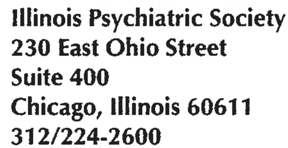

Illinois Psychiatric Society
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A District Branch of the
American Psychiatric Association

June 10, 2009

The Honorable Dick Durbin
309 Hart Senate Building
Washington, DC 20510

To the Honorable Dick Durbin:

We are writing to you on behalf of the Illinois Psychiatric Society (IPS) to share our views on what should be included in the healthcare reform bill. The Illinois Psychiatric Society is a medical specialty society with over 1,100 members.

1. **Pre-existing Illnesses Should not be Permitted as a Reason for Denial of claims:** At present, most psychiatric disorders are not curable but highly treatable. While symptoms may wax and wane for patients, the illness remains. Currently, insurance companies are permitted to deny coverage for claims (even if it is for a probationary period) based on preexisting illnesses. Thus, if a person with a psychiatric illness wants to switch jobs, they must be prepared to pay for visits with psychiatrists for the next 6 to 12 months and buy their medications out of pocket. The collateral damage that can be done during this period, including lower work productivity, divorce, and poor academic performance, has many larger financial ramifications for our society and businesses. One should not fear loss of healthcare benefits just because he or she wishes to switch jobs. Some people may not be able to afford such care and may decide to go without treatment. This may result in illness relapse or exacerbation. This system may eventually contribute to the strain emergency rooms already feel where care is expensive, inaccessible or denied.

2. **Adequate Psychiatric Care Coverage**: No plan can provide adequate coverage for the treatment of psychiatric disorders if visits are severely limited and medication formularies severely restricted. Although we realize tough decisions must be made in crafting health care reform legislation, we also are very aware of the impact of untreated or undertreated psychiatric illness on every aspect of society. The World Health Organization estimates that by 2012, the diagnosis responsible for the single most number of "life years" lost to disability is Major Depression worldwide.

3. **Post Partum Depression Screenings and Follow-up Care:** We advocate that Post Partum Depression (PPD) screening be required for all women post delivery and be covered by insurance. PPD occurs in 10% to 2096 of women who have given birth, but fewer than half of women suffering with postpartum depression re recognized, referred and treated. Further, PPD impacts not only the mother but her infant and entire family. Opportunities for routine PPD screening include mothers' *six* week postpartum office visits and their infants' well child visits. However, for screening to improve clinical outcomes, it needs to be combined with systems-based enhanced depression care that provides accurate diagnoses, strong collaborative relationships between primary care and

psychiatry, and longitudinal case management to assure appropriate treatment and follow-up.

Depression is common and costly, particularly for women in their childbearing years. The World Health Organization has identifiedmajor depression as the fourth leading cause of disease burden among all illnesses and the leading cause of years lived with disability, as stated above. It is estimated that depression costs the United States $30 billion to $50 billion in lost productivity and direct medical costs each year. The burden is greatest for women, with a lifetime risk for major depressive disorder of 20% to 25% approximately twice the 7% to 12% rate seen with men. In the first 3 months after child birth, 14.5% of women have a new episode of major or minor depression, and 10% to 20% of mothers are believed to suffer with depression sometime during their postpartum course, making postpartum depression the most common serious postpartum disorder.

Children of depressed mothers are more likely to have delayed psychological, cognitive, and neurological development, and are at higher risk of avoidance and distressed behavior. Compared with non-depressed mothers, depressed mothers report a 3-fold greater frequency of serious emotional problems in their children and a 10-fold greater risk of having poor mother-child attachment. Poor mother infant attachment then results in a vicious cycle that increases the likelihood of chronic psychiatric morbidity and poor family functioning. Children's behavioral difficulties associated with maternal depression may continue throughout life. These children tend to use more health care resources for a broad spectrum of concerns. Fortunately, remission of maternal depression is associated with reductions in children's mental and behavioral disorders [1]and postpartum depression screening is a primary prevention tool.

