Mental Health Liaison Group

June 23, 2017

The Honorable Lamar Alexander
Chairman
Senate Health Education Labor and
Pensions (HELP) Committee
455 Dirksen Senate Office Bldg.
Washington, DC 20510

Hon. Patty Murray
Ranking Member
Senate Health Education Labor and
Pensions (HELP Committee)
154 Russell Senate Office Bldg.
Washington, DC 20510

Dear Chairman Alexander and Ranking Member Murray:

The Mental Health Liaison Group (MHLG) wants to express our serious concerns regarding the provisions of H.R. 1628, the American Health Care Act. We want to especially voice our opposition to the restructuring of the Medicaid program into a per capita cap block grant program and to the end to Medicaid expansion. Medicaid is the major source of Federal funding in every state for mental health and substance use services, and expansion has been a significant driver in the expansion of both mental health and substance use services within Medicaid.

We also have grave concerns regarding the provisions eliminating essential benefits in Medicaid alternative benefit plans, and provisions allowing states to determine via an apparently *pro forma* waiver what benefits are deemed essential in marketplace plans and what the permitted range of insurance premiums should be. We are concerned that these provisions would result in an elimination or reduction in currently required coverage for prevention and treatment of mental illness and substance use disorders for both children and adults, and/or make coverage for those services unaffordable in combination with the reduced Federal insurance credits included in the legislation. We oppose as well provisions that would significantly reduce the Federal premium assistance that enrollees receive from the Federal government to maintain continuous insurance coverage, and the provision that would impose a significant penalty for not maintaining continuous coverage. We do not believe that the one-time funding mechanisms provided in the bill or being discussed in the Senate to reimburse insurers for high-cost and older enrollees will be adequate to ensure that premiums remain low enough so that those enrollees can remain insured over time.

The MHLG is a coalition of more than 60 national organizations representing consumers, family members, mental health and substance use treatment providers, state behavioral health agencies, advocates, payers, and other stakeholders committed to strengthening Americans' access to mental health and substance use services and programs. We specifically request the concerns expressed in this letter be taken into consideration in any Senate revisions to H.R. 1628.

The elimination of Medicaid expansion under the AHCA would leave without coverage the 1.3 million childless, non-pregnant adults with serious mental illness who were able, for the first time, to gain coverage under Medicaid expansion. It would also leave uncovered the 2.8 million

childless, non-pregnant adults with substance use disorders who gained coverage under expansion for the first time. These are populations that Congress promised and worked to serve with the passage of the 21st Century Cures Act and the Comprehensive Addiction and Recovery Act (CARA) of 2016, respectively. And it is important to remember that untreated mental health and substance use disorders intensify and serve to increase the number of co-morbid medical conditions in those populations, thereby multiplying total Medicaid program costs.

Medicaid is the single largest payer for behavioral health services in the United States, accounting for about 29 percent of state mental health agency spending, and is the largest source of funding for the country's public mental health system. The Congressional Budget Office last estimated, on May 24, that the Medicaid provisions of the AHCA would reduce Medicaid funding over 10 years by $834 billion. CBO also estimated that, by 2026, 14 million people–one in five of Medicaid's 70 million enrollees—would be thrown of the Medicaid rolls. Coincidentally, the same number of Medicaid enrollees live with mental illness or substance use disorders and depend heavily on Medicaid services.

Reducing Medicaid funding by such a significant amount percent over 10 years will force states to determine which Medicaid services should be covered, and could very well leave many low-income Americans with mental illness and substance use disorder without access to medically necessary prevention and treatment services. Former Michigan Medicaid Director and consultant Vernon K. Smith estimates states will have to increase their spending on average by 37 percent by 2026 in order to maintain benefits at today's levels.

Medicaid covers a broad range of behavioral health services at low or no cost, including but not limited to psychiatric hospital care, case management, day treatment, evaluation and testing, psychosocial rehabilitation, and medication management, as well as individual, group and family therapy. In three dozen states, Medicaid covers essential peer support services to help sustain recovery. In states that have expanded Medicaid and which have been particularly hard hit by the opioid crisis, such as Kentucky, Pennsylvania, Ohio, and West Virginia, Medicaid pays between 35 to 50 percent of medication-assisted treatment for substance use disorders. Additionally, because people with behavioral health disorders experience a higher rate of chronic physical conditions than the general population, Medicaid's coverage of primary care is critical to helping this population receive needed treatment for both their behavioral health and physical health conditions.

Converting Medicaid into a per capita cap block grant program will shift significant costs to states over time. Ultimately, states will be forced to reduce their Medicaid rolls, benefits, and already low payment rates to an already scarce workforce of behavioral health providers. Mental health and substance use disorder treatments and programs will be at high risk because, even though they are cost-effective, they are intensive and expensive. Furthermore, the elimination of the ACA's required Medicaid managed care coverage of mental health and substance use disorder services and the long-term reduction of real funding dollars will leave states and managed care plans no alternative but to either radically increase state revenues or reduce or eliminate services in order to balance state Medicaid budgets and operate within managed care organizations' capitated rates.

