Commonwealth of Massachusetts

HOUSE OF REPRESENTATIVES
STATE HOUSE, BOSTON, MA 02133-1054

JENNIFER E. BENSON
REPRESENTATIVE
37TH MIDDLESEX DISTRICT

Committees:
Education
Telecommunications, Utilities and Energy
Personnel and Administration

ROOM 130, STATE HOUSE
TEL: (617) 722-2130

Representative Peter J. Koutoujian, Chairman
Joint Committee on Financial Services
State House, Room 254
Boston, MA 02133

Dear Chairman Koutoujian:

I write in support of House bill 3897, *An Act Relative to post-partum depression.*

This bill would implement frequent, universal screenings for women during the perinatal period; would create a strong referral network for women who screen positive for depression; and would begin an education and de-stigmatization campaign so that we may all address the challenges that post-partum depression presents to the Commonwealth.

Post-partum depression is the most common complication of pregnancy, affecting 15% of mothers. When a woman experiences depression during the perinatal period, it is unlikely to be recognized, because screening for this mental health condition is infrequent at well-child visits and obstetrical check-ups, and because women are hesitant to reveal the symptoms of their depression to a pediatrician or obstetrician.

Fortunately, post-partum depression is treatable, and a simple screen, followed by a referral, can get women the help they need. The screenings called for in H 3897 would not cost the Commonwealth any money, as MassHealth already provides them as an insurance benefit. The screening, referral and education model presented in H 3897 will make our world-class health system even stronger by ensuring that perinatal depression is diagnosed and treated early, preventing long-term complications of untreated depression, and ensuring a well-adjusted infancy for newborns.

Please join me in supporting House bill 3897, *An Act Relative to post-partum depression.* I hope that you will urge the Committee on Financial Services to report this bill favorably, so that it may come before the full House for a vote this year.

Sincerely,

Jennifer Benson
State Representative
37th Middlesex

The Commonwealth of Massachusetts

HOUSE OF REPRESENTATIVES
STATE HOUSE, BOSTON, MA 02133-1054

KAY KHAN
REPRESENTATIVE
11TH MIDDLESEX DISTRICT (NEWTON)
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CHAIR:
JOINT COMMITTEE ON CHILDREN, FAMILIES
AND PERSONS WITH DISABILITIES

January 27, 2010

The Honorable Stephen J. Buoniconti
Senate Chair, Joint Committee on Financial Services
Room 309
State House
Boston, MA 02133

The Honorable Peter J. Koutoujian
House Chair, Joint Committee on Financial Services
Room 254
State House
Boston, MA 02133

Dear Chairman Buoniconti, Chairman Koutoujian and Members of the Committee:

I am writing to voice my support for *An Act Relative to Post-Partum Depression* (**H. 3897**), filed by Representative Ellen Story. This legislation would ensure that pregnant women will be able to receive universal screening and the necessary referral for treatment of depression during pregnancy and in the first year of their baby's life.

Approximately 15 percent of new mothers in Massachusetts suffer from postpartum depression. For these women, the birth of a baby is not a joyous time, but is characterized by despair, guilt, anxiety, and fear of hurting themselves or their babies. If left untreated, post partum depression can have detrimental effects on mothers such as suicidal tendencies and long-term developmental, emotional, and behavioral problems for their children.

Fortunately, post-partum depression is treatable. But in order to be effectively treated, it must be identified. This legislation will greatly improve our ability to detect and treat post-partum

depression in Massachusetts by requiring health care providers to screen mothers for depression regularly and for these screenings to be covered by insurance.

This bill would also make Massachusetts a national leader in implementing comprehensive, repeated screening. Furthermore, the public and professional education of this condition will address one of the toughest barriers for families dealing with mental illness- stigma- and empower them to seek the necessary treatment.

Thank you for your consideration of this important matter. I strongly encourage the Committee to adopt a favorable report for H. 3897 as expeditiously as possible.

Sincerely,

Kay Khan

Kay Khan
State Representative

The Commonwealth of Massachusetts

HOUSE OF REPRESENTATIVES
STATE HOUSE, BOSTON, MA 02133-1054

KAY KHAN
REPRESENTATIVE
11TH MIDDLESEX DISTRICT (NEWTON)
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Thank you for your consideration of this important matter. I strongly encourage the Committee to adopt a favorable report for H. 3897 as expeditiously as possible.

