



AMERICAN
PSYCHOLOGICAL
ASSOCIATION

May 22, 2009

The Honorable Max Baucus, Chairman
Committee on Finance
United States Senate
Washington, DC 20510-6200

The Honorable Charles E. Grassley, Ranking Member
Committee on Finance
United States Senate
Washington, DC 20510-6200

Re: Senate Finance Committee Health Care Reform Policy Options (#2)—*Expanding Health Care Coverage: Proposals to Provide Affordable Coverage to All Americans*

Dear Chairman Baucus and Ranking Member Grassley:

On behalf of the 150,000 members and affiliates of the American Psychological Association (APA), I would like to thank you for the opportunity to provide comments regarding the health care reform policy options paper released by the Committee on Finance on May 14, 2009. APA is the largest scientific and professional organization representing psychology in the United States and is the world's largest association of psychologists. Comprised of researchers, educators, clinicians, consultants, and students, APA works to advance psychology as a science, a profession, and a means of promoting health, education and human welfare.

The comments that follow highlight APA's views concerning key issues addressed in the second policy options proposal in the order in which they appeared in the document. *Our most important recommendations relate to the importance of: including mental health and substance use services as a separate, required Medicaid benefit category; making psychological services a mandatory Medicaid benefit; promoting an integrated care model of interdisciplinary teams of health care professionals in primary care and other health care settings; recognizing the unique service needs of special populations, such as children, older adults, ethnic minorities, lesbian, gay, bisexual, and transgender persons, and individuals with disabilities; increasing access to a range of preventive and wellness services; and conducting comprehensive data collection.*

We hope that you will carefully consider these recommendations as you continue to develop legislation to reform our nation's health care system.

SECTION I: Individual Market Reforms

Non-Group and Micro-Group Market Reforms

Older Adults. APA strongly supports eliminating the practice of denying individuals health coverage for pre-existing medical conditions or charging them higher premiums because of their health status. At the same time, we are concerned that allowing health insurance companies to charge older consumers up to five times more than younger adults based on their age in the non-group, micro-group, and small group markets (the 5:1 rating rules) may result in many older adults not having access to affordable, quality coverage. In addition, age rating is also a concern because advancing age is strongly associated with declines in health status. As individuals age, they are more likely to experience one or more chronic health conditions. It seems counterintuitive to prohibit insurance rating on health status, yet allow rating based on age, which would have the same effect.

SECTION II: Making Coverage Affordable

Benefit Options

APA commends the Committee for including mental health and substance abuse services, at parity, in the broad range of benefits required of all health insurance plans in the non-group and small group market.

APA opposes cost-sharing for prevention services, but if cost-sharing must be imposed we support placing “mental health and substance abuse services” as a separate category of benefits. The new proposed option would list: (1) inpatient hospital, (2) outpatient hospital, (3) physician services, (4) mental health and substance use services, and (5) other items and services. Under each plan’s design, there would also be a requirement to apply parity to treatment limitations as well as cost-sharing of conditions.

SECTION III: Public Health Insurance Option

Establishment of a public health insurance option will probably result in high enrollment of individuals who previously lacked coverage and delayed treatment for pre-existing conditions. These individuals are likely to present with a variety of physical and mental health problems that will be challenging for providers to address. If Medicare providers are required to participate in the public health plan, it is critical that they receive additional payment for providing services to this population. Without such an incentive, providers may decide to abandon the Medicare program altogether.

Regardless of which option is chosen, payments for services under the public health insurance plan must not devalue reimbursement in the private market.

SECTION IV: Role of Public Programs

Health Policy Changes Affecting Working Individuals with Disabilities. Many people with significant disabilities are discouraged from working because their health care coverage is tied to federal programs with income and/or asset-related limits on cash benefit eligibility or the private policies’ higher premiums make it cost prohibitive.

To this end, APA recommends the following:

- Health insurance premium costs should be considered an impairment-related work expense and deductible on the tax returns of working people with disabilities because of the higher premiums they must pay for health insurance coverage.
- Private long-term disability insurance policies should no longer require those covered to apply for federal disability benefits. This requirement forces people with disabilities to leave the workforce permanently to receive their private long-term disability benefits.
- The federal government's long-term care insurance policies should be changed to offer coverage to federal employees with disabilities. Currently, federal employees who have a disability must stop working to receive long-term care benefits under Medicaid.