The per capita caps approach taken in H.R. 1628 will also lock each state into its current state of cost-effectiveness, into perpetuity. States that have taken steps to reduce Medicaid costs through value-based purchasing and delivery system reforms will now discover that no past good deed will go unpunished, far into the future. In addition, locking states into their 2016 spending will

fail to provide flexibility as populations age or population mixes change through migration. Nor will it provide the funding margin needed for the kind of state innovation that helps to reduce Medicaid costs.

In addition, these cuts will hit children with serious emotional disorders, as well as adults with mental illness. Fifty percent of Medicaid beneficiaries are children. Seventy-five percent of mental conditions emerge by late adolescence. The loss of Medicaid-covered mental and substance use disorder services for adults will likely result in more family disruption and out-of-home placements for children, significant trauma which has its own long-term health effects, and a further burden on a child welfare system that is struggling to meet the current demand for foster home capacity. In addition, we estimate $4 to $5 billion in Medicaid assistance will be lost by schools for specialized instructional support services, including mental and behavioral health services.

More directly, the rollback of the maximum eligibility level for children ages 6 to 19 from 133 percent of the Federal Poverty Level to 100 percent FPL will undoubtedly have the result of reducing access to mental health and substance use disorder services, and critical Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, for those older children. This is a particularly problematic change since 5 percent (1.2 million) of adolescents between the ages of 12 and 17 had substance use disorders in 2015 and EPSDT screening is the most effective early identifier for emergent mental health issues.

AHCA Changes to Private Insurance Coverage

If Medicaid is not to provide the avenue for recovery for individuals with mental illness or substance use disorders, then the private insurance market may have to serve as an alternative, but allowing states to determine essential health benefits in the marketplace could imperil private market coverage for these services. In addition, the refundable tax credits provided under the AHCA to subsidize insurance premiums constitute a significant reduction in the advance premium tax credits paid under the ACA, which averaged 72 percent of gross premiums. With the permitted changes to the age-banding ratio premium limits, premiums for older enrollees will rise, and the less generous refundable tax credits provided will make coverage unaffordable for many older enrollees, particularly those with mental illness or substance use disorders.

Further, the 30 percent premium surcharge required under AHCA to be imposed for a failure to maintain continuous coverage will likely hit hardest the lowest-income enrollees who will be struggling to maintain premium payments for coverage. It will be particularly destructive for those enrollees whose serious mental illness or substance use disorders may render them cognitively impaired and thus unable to maintain premium payment schedules until they recover, when the sizeable surcharge will leave them unable to pick up coverage. These provisions of the AHCA leave us very concerned for the continued well-being of the individuals with serious mental illness and substance use disorders we have been better able to serve since the implementation of the ACA's expanded coverage.

We also hope that Congress will persist in encouraging the White House to continue to make Cost Sharing Reduction (CSR) payments to plans to reduce premium costs for lower-income enrollees in the private insurance market for as long as necessary to ensure additional insurers do not withdraw from markets, leaving low-income enrollees—particularly those with mental illness and/or substance use disorders—without affordable coverage.

We urge you to continue to protect these vulnerable Americans' access to and coverage of vital mental health and substance use disorder care and services, and to not reverse the recent progress made with the enactment of key mental health and substance use disorder prevention and treatment reforms under the 21st Century Cures Act and CARA.

Sincerely,

American Art Therapy Association
American Association of Child & Adolescent Psychiatry
American Association for Marriage and Family Therapy
American Association for Geriatric Psychiatry
American Association for Psychoanalysis in Clinical Social Work
American Association on Health and Disability
American Dance Therapy Association
American Foundation for Suicide Prevention
American Group Psychotherapy Association
American Nurses Association
American Psychiatric Association
American Psychoanalytic Association (APsaA)
American Psychological Association
American Society of Addiction Medicine
Anxiety and Depression Association of America
Association for Ambulatory Behavioral Healthcare
Bazelon Center for Mental Health Law
Campaign for Trauma-Informed Policy and Practice
Children and Adults with Attention-Deficit Hyperactivity Disorder (CHADD)
Clinical Social Work Association
Clinical Social Work Guild 49-OPEIU
Depression and Bipolar Support Alliance
Eating Disorders Coalition
EMDR International Association
Global Alliance for Behavioral Health and Social Justice
International Certification & Reciprocity Consortium (IC&RC)
Mental Health America
National Association for Children's Behavioral Health
The National Association of County Behavioral Health and Developmental Disability Directors (NACBHDD)
The National Association for Rural Mental Health (NARMH)
National Association of Social Workers
National Association of State Mental Health Program Directors (NASMHPD)
National Alliance on the Mental Illness (NAMI)
National Council for Behavioral Health
National Disability Rights Network
National Federation of Families for Children's Mental Health
National Health Care for the Homeless Council
National Register of Health Service Psychologists
No Health Without Mental Health (NHMH)
Psychiatric Rehabilitation Association and Foundation
School Social Work Association of America

Treatment Communities of America
Trinity Health of Livonia, Michigan
Young Invincibles