Sincerely,

Kay Khan

Kay Khan
State Representative

Commonwealth of Massachusetts

HOUSE OF REPRESENTATIVES
STATE HOUSE, BOSTON, MA 02133-1054

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January 27, 2010

Stephen J. Buoniconti, Senate Chair
Peter J. Koutoujian, House Chair
Joint Committee on Financial Services
State House, Room 254
Boston, MA 02133

RE: Committee Hearing January 27, 2010

Dear Chairmen Buoniconti and Koutoujian,

I am writing in response to today's hearing for the Joint Committee on Financial Services. The hearing will discuss the following bill:

> **H3897: An Act Relative to Postpartum Depression.**
> This bill would require that insurance covers the screening by OB/GYNs, midwives, pediatricians and other primary care providers for depression during pregnancy and in the first year of the baby's life.

I am unable to testify in support of this bill in person today, but wanted to inform the committee that I am in favor of the above listed legislation. This is an important issue for Massachusetts families. With 15% of mothers in Massachusetts suffering from Postpartum Depression unnecessarily, this bill would ensure that women would be treated while simultaneously breaking stigmas associated with this mental illness. I respectfully request that this bill be considered during the next executive session and reported out favorably. Should you have any further questions or comments, please do not hesitate to contact me.

Very truly yours,

Barbara L'Italien

COMMONWEALTH OF MASSACHUSETTS

MASSACHUSETTS SENATE

STATE HOUSE, BOSTON 02133-1053

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BILLS IN THIRD READING
TRANSPORTATION
FEDERAL STIMULUS OVERSIGHT
FINANCIAL SERVICES

January 25,2010

Honorable Stephen J. Buoniconti
State House , Room 309
Boston, MA 02133

Honorable Peter J. Koutoujian
State House , Room 254
Boston, MA 02133

Dear Chairman Buoniconti and Chairman Koutoujian:

I am writing in support of *An Act Relative to Cognitive Rehabilitation* (S. 493), which is currently before your committee.

Today, nearly six million Americans are stroke survivors, and as many as 30 percent of them are permanently disabled. This bill would provide as a basic insurance benefit, necessary long term rehabilitative services for those who suffer from a serious brain injury or a stroke. Under S. 493, cognitive behavioral therapy means medically necessary treatments following a person's brain injury or stroke. Such therapy would take place in a hospital, an inpatient facility or an outpatient rehabilitation center.

I ask that you report this bill favorably out of committee and thank you again for considering this legislation. Please don't hesitate to contact my office if you have any questions.

Sincerely,

Mark Montigny
SENATOR

The Commonwealth of Massachusetts

HOUSE OF REPRESENTATIVES
STATE HOUSE, BOSTON 02133-1054

MARK FALZONE
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January 27, 2010

The Honorable Peter J. Koutoujian
House Chairman, Joint Committee on Financial Services
State House, Room 254
Boston, MA 02133

The Honorable Stephen Buoniconti
Senate Chairman, Joint Committee on Financial Services
State House, Room 309
Boston, MA 02133

Dear Chairman Koutoujian and Chairman Buoniconti:

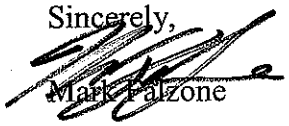
I am writing to you in support of House bill 3897, *An Act Relative to post-partum depression.* This bill would aid in the early detection and subsequent proper treatment of depression during pregnancy. It is common for women to be affected by depression during the perinatal period, and implementing this bill would provide frequent and universal depression screenings for pregnant women. A support network would be created for women with this condition, and would help educate those affected and raise awareness about the universal nature of this condition.

As the most common complication of pregnancy, post-partum depression affects mothers throughout the socio-economic spectrum. Without specifically focused screenings, the precursor to this, perinatal depression, is unlikely to be recognized. Many women are not open about any symptoms of depression they may be experiencing, and many pediatricians or obstetricians do not look for it specifically.

Post-partum depression is a very serious condition, but fortunately it is a treatable one. The depression screenings called for in H 3897 would not pose any expense to the Commonwealth because MassHealth already provides them as an insurance benefit. Massachusetts boasts a world-class health system, and screening for perinatal depression is a necessary and viable addition to our health services. H 3897 would ensure that perinatal depression is diagnosed and treated early, which would go a long way in the prevention of the long-term complications of untreated depression, and help to ensure a healthy infancy for newborns.

