Statement of

Michael Fitzpatrick, Executive Director,
National Alliance on Mental Illness (NAMI)

and

Mark Covall, President and CEO,
National Association of Psychiatric Health Systems (NAPHS)

on the

"Medicare 190-Day Lifetime Limit"

to the

House Ways and Means Health Subcommittee

Hearing on "Examining Traditional Medicare's Benefit Design"

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Mr. Chairman and members of the Subcommittee, we want to thank you for holding this hearing on "Examining Traditional Medicare's Benefit Design."

On behalf of our respective memberships, we are pleased to provide perspective on the need for Medicare modernization that could play a critical role in improving the lives of millions of Americans who live with serious mental and addictive disorders.

Together, our associations represent America's treatment providers, consumers, and families.

The National Alliance on Mental Illness (NAMI) is the nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness. NAMI advocates for access to services, treatment, supports and research and is steadfast in its commitment to raise awareness and build a community for hope for all of those in need.

The National Association of Psychiatric Health Systems (NAPHS), which was founded in 1933, advocates for behavioral health and represents provider systems that are committed to the delivery of responsive, accountable, and clinically effective prevention, treatment, and care for children, adolescents, adults, and older adults with mental and substance use disorders. NAPHS members are behavioral healthcare provider organizations that own or manage more than 700 specialty psychiatric hospitals, general hospital psychiatric and addiction treatment units and behavioral healthcare divisions, residential treatment facilities, youth services organizations, and extensive outpatient networks.

Medicare Modernization Is Necessary.

As you know, Medicare was established in 1965 when our healthcare delivery system and insurance system were very different than today's.

This is even more the case for mental health and addiction coverage. In 1965, most care for people living with mental illnesses was provided in state mental hospitals. Inpatient stays were counted in months and years, and much of the care was custodial in nature. Diagnosis and treatment was in its infancy for psychiatric illnesses. So when Congress was considering establishing the Medicare program, this was the framework that Congress had to work within in establishing coverage for mental illnesses. This resulted in a very limited benefit for mental illnesses under the original Medicare program and a benefit that provided much less coverage compared to that for other medical disorders. The benefits for mental illnesses included just inpatient hospital and outpatient office-based visits, but more importantly these benefits had limits in duration, scope, and cost-sharing. For example, outpatient psychiatric care had a 50% cost-sharing requirement (compared to an 80% cost-sharing requirement for all other Medicare outpatient services). Also, inpatient psychiatric care provided in freestanding psychiatric hospitals was limited to 190 days during the lifetime of a Medicare beneficiary.

These discriminatory benefits for mental illnesses remained in place until 2008 when Congress made the first change in mental health coverage since 1965. In 2008, Congress changed the cost-sharing for outpatient mental health services from 50% to 80% (phased in over several years) to make cost-sharing for mental health just like that for all other Medicare outpatient services. Yet the Medicare 190-day lifetime limit for inpatient psychiatric care in freestanding psychiatric hospitals remains unchanged to this day.

During the 1980s, there was a growth in the number of community private psychiatric hospitals that provided short-term, acute, inpatient psychiatric care. At the same time, the downsizing and closing of state mental hospitals intensified. During this period, diagnosis and treatment of mental illnesses dramatically improved and new medications became available. This resulted in briefer inpatient stays compared to the longer-term care that was provide in the 1960s when Medicare was first established. The 1990s saw a decline (more than 30%) of the overall inpatient psychiatric bed capacity. The decline in beds was in all settings, including state mental hospitals, community private psychiatric hospitals, and general hospitals' psychiatric units. Today, many communities do not have enough inpatient psychiatric beds—leading to an increase in emergency room visits, longer time spent in the emergency departments, and patients needing to travel long distances to receive inpatient psychiatric care.

In 2008, Congress passed landmark legislation called the *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Ac*t (MHPEA). This legislation changed the landscape of coverage for mental and addictive disorders by requiring private commercial health plans that offered coverage for mental health and addictive services to provide that coverage on par with all other medical disorders. However, the major governmental health insurance program for seniors and the disabled—the Medicare program—still has discriminatory coverage for inpatient psychiatric care. It is long past due to bring the

Medicare program up to the standard of all other insurance plans and to – once and for all – eliminate Medicare's 190-day lifetime limit for inpatient psychiatric care delivered in community private psychiatric hospitals.

The need to get rid of this long-standing discriminatory provision for inpatient psychiatric care is not just about fairness and equity, but it is about real people who are dealing with debilitating, but very treatable diseases who so desperately need this care.

Who Are These Medicare Beneficiaries? Why Is Elimination of the 190-Day Lifetime Limit Critical?

The Medicare Payment Advisory Commission[1] has outlined key characteristics of Medicare beneficiaries who receive inpatient psychiatric care.

Unlike beneficiaries seen in other types of hospitals, most Medicare beneficiaries treated in inpatient psychiatric facilities (known as "IPFs") qualify for Medicare because of disability. Patients being treated in inpatient psychiatric facilities tend to be younger and poorer than the typical Medicare beneficiary.

In 2008, 65% of discharges in IPFs were for beneficiaries under age 65, and almost 29% were for beneficiaries under age 45.

As baby boomers have aged, the number of IPF beneficiaries between the ages of 45 and 64 has grown, rising 18% between 2002 and 2009.

In 2008, 28% of beneficiaries admitted to an IPF had more than one admission during the 12-month period.

Beneficiaries with multiple stays were more likely than other IPF patients to be under the age of 65 (70% compared with 52%) and to be diagnosed with psychoses (78% compared with 66%).

These demographics provide a picture of Medicare beneficiaries who have serious mental illnesses (such as schizophrenia and bipolar disorder) and who are living with these disorders from a relatively young age. These illnesses are chronic and will require ongoing treatment and care over lifetimes, including hospitalization when in crisis.

[1] Medicare Payment Advisory Commission (MedPAC). "Inpatient psychiatric care in Medicare: Trends and issues." Chapter 6 in *Report to Congress*. June 2010. See http://www.medpac.gov/chapters/Jun10_Ch06.pdf.

Care for these sickest patients continues to have complexity and barriers that don't exist for other complex or chronic illnesses. These Medicare beneficiaries can easily exceed the 190-day lifetime limit because the chronicity of their illness.

The 190-day lifetime limit restricts access to critical, life-saving treatment just when it is most needed.

The 190-day lifetime limit also impacts the continuity of care for people living with serious mental illnesses. Just when they need crisis stabilization in a hospital setting, they may not be able to go to the hospital and doctors who have been treating them for many years because of the arbitrary lifetime limit.

Legislation has been introduced in previous Congresses to eliminate the 190-day lifetime limit, and it has been both bipartisan and supported by broad coalition of national organizations.

In closing, the science and knowledge base about mental illnesses has grown exponentially in recent years. These illnesses can be diagnosed and treated effectively. People can recover and live productive lives. What we need to do as a society is to give people the hope and help they deserve – just as we would for someone who has a heart condition or cancer.

Eliminating the 190-day lifetime limit will equalize Medicare mental health coverage with private health insurance coverage, expand beneficiary choice, increase access for the most seriously ill, improve continuity of care, and create a more cost-effective Medicare program.

Mr. Chairman, again, thank you for holding this very important hearing. We look forward to working with you and the entire Subcommittee to ensure that Medicare beneficiaries living with serious mental illnesses are able to have coverage that is comparable to what is available for all other Medicare beneficiaries.

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