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**Testimony in Support of H 3559  
for Continuity of Care for Behavioral Health Treatment**

I am Dr. Elena Eisman providing testimony from the Massachusetts Psychological Association in support of H3559. There are approximately 5000 licensed psychologists in the Commonwealth. We are testifying in support of H 3559. This bill requires insurers to maintain coverage of clinicians for clients in a course of treatment, even if the clinician is no longer in network. This is especially important as more people lose their jobs and change insurance.

Research shows that 30% of the efficacy of behavioral health treatment is related to the relationship between the provider and the consumer of services. For this reason, both the Institute of Medicine and the American Psychological Association include these factors in their definitions of treatment that is evidence based.

Given these data, if a provider has been treating a patient and this treatment is going well and the insurance changes due to no fault of the provider or the consumer (change of jobs, lay-offs, re-contracting of insurance with another company by the employer or individual, etc.) then this bill would allow the treatment relationship to continue to be reimbursed. This ultimately is better for the consumer and is ultimately more effective and less costly to the healthcare system than having the consumer start from scratch with a different provider with whom they need to build trust and understanding of their history and treatment needs from scratch.

The issue of network membership for behavioral health providers is different from that for other types of healthcare providers in that it is much more difficult to get admitted to a new panel if you are a behavioral health provider than if you are a medical/surgical provider because many of the networks are closed to new behavioral health providers. So even if the patient wishes to stay with their provider as their insurance changes and even if the provider wishes to join the new provider network to remain treating the patient, this is often not allowed by the insurer. This bill would still allow the treatment to continue to completion even if the provider was not admitted to the new provider panel.

This legislature has already recognized the unique treatment needs of patients seeing obstetricians and those in treatment for cancer as needing to stay with their provider if their insurance changes. This bill would extend this benefit to those in behavioral health treatment for similar reasons.

In this age of economic challenge when people are going through many disruptions in their lives it is crucial for people in behavioral health treatment to be able to deal with disruptions in their lives through continuity with their treatment providers. Universal coverage works promises that individuals can change insurance companies if they are not getting what they need from a particular policy, but this is an false promise if the impact of such a switch is to lose their behavioral health provider upon which they are relying on and which would disservice the consumer and set their treatment back if they could not continue.

Treatment for behavioral health disorders is not pleasant and it is not easy to build sufficient trust in a provider to reveal all of the issues one is most distressed and embarrassed about. These are often necessary components of the treatment process so once accomplished it is counterproductive to expect that the consumer will need to go through the process again in mid-stream with a new provider. History is also important to consider in thinking about this bill. An understanding of things such as which medications have worked or not worked for the patient, how the consumer can best hear feedback from the provider, and small bits of history that might be important in understanding current functional problems are all part of the therapeutic intervention. The negative impact of losing both the relationship and the history are somewhat unique to the behavioral treatment process and if lost would set the treatment and the consumer back more than with other types of healthcare services. It is in the best interest of the consumers to report this bill out favorably.

Thank you for allowing me to present this testimony  
January 27, 2010

# MAMH

Massachusetts Association for Mental Health

Thaleia Tsongas Schlesinger  
President

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Past-President

Bernard J. Carey, Jr.  
Executive Director

January 27, 2010  
(BY HAND)

To: Hon. Stephen J. Buoniconti, Senate Chair ✓  
Hon. Peter J. Koutoujian, House Chair  
Members of the Joint Committee on Financial Services

From: Timothy O'Leary, Deputy Director  
Massachusetts Association for Mental Health

Re: **HOUSE No. 3897 – AN ACT RELATIVE TO POST-PARTUM  
DEPRESSION**

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Please record the Massachusetts Association for Mental Health, Inc. (MAMH) **in support** of the above referenced bill.

For the reasons outlined below, we believe the bill **does not impose any new mandates on health insurers**, while it fosters important preventative measures to screen and get treatment for depression.

If the Committee believes a redraft is necessary to advance this legislation, MAMH would be pleased to participate and provide assistance in any such effort.

## **I. ABOUT MAMH:**

Since 1913, the Massachusetts Association for Mental Health, Inc. (MAMH) has been an independent, non-profit Massachusetts corporation engaged in educational outreach and advocacy focused on promoting mental health, and community based services, including housing, treatment, education and employment for people with mental illnesses and their families. The National Institute for Mental Health (NIMH) has designated MAMH as its Massachusetts partner for educational outreach under its Outreach Partnership Program.