I urge you to join me in supporting House bill 3897, *An Act Relative to post-partum depression*, and recommend the Committee on Financial Services to report this bill favorably, so that it may come before the full House for a vote this year.

Sincerely,



Mark Falzone

MENTAL HEALTH LEGAL ADVISORS COMMITTEE

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Testimony of the Mental Health Coalition

before the Joint Committee on Health Care Financing

Supporting H. 3559

An Act Relative to the Continuity of Care of Mental Health Treatment

January 27, 2010

I am testifying on behalf of the Mental Health Coalition, consisting of mental health professional organizations, consumer advocacy groups and representatives of families. I am Senior Attorney for the Mental Health Legal Advisors Committee, an agency within the Supreme Judicial Court that represents low-income persons with mental disabilities and that provides information on mental health legal matters to health care providers, family members, the judiciary, the general public and, of course, the legislature. Over the past 18 years, I have seen the insurance industry, with its administrative requirements and hurdles, has robbed people with mental illness of the care they need. Today I am here to urge the passage of H. 3559, a bill that will insure that persons, whose providers go out of a particular insurer's network, may continue to receive the care they need from those providers.

And while I have spoken harshly of the insurance industry's bureaucratic barriers to care, I would like to note that this bill will not require insurers to pay providers a penny more than if the providers had stayed in-network.

I. Brief Summary of the Bill

H. 3559 is simple. It amends the managed care statute, Chapter 176O. If a person is in a course of treatment with a mental health clinician,[1] and that clinician becomes an out-of-network provider for any reason other than quality-related reasons or fraud, then the current insurer of the person must continue to pay for medically necessary services with that provider at the current insurer's in-network reimbursement rate. The current insurer may even require the insured to pay a higher co-payment if the insurer can show that it is incurring increased costs due to having to pay an out-of-network provider. No cost to the insurer and continuity of care for the insured.

II. The Need for Continuity of Care Legislation

Continuity of care provisions are intended to protect patients from disruptions in care caused by a change in their health care plan or in a provider's network status. Continuity of care for mental health services is an essential part of treatment and the recovery process. Continuity of care is disrupted when the therapeutic relationship between a patient and her/his provider is terminated. Such termination may occur when a provider leaves a carrier's network either voluntarily or involuntarily, or when a patient switches health plans voluntarily or involuntarily through job termination, and the new health plan does not include the patient's existing provider in its network. These changes can have extremely detrimental effects on a mental health patient's condition and progress.

Current law inadequate

Massachusetts law currently provides for very limited continuity of care when a provider or physician is involuntarily disenrolled from a carrier's network. Under Mass.Gen.L. §15 of Chapter 176O, if a provider is involuntarily disenrolled, other than disenrollment for quality-related reasons or for fraud, a carrier must allow continued treatment with that provider for: 1)

[1] Defined as having at least one visit in the past four months for the same or similar mental health diagnosis or set of symptoms.

any female insured who is in her second or third trimester of pregnancy for the period up to and including the insured's first postpartum visit, and 2) any insured who is terminally ill until the insured's death. The law includes only thirty days for continued treatment for individuals with mental illness. As a result, those with mental illness are often left with no option to continue treatment with a provider with whom they have built a positive trusting relationship, perhaps over years. Mental health treatment should be given the same continuity of care protection as currently exists for maternity care and the treatment of terminal illness.

Economic forces expand disruption of care to many

This proposed legislation provides needed changes to the current law because the current law contains no adequate provisions for continued coverage for patients in a continuing course of mental health treatment. As few providers are on all of the networks, a change of coverage may lead to a change of providers. While some changes in coverage and carrier are at the request of the patient, most are the result of the employer switching carrier or the patient changing employers.[2]

As employers face increasing health care costs, they may opt to change carriers in order to minimize increasing premiums and other costs.[3] In Massachusetts, this is particularly relevant with the health reform law of 2006, which requires that all employers, except firms with less than eleven workers, allow employees to purchase insurance with pre-tax dollars and to pay a $295 annual fee if they do not make a "fair and reasonable" contribution to the cost of workers' coverage. Furthermore, the individual mandate for all residents to have a minimum level of health insurance may add costs for firms if more workers take up coverage offers, seek more generous coverage or pressure employers to offer coverage.[4] These added costs may cause employers to switch to cheaper health plans, which could in turn leave many employees facing a change in provider choices.