4. **<u>Improved Reimbursement Rates for Psychiatrists</u>**: In Illinois, and throughout the United States, access to psychiatric care is an issue. Access to care involves two aspects. Mental health care in rural areas can be difficult to obtain regardless of the type of mental health care provider sought. Illinois has recognized that the access to care issue cannot be solved by persuading psychiatrists and other mental healthcare providers to locate to rural areas. Therefore, Illinois now requires that Medicaid pays for telepsychiatry services. Telepsychiatry is a successful method for providing excellent psychiatric care to those in rural and underserved areas and should be considered as a nationwide initiative.

   The second aspect of access to care involves reimbursement. In Illinois, Medicaid reimbursement rates for psychiatrists are approximately 60% of those for Medicare. Psychiatrists, like all physicians, enter practice with substantial student debt (on average $150,000) due to four years of medical school and four years of residency. This debt must begin to be paid starting in residency when salaries are quite low. For residents who choose to go into a lower paying specialty, such as psychiatry, to pay back student loans, support their families and establish a practice, many must severely limit the number of Medicaid patients they can see. This is also happening with Medicare. Therefore, unless reimbursement rates for psychiatrists are considered on par with other

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[1] Postpartum Depression Screening: Importance, Methods, Barriers and Recommendations for Practice, Dwenda K. Gjerdingen, MD, MS and Barbara P. Yawn, MD MSc, the Journal of American Board of Family Medicine, *20 (3):* 280-288 (2007).

specialties that include much primary care coordination, access to care for patients will remain an issue.

5. **Prior/Pre-authorization Should Not Be Required for Psychiatric Medications:** Currently, psychiatrists may be required to obtain prior authorization for medications for their patients. Patients respond to medications differently. Thus, with health care reform, it is in the best interest of patients to establish sophisticated formularies that do not require psychiatrists to seek prior authorization for medications that are on the formulary or that a patient has been stable on for some time. As a specialty, we are trained to understand individual differences in how medications are metabolized, are efficacious, and may be tolerated differently by different ethnicities. It is demoralizing for physicians trained in psychopharmacology and builds in an expensive and unnecessary layer of bureaucracy to ask permission to prescribe a medication for persons with little or no training in psychiatry. We view this as another mechanism for insurance companies to withhold payments and cause a delay for patients getting their medication. Additionally, these requirements take time away from direct patient care, a far more important use of psychiatrists' time.[2]

6. **Elimination of Pharmacy Benefit Management (PBM):** Access to medications is a key component of health care for psychiatrically ill patients. Without access to the medications, patients with psychiatric illness cannot lead productive lives. When patients are denied access to appropriate medications, or are required to use ineffective medications, additional societal costs are incurred such as over reliance on emergency room services, reliance on public assistance, and commission of crimes.

   A recently released study entitled, "Medicaid Prescription Drug Policies and Medication Access and Continuity Findings from Ten States"[3] shows that certain state Medicaid practices intended to save money were associated with increased adverse outcomes among mentally ill patients. Five types of prescription drug utilization management features were studied: use of preferred drug or formulary list; prior authorization; requirements to switch to generics; limits on the number or dosage of medications; and use of step therapy or fail-first protocols. Statistics gathered from patients with many psychiatric diagnoses were controlled for sociodemographic and clinical variables. This study found that patients with medication access problems from any of the above mentioned utilization management tactics had a 3.6 times greater likelihood of adverse events. Adverse events included increased emergency visits, psychiatric hospitalizations, homelessness, suicidal ideation or attempts, or incarceration. Overall 56.7% of patients with state systems that required utilization management protocols reported medication access or continuity problem; among patients without prescription drug utilization management, 13.6% had a medication access problem.

   We have grave concerns that attempts to save money by limiting access to psychiatric medications will actually result in increased costs to the state and tragic consequences to patients. We understand and support the need for savings, but a new approach that allows physicians to practice medicine and that cuts out the middle layer of interference may be the most streamlined approach. It is our understanding, based on comments by the Executive Director of the Illinois Pharmaceutical Association, that PBMs are the beneficiaries of cost savings from pharmaceutical benefit management rather than the State or Federal Government healthcare programs.

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[2] "Medicaid Prescription Drug Policies and Medication Access and Continuity Findings From Ten States," Joyce C. West PhD, M.P.P. et al, Psychiatric Services, May 2009, Vol. *60,* No. *5.*

[3] Id.