We are not a provider of mental health services, or a trade association, or a consumer or family member run organization. As such, we are often the convener of stakeholders to address serious policy issues within the mental health community. The membership of our board of directors – 80 strong – includes people from virtually every profession in Massachusetts – law, banking and finance, health care, government, education, housing, human services, child welfare and insurance. Our board includes consumers, their family members and community activists. We have clinicians and two former mental health

commissioners on our board, as well as a sitting United States Congressman. **A listing of our board members is attached.**

MAMH also works with individuals with mental illness and their family members or friends to help them access services, whether housing, treatment, education, employment, or health insurance. Our referrals come from the United Way of Massachusetts Bay and Merrimack Valley, as well as from our network of supporters, including legislators helping a constituent, providers, clinicians, family members, or others we have helped.

## **II. HOUSE No. 3897**

### **(A) This is not a new health coverage mandate**

At the outset, we should note our anticipation that insurers and others might well argue that this legislation imposes a health insurance coverage mandate. From this starting point the argument in opposition becomes predictable: Opponents will argue it requires coverage and payment for unnecessary services for imaginary or illusionary illnesses. They will exaggerate its cost implications, and predict employers would either reduce or eliminate insurance benefits. And they will assert that because of the declining economy and the cost implications of the Commonwealth's health care reform law this is not the time to create another health insurance mandate. Finally, they will argue that since it is a mandate there needs to be an actuarial analysis before the legislation can move forward.

Sound familiar?

It should because these are the same arguments advanced against the mental health parity law, enacted in 2000 (St. 2000, c. 80) and improved and extended in 2008 (St. 2008, c. 256). And, we contend the very passage of the parity law obviates the necessity of any mandated language in this bill.

**This is depression and depression is covered under mental health parity and medically necessary or appropriate screenings for depression should be covered as well.** Why should a pregnant woman be covered for medically necessary mammogram or screening or tests for other illnesses, but not for depression? The economic point of health insurance is to spread and manage risk, not to let insurers isolate recognized illnesses and avoid coverage through limits not imposed on other illnesses, or through outright exclusions.

### **Section 13 of the 2008 Mental Health Parity Act (Chapter 256 of the Acts of 2008) provided, in part:**

SECTION 13. A health maintenance contract shall provide coverage for:

- (a) pregnant women, infants and children as set forth in section 47C of chapter 175;
- (b) ....
- (c) .....

- (d) prenatal care, childbirth and postpartum care as set forth in section 47F of Chapter 175
- (e) ....
- (f) .....

**B. The bill should be redrafted**

To be fair and candid, we concede the language of the bill is not the best and, in our view, it plays into the hands of those who agree this is a mandate. The level of detail (at least in the version of the bill we reviewed) as to the number and times of screenings is unwise and better left to clinicians rather than legislators grappling with a myriad of other issues.

For that reason we believe a redraft is appropriate and we would be pleased to assist in the effort. However, to be clear, we support the bill and all efforts to increase awareness of this form of depression, the importance of screenings and the availability of treatment.

Thank you

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Testimony in support of House Bill 3897: *An Act Relative to  
Postpartum Depression*  
Committee on Financial Services  
January 27, 2010

Thank you for the opportunity to speak today in favor of House Bill 3897. My name is Kate Weldon LeBlanc, and I live in Malden with my husband and two-year-old daughter. I worked in Government Relations for 13 years, including three wonderful years in this building and 10 more at Children's Hospital Boston. During that time, I helped and prepped probably over 100 people to testify, but this is my first time here testifying myself. But from the first moment I heard about this bill, I knew I wanted to share the story of our family's experience with postpartum depression. I am here today because not only do I strongly support this legislation but also because I think that the more we talk, write, and learn about postpartum depression, it will lessen the stigma and more families will get help.

I never knew that approximately 15% of new mothers in Massachusetts suffer from postpartum depression, and I certainly never expected to be one of them. But I realize now that nothing guarantees that someone will, or will not, suffer from postpartum depression. And that no two mothers will experience it in exactly the same way.