Disputes between health plans and providers may also result in disruption of care, when providers drop out of plans' networks, or threaten to, or when health plans unexpectedly drop

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[2] Linda Wolfe Keister, *Switching Doctors, Switching Plans: The 'Revolving Door' Problem,* Managed Care Magazine, http://www.managedcaremag.com/archives/9605/MC9605.turnover.shtml, (1996).

[3] *Id.*

[4] Laurie E. Felland, Debra A. Draper, Allison Liebhaber, *Massachusetts Health Reform: Employers, Lower-Wage Workers and Universal Coverage*, Center for Studying Heath System Change, Issue Brief No. 113 (July 2007).

providers.[5] Contract disputes between health plans and providers are the most common cause of network instability and typically center on disagreements about payment levels, financial risk-sharing arrangements and accuracy or timeliness of payments.[6] When a provider leaves a plan network, patients may suddenly face the choice of forming a new relationship with a network provider, or paying higher out-of-pocket costs to continue seeing their usual providers on an out-of-network basis. These choices are especially difficult for patients who have long-standing relationships with particular caregivers or those receiving care for serious or chronic conditions. The sickest patients, who are most in need of uninterrupted care, also are most likely to find the costs of out-of-network care prohibitive, particularly if they are enrolled in traditional health maintenance organizations (HMOs) lacking out of network coverage. [7]

Furthermore, individuals may need to switch plans due to economic reasons, when they can no longer afford increasing premiums and other costs. Patients may also try to switch to a different plan that contracts with the original provider, but this option may not be available or it may not be economically feasible for the patient to pay higher out-of-pocket costs.[8] Continuity of care should therefore cover both voluntary and involuntary carrier switches because patients may be forced to switch carriers due to economic compulsion. Employer carrier switches and provider-carrier disputes are also not in the patient's control, and therefore patients should not have to bear the burden when such changes lead to a disruption in the patient-provider relationship.

According to the Massachusetts Office of Patient Protection's Annual Reports from 2003-2007, behavioral health is the highest category for external review requests. Included in this category are disputes over the medical necessity of continued inpatient care, acute residential treatment, various levels of care for eating disorders, and requests for outpatient services with providers that are not in the health plan's network.[9]

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[5] A. C. Short, G.P. Mays, & T.K. Lake, *Provider Network Instability: Implications for Choice, Costs and Continuity of Care*, Issue Brief No. 39, Center for Studying Health System Change (2001), http://www.hschange.com/CONTENT/325/.

[6] *Id.* at 2.

[7] *Id.* at 3.

[8] In Massachusetts, increasing health care costs have led to higher costs for patients, and health plan choice may therefore be limited by economic status: Jeffrey Krasner, *Insurers' plan seeks to curb rising costs of healthcare*, The Boston Globe, December 4, 2007; Linda Wolfe Keister, *Switching Doctors, Switching Plans: The 'Revolving Door' Problem*, Managed Care Magazine, (1996).

[9] Request pending for percentage breakdown for outpatient services with providers that are not in the health plan's network over the past three years from the Office of Patient Protection.

MHLAC intake data has additionally shown the problems that patients face when trying to access out-of-network coverage and continuity of care. From August 2005 through August 2008, 34% of the private insurance cases were due to problems with accessing out-of-network coverage and/or obtaining continuity of coverage to maintain an established relationship with a provider.

MHLAC supports quality of care standards and evaluations and recognizes the necessity for termination of contracts for services that are substandard. However, when health plans decide to terminate contracts for reasons other than for quality of care concerns, or when providers leave carrier networks, patients need assurances that critical medical relationships are not severed in the midst of care for a mental illness. Patients rely on the coverage assurances of their health plan and on the ongoing medical care of their chosen mental health care providers and should not be subjected to a loss of such services and treatment.