Medicaid Coverage

Disability and Medicaid Limitations. The minimum recommended benefits package for private insurance must contain appropriate supports and services for people with disabilities. Otherwise, these individuals will be forced to remain on public benefit programs just to obtain appropriate health insurance coverage and access to the services and supports they need to survive.

APA supports the following recommendations to address these potential problems:

- Either increase or eliminate Medicaid's assets and resource limits. These limitations have not been increased since 1974. Combined with the additional costs incurred by individuals with disabilities for services and supports necessary to manage their impairment and maintain health and independence, it is of little surprise that poverty is one of the critical challenges faced by people with disabilities and that these provisions act as a disincentive to work.
- States should be required to establish Medicaid buy-in programs or deemed Medicaid eligibility should be provided to Title II beneficiaries up to the current buy-in earnings levels. This latter change is especially important for individuals receiving SSI who wish to use the program's work incentives.
- Raising the eligibility age for the Medicaid buy-ins would make it consistent with Social Security's normal retirement age.

Medicaid vs. Medicare Reimbursement. States currently have broad authority to establish provider payment rates under Medicaid. However, surveys report that Medicaid pays 58 percent of private pay. As a result, service providers in private practice find they must limit their number of Medicaid patients and patients find it difficult to access care. The difference in reimbursement rates between Medicare and Medicaid has created a disparity in the quality and accessibility of services provided. APA supports the Committee's option that seeks to link payments to providers under Medicaid to payments to providers under Medicare. However, we support equivalent percentage of Medicare reimbursement rates for the same or similar services in Medicaid. APA strongly supports this equivalency to prevent the potential disparate impact and unintended discrimination based on which public program an individual participates.

Children's Health Insurance Program (CHIP)

Medicaid's Early and Periodic, Screening, Diagnostic and Treatment Services (EPSDT). APA is concerned with the proposed option that CHIP enrollees would obtain their primary coverage through the Health Insurance Exchange with CHIP serving as a secondary payer. States would arrange coverage for health services of an amount, type and scope that exceeds or falls outside the limits of the Health Insurance Exchange coverage, such as EPSDT.

EPSDT requires that all Medicaid beneficiaries under age 21 receive all necessary services listed in section 1905(a) of the Social Security Act to correct or ameliorate physical or mental disorders and conditions, regardless of whether those services are covered under a state's Medicaid plan.

APA is concerned that this provision could significantly decrease access to critical services and could potentially create additional confusion and complexity for families attempting to navigate the provision of health care services for their children. In addition, this may result in a fragmentation of service delivery.

Other Improvements to Medicaid

Treatment of Selected Optional Benefits. Psychological services should be a mandatory Medicaid benefit so that all beneficiaries may access valuable testing and assessment, psychotherapy, and other mental and behavioral health services. While currently optional, 31 states now recognize that mental and physical health are inter-related and cover various services by psychologists in their Medicaid plans. By not making psychological services a mandatory Medicaid benefit, this proposal fails to acknowledge the role of psychologists in integrated health care and deprives many Medicaid beneficiaries of critical mental and behavioral health services.

Medicare Coverage

Medicare Waiting Period. APA appreciates the policy options presented in this section. The two-year wait for Medicare puts effective treatment and care for people with significant disabilities at risk. Many forgo treatment and stop taking medications, compromising their already fragile health and resulting ultimately in conditions that are often more costly to treat when Medicare coverage finally begins.

APA supports Approach 3, which would reduce the waiting period in six month increments, with complete elimination after one-and-a-half years. Approach 2, which would phase-out the waiting period by 2015, is the next best option. It is critical that the waiting period be eliminated and that the phase-out period be utilized as the chief mechanism to accommodate budgetary pressures. As such, APA opposes Approach 1 which retains a 12-month waiting period. APA is concerned with Approach 4, which would maintain the waiting period for people with access to private insurance that meets or exceeds an actuarial standard. An actuarial standard does not guarantee that coverage is affordable, nor does it ensure that out-of-pocket costs for health care are limited, particularly to the majority of people with disabilities with low incomes. In addition, private coverage that meets an actuarial standard may still have benefit caps or restrictions on services vital to people with disabilities.

