health and substance abuse if it exists on the medical-surgical side.

Mr. Chairman, NAMI has endorsed the Senate bill. It is product of significant work by all sides in this debate and has already been reported by the Senate Health, Education, Labor and Pensions (HELP) Committee by an 18-3 vote. The Senate bill also has the support of groups representing employers and health plans that have fiercely resisted parity legislation in the past. The House bill also has broad support, with more than 250 cosponsors.

In NAMI's view, these circumstances create an enormous opportunity for agreement from all sides --

- Democrats and Republicans in both the House and Senate,
- President Bush,
- Groups representing employers and health plans, and
- NAMI's colleagues among the advocacy groups representing consumers, families, providers and professionals.

This is the moment for mental illness and substance abuse insurance parity. The differences between the House and Senate bills are narrow and can easily be bridged if the political will is there among all sides. More importantly, the broad bipartisan support for this legislation exceeds that for any other major health care proposal in the 110th Congress. Enactment of mental illness parity will demonstrate that Congress and the President can come together to produce meaningful health care reform for the American people. It is imperative that equitable coverage for mental illness treatment reach the 82 million Americans in ERISA self-insured plans that are beyond the reach of the 42 state parity laws.

Conclusion

Mr. Chairman, thank you for convening this important hearing. NAMI looks forward to working with you to achieve enactment of both HR 1663 and S 558-HR 1402 this year.