III. Solution: Continuity of Care Legislation

As a solution to this problem, H. 3559 amends M.G.L §15 of Chapter 176O to require that a carrier continue coverage of treatment through an out-of-network option for any insured who is engaged in a continuing course of treatment with a licensed mental health provider who was eligible for payment under the plan, and 1) whose provider is involuntarily or voluntarily disenrolled, other than for quality-related reasons or for fraud, or 2) whose carrier has changed for any reason, thereby moving the provider out-of-network. This option is limited to patients who are in a continuing therapeutic relationship with their provider. The proposed legislation would also require that the carrier reimburse the licensed mental health care professional the usual network per-unit reimbursement rate for the relevant service and provider type as payment in full, or alternatively the median reimbursement rate if more than one rate exists. Furthermore, the carrier may require that a covered person pay a higher co-payment. However, this higher co-payment may be charged only if the higher co-payment results from increased costs caused by the use of a non-network provider, and the carrier must provide an actuarial demonstration of those increased costs. All existing requirements for providers who continue coverage would remain unchanged.

Other states provide more generous continuity of care than Massachusetts

Continuity of care provisions typically require insurers or managed care companies to allow insured individuals to continue care for a specified length of time with a provider that has been terminated from the plan, provided that the insured has a life-threatening or a disabling and degenerative condition. Many states have continuity of care laws that are far more extensive than the current law in Massachusetts. Lengthy transition periods indicate a recognition that a disruption of care is detrimental to a patient's course of treatment.

One state with special provisions for persons with mental disabilities is Minnesota. While Minnesota's first continuity of care law was passed in 1997, the law was amended during the 2001 special session[10] to expand the conditions eligible for continued coverage to include: a life-threatening mental or physical illness; a physical or mental disability defined as an inability to engage in one or more major life activities, provided that the disability has lasted or can be expected to last for at least one year; and/or a disabling or chronic condition that is in an acute phase.[11] Furthermore, the statute requires the health plan company to grant the request for continuity of coverage unless the enrollee does not meet the criteria. Prior to this amendment, patients with special needs, special risks, or other special circumstances, such as cultural or language barriers, had the option of requesting continuity of care with their former provider for up to 120 days, but no such request was guaranteed.[12] Supporters of the amended continuity of care legislation included the Minnesota Mental Health Association, the Minnesota Nurses Association and the Legal Services Advocacy Project. Major lobbyists and supporters of the bill reported that the bill was passed as part of series of patient protections laws. Supporters further stated that they relied on philosophical arguments that it was the "right thing to do" instead of relying on data or reports despite opposition from the health insurance industry.[13]

California's continuity of care laws also developed over a number of years.[14] Chapter 591, passed in 2003, allows a patient to continue with his or her provider for a reasonable period of time under specified conditions whenever the relationship between patient, provider or health

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[10] 2001 Minn. Laws, 1 Spec. Sess., c. 9, Art.16, S.7.
[11] Minnesota Requirements for Health Plan Companies, §62Q.56 Continuity of Care, Subd.1a, Subd. 2.
[12] 1997 Minn. Laws, c.237 s.12.
[13] Phone interview of Rappaport Fellow with Bill Conley, former lobbyist for Minnesota Mental Health Association, July 12, 2008; Phone Interview of Rappaport Fellow with Susan Stout, former lobbyist for Minnesota Nurses Association, July 24, 2008.
[14] Thomas R. Clark, *Chapter 591: Ensuring "Continuity of Care" In A Group-Dominated Health Care Market*, 35 McGeorge L. Rev. 507 (2004).

plan is disrupted.[15] It also requires every plan to have and submit to the Department of Managed Health Care (DMHC) a written continuity of care policy that describes how it will handle transfers of enrollees from a terminated provider to a new provider.[16] The preceding bill, AB 1286 Continuity of Care, expanded the ability of health plan enrollees to receive continuity of care following contract termination by increasing notice to enrollees when a contract is terminated and increasing transition time to a maximum of 180 days for individual coverage and 12 months for group coverage.[17] The bill received support from numerous consumer and trade organizations, including the Department of Managed Health Care (DMHC), Health Net, Health Access California, NAMI California, the Western Center on Law and Poverty, California Independent Public Employees Legislative Council, and the California Nurses Association. No cost analyses on continuity of care have been conducted since the passage of the bill.

IV. Clinical rationale for continuity of care and the therapeutic relationship

Continuity of care provisions are critical because of the importance of the therapeutic relationship in mental health treatment and recovery. Mental health treatment cannot easily be picked up mid-episode of care and continued with another provider as can some other types of medical care and procedures. The unique role of the establishment of trust for confidentiality and the creation of the therapeutic relationship makes it clinically unwise and overly costly to force patients who are in the middle of treatment to begin again with a new provider.