My first mistake was believing that postpartum depression would not happen to me because we so wanted, and were so excited, to become parents. It had been difficult for us to conceive, so words can't even describe how thrilled my husband Joe and I were when I finally got pregnant, and that feeling continued through my healthy pregnancy and delivery. In fact, I looked so happy when I arrived at the hospital to give birth that at first they didn't believe I was in active labor! But I certainly was, and our healthy baby girl Sophie was born a few hours later. We were overjoyed, and so were our large group of family and friends that we are so blessed to have. Those first few weeks at home were tiring and challenging as they are for most parents with a newborn, but nothing out of the ordinary. We were getting to know and enjoying our little girl. But then at around three weeks postpartum, I began to get increasingly overwhelmed and

irrationally anxious. Some stress was understandable: Joe had just returned to work after paternity leave, and Sophie was fussy and hard to soothe because she had reflux. But I started to be obsessively nervous about everything related to caring for my baby, even about things that were going well, like breastfeeding. Each day it got worse, to the point that I felt incapable of doing even the simplest tasks with Sophie. Fortunately, my mom lived close by and came over every day, and Joe was very helpful.

I usually express my emotions very openly – laughing as much as possible, crying when I am sad, and even when I am happy, as anyone who has seen me at a wedding can confirm. But during this time, my emotions were just flat, like I was dead inside. I had little interest in leaving the house and barely did, and was basically incapacitated.

However, the breaking point was when I stopped sleeping. You don't expect to get much sleep when you have a newborn, but this was different. I went one full week with no sleep. I would go to bed at night and sometimes fall asleep for 20 minutes, but then I'd wake up and not sleep again for the rest of the night. I used to just lay there with my mind spiraling around about all different things, and I could not make it stop. I had never experienced insomnia like this and it was like torture - to be awake while my baby was sleeping and to be so tired but incapable of resting!

Joe and my mother were understandably scared about these changes in me and encouraged me to get help, which I resisted at first. I thought that this was my "new normal". I was convinced that this was how I was going to always be as a mother – miserable and nervous and hopeless. Fortunately, Sophie has a wonderful and attentive pediatrician. During this time I often called her with my anxious questions, mainly about feeding, and she answered all of them kindly and patiently. But like my family, she was becoming troubled by the number and nature of my parenting concerns, and when she heard how long it had been since I slept, she insisted that I be seen by a mental health provider. Fortunately she is part of a broader practice that has mental health in the same facility so she literally walked down the hall to her psychiatrist colleague and urged him to see me that day, which he did. After this first visit, he



continued to treat me over the next several months, with a combination of medications and counseling.

Soon after my first visit to the psychiatrist, we went to stay with Joe's family for two weeks, which was very reassuring and helpful. But it was also tough not to be in our own home during this time that was supposed to be so special, and even harder to admit that I could not take care of my child by myself. I felt like such a failure.

The combination of the medications, more rest, and the support of our family and close friends helped me to get out of crisis, but I continued to suffer and to be scared of my own baby. I did not have suicidal thoughts during my postpartum depression, but yet I did have this vague and inexplicable feeling that I was not going to be around to raise Sophie – like I would just disappear and be replaced by someone who would be the good mother that my husband and daughter deserved.

While we were living with my in-laws, I also learned about a program called Early Connections<sup>®</sup>, which was run by the Center for Early Relationship Support at Jewish Family and Children's Service. EC provides home-based therapy for new mothers with postpartum depression and anxiety, and their babies, together. I requested their services right away because EC sounded ideal to me. Despite my anxiety about parenting, it had never manifested itself in withdrawing from Sophie and I loved the idea of having her with me during the sessions, unlike when I saw my psychiatrist. Frankly, I also liked the idea of not having to leave the house. My EC clinician visited us first at my in-laws house and continued when we returned home, and it was enormously helpful. I remember distinctly that during one visit the clinician said "You are so patient and nurturing with your daughter" and I almost cried, I think because for the first time, I believed it.

I know that one of the hardest parts of our experience with postpartum depression was my resistance to my husband and family's persistent efforts to help me. And I am grateful every day for the patience and love they showed me throughout. But I realize now that I needed the diagnosis by medical professionals because I trusted their expertise and that they were being impartial.

My postpartum depression and anxiety steadily improved over time. I reduced my counseling and medications gradually and then stopped everything after six months. I am happy to tell you that over two years later, I love being a mother. Sophie is absolutely the light of our lives. As much as I wish that I never had postpartum depression, I also feel profoundly grateful that I received excellent care and recovered quickly. I know firsthand that screening and treatment can pull mothers out of this darkness. It is the cases of postpartum depression that go undiagnosed and untreated that are devastating. The mother, and her family, suffers unnecessarily and silently, sometimes with tragic results. And that is why we are here today to support this bill.

I want to thank Representative Story and her excellent staff for their leadership and hard work on this bill, and all of you for listening to my testimony this morning.