One alternative to consider for accomplishing the goal of pharmacy savings, while not resulting in unintended consequences for patients, is to utilize a technique called "audit and feedback." Audit and feedback is a demonstrated educational method of changing prescribing behavior to be in keeping with appropriate use while reducing costs and not resulting in unintended consequences for patients. This method has been used in Illinois by Your Healthcare Plus (YHP) and Comprehensive Neuroscience Inc. (CNS). [4]The Illinois Psychiatric Society has worked closely with YHP and CNS to make sure that the appropriate clinical indicators are used to evaluate physician prescribing of psychotropic medications.

It is important to note that in general medicine, research has suggested that such managed care techniques can result in significant cost savings with little evidence of unintended financial or clinical consequences. However, this research does NOT exist for psychiatric care and models that are based on other areas of medicine are not adequate to the specialty of psychiatry and the care of our patients. With the fragile state of our public mental health system, we urge your wisdom in the development of new healthcare delivery systems that are far sighted. A "penny wise and pound foolish" approach to these complicated issues that are at the interface of psychiatry, society and justice would be deadly. [5]

7. **Eliminate 2 year waiting period for Medicare Benefits:** When Medicare expanded in 1972 to include individuals with significant physical and psychiatric disabilities, Congress stipulated that people with disabilities must first receive Social Security Disability Insurance (SSDI) before gaining Medicare eligibility. This reason the waiting period was included was to keep costs down and to avoid replacing coverage for a disabled worker still receiving benefits under a private group health plan.

   Individuals with disabilities must undergo a lengthy process before receiving Medicare coverage. First, the Social Security Administration must make a determination of SSDI approval. Second, individuals with disabilities must wait five months before receiving SSDI benefits. Finally, after receiving their SSDI benefits, individuals must wait an additional 24 months before they receive Medicare coverage.

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[4] http://www.chcs.org/usr_doc/bh_pharmacy.pdf

[5] Instead, people in the Medicare waiting period generally obtain coverage if they qualify for Medicaid, or if they can pay the premium to continue under their former employers plan under COBRA. According to a July 2003 Commonwealth Fund Report, nearly 39% of these individuals do not have health insurance coverage at some point during the waiting period and 24% have no health insurance during this entire period. (Elimination of Medicare's Waiting Period for seriously Disabled Adults: Impact on Coverage and Costs, The Commonwealth Fund, July 2003). study examining coverage during the waiting period for Americans aged 55-64 found that of those without coverage, about half were uninsured prior to the waiting period. The loss of employer coverage accounted for 36 percent of the uninsured, and 4% had lost the Medicaid coverage they had prior to the waiting period due to their SSDI cash benefit. (Transitioning to Medicare Before Sixty-Five, Health Affairs, March 2008). For those with COBRA or other private coverage at some point during the waiting period (58% of individuals 55-64) the costs are very high: For the first 18 months, the premium for continuing health insurance coverage through COBRA costs up to 102 percent of the total cost of coverage (full premium plus a 2% administrative fee). It is common that during these 24 months, vulnerable individuals will lose their health insurance because they can no longer afford their COBRA or other private health insurance plans.

An estimated 1.8 million people with permanent disabilities are caught in this waiting period for Medicare. Since SSDI recipients are unable to work, they cannot access the principal source of coverage for people under 65--employer sponsored insurance.

Up to 40% of these individuals do not have health coverage. For individuals with severe and persistent mental illness (SMI), this gap in coverage can lead to tragic results. Congress has already acknowledged that the 24-month waiting period for people with amyotrophic lateral sclerosis (Lou Gehrig's disease) and for endstage renal disease for which a lack of treatment is fatal.

The Ending the Medicare Disability Waiting Period Act of 2007, sponsored in the 110th Congress by Senator Jeff Bingaman (S. 2101) and Rep. Gene Green (H.R. 154) phases out the two year waiting period over ten years. The bill also would immediately eliminate the wait for people with life threatening illnesses.

As Congress approaches healthcare reform, we would ask that the two year Medicare waiting period be eliminated or phased out for those with permanent or severe disabilities. No one with disabilities significant enough to qualify for SSDI should be without health insurance. Eliminating the 24-month Medicare waiting period for individuals who qualify for SSDI will cost the federal government $1 13 billion over ten years, while decreasing federal Medicaid spending by about $32 billion over the same period. This option would boost tax revenue by about $3 billion over the ten year span because of lower health insurance costs for employment-based plans, bringing the net deficit to about $1 10 billion. Reducing the wait for Medicare coverage to twelve months would cost $65 billion, according to a recent analysis of health policy options by the Congressional Budget Office *(Budget Options, Volume 1. Health Care* Congressional Budget Office, December, 2008).