A recent study published in the *Psychiatric Rehabilitation Journal* stressed the importance of relational continuity of care – seeing the same clinician over time – as it builds on the human relationships and interactions inherent in good care. According to the study, which took place in a managed care setting, positive and trusting relationships with clinicians, developed over time, aid recovery of serious mental illness.[18] Among the overlapping themes that patients described as important to their long-term relationships with clinicians were fit and comfort, mutual trust, and continuity with the same clinician. When the "fit" with clinicians is good, long-term relational continuity of care allows development of close, collaborative

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[15] Senate Committee on Insurance, Committee Analysis of AB 1286, at 6-7, 9-11, (July 2, 2003).
[16] California Health and Safety Code § 1373.95
[17] California Health and Safety Code § 1373.96
[18] Carla A. Green, Michael R. Polen, Shannon L. Janoff, David K. Castleton, Jennifer P. Wisdom, Nancy Vuckovic, Nancy A. Perrin, Robert I. Paulson & Stuart L. Oken, *Understanding How Clinician-Patient Relationships and Relational Continuity of Care Affect Recovery from Serious Mental Illness: STARS Results*, Psychiatric Rehabilitation Journal, Vol. 31, No. 1, 9-22 (2008).

relationships, fosters good illness and medication management, and supports patient-directed decisions. Conversely, comfortable relationships encouraged communication about decisions and concerns that positively affected mental health outcomes.[19]

Study participants talked frequently about the importance of being able to trust their clinician and to have their clinician trust them. Such trust was developed in the context of long-term ongoing relationships built over time and provided important boosts to self-esteem and self-worth.[20] Patients furthermore reported that seeing the same clinician over time provided the historical background and experience necessary to get good care and to form a good working partnership. Losing access to a longstanding clinician could be devastating. One participant described it as feeling like "a plant that had been ripped up by its roots."[21] Individuals with serious and chronic mental health problems were likely to have even a greater need for continuity of care because of recurring symptoms, memory problems, and cognitive deficits that may interfere with their ability to provide information about their treatment history. In addition, medical records do not provide sufficient detail to substitute for personal history with a patient.

Both quantitative and qualitative findings in the study indicated that individuals with serious mental illness who receive recovery-oriented care in the context of long-term, close, collaborative relationships with their clinicians are more satisfied with their care, have fewer psychiatric symptoms, better recovery outcomes, and a better quality of life.[22] Relationships that were deemed most helpful and collaborative took significant time to establish, with mutual experience and trust developing over a number of years.[23] Such findings suggest that clinician turnover in the mental health system may negatively affect patients. While this study took place in a health plan with low staff turnover, the authors point to the challenge in increasing continuity and collaboration in systems plagued by high staff turnover, and suggest that improvements at the micro-level to improve relational continuity of care could enhance recovery more than major transformations within the health system.[24]

Another study that measured continuity of care and health outcomes among persons with severe mental illness reported similar results. Continuity of care, including a consistent and

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[19] *Id.* at 14.
[20] *Id.* at 16.
[21] *Id.* at 17.
[22] *Id.* at 19.
[23] *Id.* at 20.
[24] *Id.* at 21.

dependable relationship with the primary caregiver and treatment team, was significantly associated with a better quality of life, better community functioning, lower severity of symptoms and greater service satisfactions. [25]

The importance of continuity of care has also received attention from national organizations that work to assist individuals with mental illness. The American Psychiatric Association's (APA) position statement on continuity of care holds that continuity of care is an essential component of the quality treatment of psychiatric patients.[26] The statement reads that while all doctor-patient relationships are important, the psychiatrist-patient relationship is an especially significant therapeutic component of psychiatric treatment, and thus continuity of care should be preserved when insurance benefits programs change, such that care is not disrupted. APA states that for patients in treatment with psychiatrists who are not included in the new network, the disruption in their care may have detrimental effects on their stability and/or progress. The position statement advises that when transfer is unavoidable, the opportunity for an appropriate period of termination and transfer should be maintained in all treatment settings and included in managed care and other insurance plans.[27] The statement also suggests that for those patients who wish to continue treatment with psychiatrists not in the new system, treating psychiatrists should be brought into the new network, and if not possible, psychiatrists should be given provisional in-network status to continue/complete work with the assigned patients, depending upon the psychiatrist's willingness to accept fee schedules and the terms of interaction with the new MCO.[28] An advocacy strategies report from the National Alliance for the Mental Ill (NAMI) additionally stresses the importance of continuity of care for individuals with serious mental illness.[29] Even clients not categorized as seriously or chronically mentally ill require continuity of care. Persons with histories of abuse find it difficult, if not impossible, to retell their traumatic histories and should not be forced to do so because of insurance considerations.