Medicare and Working People with Disabilities. APA commends the Committee on their recognition of the difficulties faced by older adults between the ages of 55 and 65. APA also urges the Committee to consider the impact of health reform changes on individuals with disabilities who are beneficiaries of the Medicare program.

As such, APA has the following recommendations to ensure that individuals with disabilities have the ability to participate in the workforce without the potential disincentive of losing critical health-related services and supports:

- Beneficiaries who are employed should retain permanent premium-free access to the Medicare program. Providing continued attachment to Medicare for working beneficiaries would ensure on-going eligibility for health care. Some beneficiaries, based on their earnings, should have the ability to obtain this coverage through a buy-in program.
- The “in the home” rule under Medicare policy for durable medical equipment (DME) should be eliminated. Recipients of SSDI who rely on devices and technology for independent living should not risk violating the law if they use their DME to go to work.

SECTION VI: Options to Improve Access to Preventive Services and Encourage Healthy Lifestyles

Promotion of Prevention and Wellness in Medicare/Medicaid

Beneficiary Cost-Sharing for Preventive Services. APA greatly appreciates the Committee’s leadership in including a proposed option to authorize a personalized prevention plan for all Medicare-enrolled beneficiaries and supports the Committee’s recommendation that no co-payment or deductible apply. Under traditional Medicaid, States may impose on beneficiaries certain costs, such as enrollment fees, premiums, deductions, and cost-sharing.

Research studies have shown that higher copayments generally cause low-income individuals and families to reduce their use of health care services, including screening, prevention and wellness services. This can result in subsequent use of costlier forms of care, such as hospitalizations and emergency room visits. APA urges the Committee to consider the removal of cost-sharing for preventive and wellness services under Medicaid.

Included Prevention and Wellness Services. APA is concerned about requiring that the recommendations of the U.S. Preventive Services Task Force (USPSTF) be used to determine coverage decisions for appropriate screening, prevention, and wellness services for both Medicare and Medicaid. The USPSTF’s recommendations have traditionally been limited to research based on clinical preventive services delivered to an individual before being diagnosed with a disease. Preventive services utilized post-diagnosis to prevent worsening of the condition, to prevent complications, or to prevent co-morbidity with other health conditions should also be included. These preventive measures can be very important to maintaining health and productivity, particularly with regard to individuals with disabilities, children, older adults, and those with chronic conditions.

The USPSTF relies on scientific evidence from multiple large, well-conducted, randomized clinical trials (RCTs). However, for policy recommendations purposes, it should be noted that many valuable preventive interventions will never be evaluated in an RCT because a trial may be too expensive or recruiting different types of individuals, such as children, individuals with disabilities, and ethnic minorities, might not be feasible.

Relying solely on a USPSTF recommendation of “A” or “B” for making suggestions, either for provider action or for coverage, may lead to a limited pool of preventive services being available and accessible to patients and decrease the responsiveness of the health system

to secondary health conditions. APA strongly urges the Committee to include provisions ensuring that when the USPSTF's recommendation falls into the "I" (insufficient evidence to recommend for or against) category, it will not automatically result in denial of coverage.

In addition, many health professions and organizations have built upon the approach adopted by the USPSTF in developing appropriate clinical guidelines for preventive services based on surrogate data markers to determine efficacy of a preventive service. APA supports the utilization of such guidelines to expand coverage of preventive services beyond those that meet the current criteria used by USPSTF. This would enhance opportunities to prevent costly chronic health conditions and decrease health disparities for certain vulnerable populations.

Specific Preventive Services. APA urges the Committee to include postpartum depression screening as an approved Medicaid benefit and educate Medicaid beneficiaries about the importance of postpartum depression screening and treatment.