When instituted in 1972, the waiting period was intended to limit Medicare costs. However, providing health insurance to those in the waiting period may reduce Medicare spending for these individuals over the long term. Many individuals forgo medical treatments, stop medications, and further compromise their health during these twenty-four months, which can lead to higher *costs* of care once covered. Tragically, 4% die during their wait for Medicare coverage. In addition, those with SMI who are unable to access psychiatric care and medications, will end up in either emergency room where their care will be very expensive or they will end up in jail or prison where care for them will be far costlier than care for them in the community.

A study examining previously uninsured adults who enroll in Medicare because of age, found these individuals required more intensive and costlier care than those previously insured:

- Previously uninsured individuals reported 20% more hospital visits;
- Medical expenditures were 1.87 times higher than previously insured adults.[6]

8. **Interrelationship between Prison and the Community:**

The Prison Medicaid Law has passed both houses in Illinois and is awaiting the Governor's signature. Illinois, as in many states, has not adequately funded mental health care. Patients that could be kept in community mental health clinics may now end up in the custody of the Department of Corrections. Often patients with psychiatric illnesses,

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[6] *Use of Health Services by Previously Uninsured Medicare Beneficiaries,* New England Journal of Medicine, July 2007

and others with chronic health conditions, have Medicaid benefits that are terminated upon entry into prison *or* jail system. Upon discharge, the ex-offender is required to reapply for Medicaid benefits and this process takes, at a minimum, three months. During this period, patients do not have coverage for medications or medical visits. Patients with psychiatric illness may receive mental health care for the first time in prison or jail. During the three month waiting period, patients may decompensate and return to the behaviors that resulted in prison originally. The new law in Illinois will require that when offenders with Medicaid benefits enter prison or jail that these benefits will be suspended and they will be reinstated upon discharge thereby creating continuity of care for the patient. This law will also help patients with other chronic conditions such as diabetes, asthma, cardiac disease, HIV, etc. The Centers for Medicare and Medicaid (CMS) have supported this initiative from a national perspective. Also, since more women have Medicaid benefits, this initiative will have a significant impact on women's health and allow immediate access to contraception, pregnancy care, and wellness care.

9. **Domestic Violence:** The members of the Illinois Psychiatric Society would like to voice their support for the rights of immigrant victims of domestic violence, under VAWA, to self petition in order to establish their immigration status. In recent years, there has been a trend toward requiring affidavits from licensed clinicians documenting the extent of trauma these women have suffered. IPS recognizes that most agencies serving domestic violence victims are staffed by highly trained advocates who can provide appropriate documentation of the level of abuse and trauma experienced by immigrant victims of domestic violence. In addition, insurance, or some other safety net as a part of health care reform must include reimbursement or funding for social service positions that could help women be protected and diminish future hospital visits and utilization of medical resources.

10. **Substance Use Disorders should be covered by Healthcare Reform:**
Substance use disorders (SUDs) have been recognized as addictions and are therefore covered as a psychiatric illness under the Diagnostic and Statistical Manual of Mental Disorders IV. Historically, SUDs have been subject to even a greater stigma than other psychiatric illnesses because society has perceived these disorders to be completely within the control of the individual rather than other psychiatric illnesses which have been recognized to be biologically based disorders. Clearly, science has proven this contention to be false. Addictions, like other psychiatric illnesses, are treatable and with help recovering addicts can become functioning members of society rather than persons who must commit crimes to fuel their addictions or treat psychiatric illness themselves. It is far more cost effective to treat persons with addictions than to house them in prisons and jails. Thus, SUDs should be covered by any health care reform bill

We welcome the opportunity to work with Congresswoman Schakowsky to provide quality care to the citizens of the United States with serious psychiatric disorders and their families. Thank you for providing this opportunity for the IPS to share its concerns with you.

Sincerely,

Lisa Rone, MD
President, Illinois Psychiatric Society