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[25] Carol E. Adair, Gerald M. McDougall, Craig R. Mitton, Anthony S. Joyce, Cameron Wild, Alan Gordon, Norman Costigan, Laura Kowalsky, Gloria Pasmeny, & Anora Beckie, *Continuity of Care and Health Outcomes Among Persons With Severe Mental Illness,* Psychiatric Services, Vol. 56 No. 9., 1062-1068 (September 2006).

[26] American Psychiatric Association Position Statement on Continuity of Care in the Psychiatrist-Patient Relationship, (1993).

[27] *Id.*

[28] *Id.*

[29] Darcy E. Gruttadaro, E. Clarke Ross & Ron Honberg, *Legal Protections and Advocacy Strategies for People with Severe Mental Illnesses in Managed Care Systems,* NAMI- National Alliance for the Mentally Ill (2001).

V. Constituent and Organizational Support

Various mental health organizations in Massachusetts have expressed their support for continuity of care legislation. While notice of the hearing of this bill has limited the numbers of persons who could come to testify today, we do know that leaders from numerous organizations such as the Massachusetts chapter of the National Association of Social Workers (NASW), Massachusetts Psychological Association (MPA), and Massachusetts Mental Health Counselors Association indicated that they would support such legislation. In a survey of organizations, one psychiatrist reported that "finding child and adult psychiatrists within a network is a contributing factor to the ability of our patients to find care since we often find them to be phantom networks."[30] The response from an organization of psychiatric nurses relayed that continuity of care is very important to the treatment process and that every clinician has been faced with the issue. A clinician and psychology fellow in a community mental health center stressed that continuity of care is a very large issue at his clinic since most of the "training cases" change over from year to year, as interns train at the clinic and then move on. This means that a substantial portion of the population that they serve has to get used to switching to new therapists every twelve months. When clinicians leave the clinic, they are allowed to take clients with them, but because the clinic and not the individual clinician has contracts with the insurers directly, these clients would have to pay out of pocket, which is not an option for much of the population served at the clinic.

Furthermore, at a meeting in July 2008 with approximately twenty social workers in attendance, the social workers reported that getting onto provider panels was one of the largest problems that they face with insurance companies, and that networks are becoming increasingly restrictive. The group reported that that even though insurance companies claim that they have the right numbers of providers for the number of their enrollees, patients often find that there are not enough therapists to meet their needs. Such problems with panel restrictions could prevent providers from continuing to see a patient when the patient's carrier changes. The social workers stated that they would therefore support legislation to improve mental health continuity of care for out-of-network coverage.

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[30] Mandated continued coverage obviates the need for patients to navigate these phantom networks.

VI. Counter-arguments and subsidiary issues

MHLAC anticipates that insurance companies would oppose continuity of care legislation based on arguments that it would result in increased costs to the health care system, encourage providers to leave panels and hinder their ability to select panels, make higher premium plans with an out-of-network option less desirable, and that health care members are able to access necessary services within existing managed care networks.

Insurance companies may claim that allowing patients to continue treatment through an out-of-network option will increase their costs of doing business, which ultimately will be passed on to employers and other policyholders. However, this legislation would not in fact significantly increase costs because under its terms, the provider would be paid the usual in-network rate as payment in full. Therefore, carriers would not be paying providers any more than any in-network provider. In addition, processing and administrative costs of conducting background investigations of new providers, as well as training new members on the procedures and practices of the network, would not apply when a provider is under contract for *continued* care in a network, as opposed to applying for membership in a new network.[31] Furthermore, the carrier could charge a higher co-payment as long as it proved that the co-payment increase had resulted from increased administrative costs.[32]