Options to Prevent Chronic Disease and Encourage Healthy Lifestyles

Structural Accessibility. People with disabilities consistently face such barriers as architectural inaccessibility, a lack of accessible examination tables and diagnostic equipment, difficulty scheduling specialist referrals, and refusals to provide reasonable assistance and translation of spoken and written words. Widespread and systemic inaccessibility translates into drastically reduced levels of basic health care. For example, 41 percent of women without disabilities have received a Pap smear, and 44 percent have had a mammogram. These same figures are respectively 23 percent and 13 percent for women with disabilities. APA strongly supports additional assurances, funding and oversight to ensure that general population prevention and wellness programs, including equipment, have full communication accessibility, are designed with maintaining function in mind, and are implemented in a way that meet the structural and programmatic accessibility requirements of the *Americans with Disabilities Act* and Section 504 of the *Rehabilitation Act*.

Prevention and Wellness Innovation Grants

APA applauds the Committee's focus on prevention and wellness and strongly supports the inclusion of efforts to promote interdisciplinary team-based health care. The establishment of locally integrated delivery systems that include support for interdisciplinary health care teams is critically needed. Such interdisciplinary community health teams must include mental and behavioral health professionals, including psychologists.

Integrated health care, often referred to as interdisciplinary 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 of information among team members related to patient care and the establishment of a comprehensive treatment plan to address the biological, psychological, and social needs of the patient. The interdisciplinary health care team includes a diverse group of members (e.g., physicians, psychologists, social workers, and occupational and physical therapists), depending on the needs of the patient.

The benefits of an integrated health care approach extend to patients, caregivers, providers, and the larger health care system. For instance, research indicates that integrated health care is effective in reducing depressive symptoms. Further evidence suggests that coordinated care, which integrates psychologists and other mental health providers within primary care, can enhance access to services, improve quality of care, and lower overall health care expenditures.

Integrated health care delivery can occur in multiple settings to benefit individuals across the lifespan. These settings include: primary care, specialized medical settings (e.g., rehabilitation units, cardiology, and surgical centers), long-term care settings, and community-based health and social service sites. The integrated health care team often functions differently according to the setting. However, mutual respect and communication are critical at all sites.

Psychologists make a variety of important contributions to the integrated health care team, including:

- Conducting cognitive, capacity, diagnostic, and personality assessments that differentiate normal processes from pathology, side effects of medications, adjustment reactions, or combinations of these problems;
- Offering behavioral health assessment and treatment that provide individuals with the skills necessary to effectively manage their chronic conditions;
- Diagnosing and treating mental and behavioral health problems (e.g., depression, suicide risk, anxiety disorders, addiction, and insomnia);
- Offering consultation and recommendations to family members, significant others, and other health care providers;
- Contributing research expertise to the design, implementation, and evaluation of team care and patient outcomes;
- Developing interventions that are responsive to specific individual and community characteristics that may impact the treatment plan.

Innovative Approaches to Promote Prevention and Wellness. Given the increasing number of scientific studies indicating that lesbian, gay, bisexual, and transgender (LGBT) individuals are at greater risk than the general population to experience physical and mental health problems, and that health care disparities affecting sexual minorities have been recognized by several federal agencies, including SAMHSA, HRSA, CDC, and NIH, the Committee should create health promotion grant programs promoting targeted specifically to the lesbian, gay, bisexual, and transgender communities. Such prevention and wellness programs should incorporate a compassionate and comprehensive understanding of the particular health care issues experienced by this population. Through evaluation and impact assessment of such grant programs, it will also be possible to better explain why the majority of gay, lesbian, bisexual, and transgender individuals lead healthy lives, despite the unique stressors they face related to prejudice and discrimination.

Community Prevention. Improving health through prevention requires awareness of environmental factors that affect individuals and families, and requires participation of health, education and human services providers. Several federal entities issue recommendations for preventive services, including the USPSTF at the Agency for Healthcare Research and Quality, and the Advisory Committee on Immunization Practices at CDC. To achieve a coordinated national strategy for establishing wellness and disease prevention as a major focus of the nation's health care system, APA recommends efforts to ensure improved coordination of federal agencies devoted to identifying, developing, and recommending evidence-based preventive health services and programs. Provisions for community preventive services

that would improve the health of the population as a whole such as walkable streets, curb cuts, accessible recreation facilities, clean water programs, and sustainable community designs must have a role in encouraging healthy lifestyles.