The providers would additionally be subject to the same utilization review requirements as if they were in-network. Therefore, carriers would not be required to cover anything that was outside the scope of "medically necessary" treatment and services. Continuity of care coverage may even decrease costs to the health care system because it is more costly when care is disrupted and a patient must start all over again with a new treatment regime and rebuild trust with a new provider. This could result in setbacks in recovery and in turn, the patient may ultimately require additional treatment that the new insurance company would need to cover. A provider who is new to a given patient is also more likely to run up costs by ordering diagnostic tests and procedures that direct knowledge of the patient could have avoided. Furthermore, when necessary care is disrupted, secondary costs to society are also likely to incur, such as loss of workplace productivity and increased sick days, job loss, reliance on public benefits, behavioral

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[31] Fred J. Hellinger, *Health Affairs Special Report: Any-Willing-Provider And Freedom-Of-Choice Laws: An Economic Assessment*, Health Affairs, Vol. 14, No. 4, 297-302, (1995)

[32] See attached Continuity of Care legislation, Section 15 (d)(2).

problems in school and involvement with the Department of Children and Families, and repercussions on families. No cost analyses on the impact of continuity of care laws have been found.

Insurance companies may argue that continuing care legislation would create an incentive for providers to leave panels. This would not occur because the insurance company would only cover continuing treatment, not the initiation of new treatment, so providers would not be able to obtain new patients and business if they left the network. Providers would also not benefit from having a definable and stable patient base through carrier affiliation, stability in medical claim billing and indirect advertising through online provider directories.[33] Insurance companies may furthermore argue that the legislation would make higher premium plans with an out-of-network option less desirable. However, as previously stated, this legislation would only address coverage of *continuing* treatment as opposed to coverage of any out-of-network treatment. Out-of-network plans are attractive to persons desiring provider choice in the event of future illness and its treatment.

Insurance companies may also argue that coverage should only cover one episode of treatment and that one visit in four months is too remote to constitute continuing treatment. However, since many mental illnesses are cyclical with certain flare-ups of symptoms, this coverage would not be effective.[34] They may argue that the length of time for coverage will be too long if there is no limitation. However, research shows that the average length of stay for outpatient treatment is eight to twelve sessions.[35] Therefore, few persons would have the need for coverage over a lengthy period, although overall a small minority may. Furthermore, if outpatient treatment sessions do surpass these numbers, coverage would only be continued if the treatment meets the insurers' own medical necessity standards.[36]

Lastly, insurance companies may argue that this legislation would hinder their ability to select only the best caregivers for their network. However, this legislation would not change a carrier's ability to select their network since it only allows *continued* coverage for those already

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[33] *Medical Billing at Chennai: In-network vs. Out-of-network Medical Claim Billing,* http://billingatchennai.blogspot.com/2008/04/in-network-vs-out-of-network-medical.html, (April 2008)

[34] Carol E. Adair et al, *Continuity of Care and Health Outcomes Among Persons With Severe Mental Illness,* Psychiatric Services, 56 No. 9., 1062-1068 (2006).

[35] Mark Olfson, Steven C Marcus, Benjamin Druss, Lynn Elinson, Terri Tanielian, Harold Alan Pincus, *National Trends in the Outpatient Treatment of Depression,* JAMA, 287 (2): 203-9 (2002).

[36] M.G.L §12 of Chapter 176O

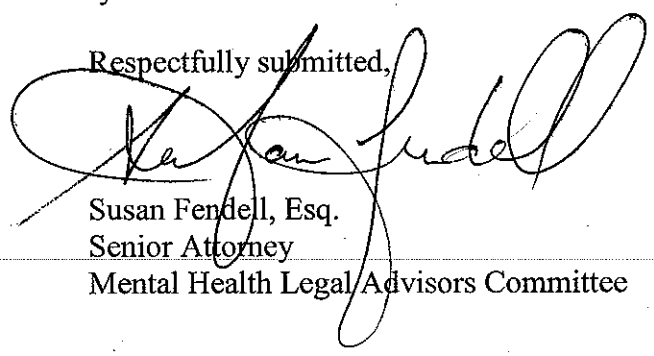
in course of treatment by providers who are not disqualified due to quality-related reasons or fraud.

VII. Specific Implications for Massachusetts

Massachusetts is at the health care forefront despite barriers of political strength of private health insurance industry. With the passage of health reform in 2006 and an improved mental health parity law passed this past 2007-2008 legislative session, a law that would support continuity of care for mental health treatment would be a next logical step for improving the quality of mental health care in Massachusetts and increasing health insurance accountability for those in need of continuing care.

Mental Health Legal Advisors Committee urges this Committee to report out H. 3559 favorably.

Respectfully submitted,



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