Investment in primary prevention strategies such as incentives to States to increase seat belt usage, motorcycle helmet use laws for all riders, helmets for bike riders; or education and awareness programs on issues such as shaken baby syndrome and preventing falls among older adults, offer unique opportunities to directly address injury prevention. In addition, funding for acute and post-acute rehabilitation helps individuals to restore/maintain physical, cognitive and emotional functioning. These are examples of preventative strategies that can minimize further harm after an initial injury has been sustained.

SECTION VIII: Options to Address Health Disparities

Required Collection of Data

National Plan. APA strongly supports the development of a national strategic plan regarding research to improve health care and eliminate health care disparities among underserved and other health disparity populations. This would include the implementation of research into scalable programs to positively impact individuals experiencing health disparities.

Racial and Ethnic Minorities. APA commends the Committee on its inclusion of Section VIII to address issues involving health disparities. Research demonstrates critical racial and ethnic disparities in mental health status, service provision, and outcomes, with minorities receiving less mental health treatment that is of a lower quality, resulting in poorer outcomes. APA strongly supports the collection and submission of self-reported data by geographic location, socioeconomic status (e.g., such indicators as employment, income, and education), primary language, disability, age, gender and gender identity, sexual orientation, and, when determined practicable, health literacy; and also the collection and submission of self-reported data on additional subpopulation groups, including cultural identification and ancestry that can be aggregated into the minimum race and ethnicity data categories.

Disability. Individuals with disabilities are more likely to experience early deaths, chronic conditions, and preventable health problems. In addition, individuals with disabilities report greater unmet health care needs than the general population and receive fewer routine and preventive services, such as blood pressure checks, cholesterol screenings, and cancer screenings. APA supports the recognition of disability as a demographically identifiable group which should be included within discussions of health and health care disparities along with other demographic categories such as race and ethnicity.

In addition, federal health surveys regularly track health indicators for the general U.S. population, including health risk behaviors/indicators such as smoking and lack of exercise, and the availability and administration of preventive medical exams/screenings/services such as mammograms, colonoscopy exams, and flu shots. People with disabilities must be included within data collection for these indicators. Furthermore, additional research is needed about whether the tracking of wellness and prevention for people with disabilities is sufficiently captured by these same general indicators. This should also include documentation of environmental barriers and clinical failings in the health care experience that may be unique to people with disabilities.

LGBT Populations. Health surveys commissioned by the federal government are instrumental in assessing and addressing health disparities in subpopulations. Sexual minorities should be included among the populations experiencing health care disparities, due to the adverse health effects of the stigma associated with being an LGBT individual. To this end, APA recommends that national health surveys consistently include data collection on sexual orientation and gender identity. This would enable government agencies to better understand and plan for the unique health needs of LGBT individuals. For example, the National Health Interview Survey is the most comprehensive and widely referenced federal health statistics survey, yet currently does not include any question relating to sexual orientation and gender identity. In addition, health information technology systems should ensure patients' privacy concerning sexual orientation and gender identity, to ensure that health care providers cannot use such information to discriminate against a member of a sexual minority group.

Language Access

APA strongly supports the Committee's proposed option to extend the 75 percent matching rate for translation services to all Medicaid beneficiaries for whom English is not their primary language, and would establish standards for culturally and linguistically appropriate services for private insurers in the Health Insurance Exchange. In addition, APA commends the Committee for supporting the establishment of grants for outreach and enrollment efforts to fund, for example, multi-lingual helplines and for data collection efforts.

Elimination of Five-Year Waiting Period for Non-Pregnant Adults

APA also commends the Committee for the proposed option that would add non-pregnant adults to the list of Medicaid beneficiaries for whom states would be permitted to waive the five-year bar to extend Medicaid coverage.

In closing, we would like to thank you once again for the opportunity to provide comments on this critically important proposal and for your ongoing efforts to reform our nation's health care system. For additional information or assistance, please contact Annie Toro, J.D., M.P.H., in our Public Interest Government Relations Office, at (202) 336-6068 or atoro@apa.org.

Sincerely,



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