

EXTENSIONS OF REMARKS

MEDICARE+CHOICE MENTAL
HEALTH COVERAGE ACCESS AS-
SURANCE ACT OF 1998

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, June 3, 1998

Mr. STARK. Mr. Speaker, I rise today to introduce the "Medicare+Choice Mental Health Coverage Access Assurance Act of 1998." This important legislation seeks to provide Medicare beneficiaries with appropriate and medically necessary mental health coverage under managed care.

Last year's Balanced Budget Act opened more managed care choices to Medicare beneficiaries through the establishment of the Medicare+Choice Program. In doing so, we enacted some patient protection measures for individuals enrolled or will be enrolled in Medicare managed care. However, because of managed care's history of putting more restrictive limits on mental health care compared to general health care, I believe that additional steps must be taken to ensure that Medicare patients with mental health needs will receive appropriate mental health care.

The amendments to the Balanced Budget Act that I am introducing today would give Medicare consumers emergency care in the case of a suicide attempt, coordination of post-stabilization care, clear descriptions of mental health and substance abuse benefits, access to mental health specialists and to inpatient treatment.

According to the Health Care Financing Administration, close to five million Medicare beneficiaries are mentally ill. Of these, 1.3 million are under age 65; they receive SSDI and Medicare due to a mental disability. The number of SSDI recipients diagnosed with a mental illness increased 17% between 1993 and 1995. And it is expected that the number of geriatric patients with mental disorders such as depression, anxiety, and Alzheimer's will grow rapidly in the coming years. To address these needs, Medicare spent close to four billion dollars on mental health services in calendar year 1994. Yet, the services presently received by Medicare beneficiaries are viewed by many as inadequate and fragmented.

While one may expect capitated systems to better provide for a full continuum of mental health care and serve individuals with mental health needs better, experience with this sector to date has been mixed. In the public sector, states are struggling to address fundamental questions of coverage, access, quality, and mental health's coordination with the rest of health care as millions of mentally disabled Medicaid beneficiaries are moved into managed care systems. It is worth noting that many public purchasers are placing their mental health and addiction disorder treatment and prevention programs into the hands of private companies far more rapidly than their own contracting abilities or the capabilities of the managed care companies may warrant.

Medicaid's transformation to managed care gives us reasons to proceed with caution. The federal government retains the ultimate responsibility of ensuring that taxpayers' money is well-spent and the mental health needs of Medicare beneficiaries are well-served if we are to turn their care over to private companies. This legislation that I am introducing today address these issues and requires the following minimum standards from health plans that wish to participate in Medicare.

First, a patient should get the psychiatric emergency care he needs if he has made a suicidal attempt or has made serious threats to inflict harm to himself. It seems that some managed care companies do not take a suicidal attempt seriously enough. According to the report Stand and Deliver: Action Called to a Failing Industry, 1997 by the National Alliance for the Mentally Ill, five of the nine largest behavioral managed care companies surveyed failed to provide a response that acknowledged a suicide attempt as a potentially deadly emergency requiring prompt attention.

Second, should a patient show up in an emergency room in an emotional crisis and the managed care plan decides that he does not meet the criteria for an inpatient admission, the plan must still do what it takes to stabilize the patient. Treatment decisions should include a realistic assessment of the availability of community supports and other treatment setting options that would serve as an alternative to inpatient care such as partial hospitalization or acute diversion units.

Third, Medicare beneficiaries are entitled to and should get a clear description of mental health and addictive disorder treatment benefits from health plans. This should include any front-end restrictions on utilization of mental health services such as premiums, co-insurance, deductibles, number of visits and days limits, and the range of services provided. In addition, plans should also disclose annual and lifetime limits on mental health spending. This would enable Medicare beneficiaries, and specifically those with mental disability, to make an informed choice of a plan that best serves their needs.

Fourth, a Medicare+Choice plan should provide beneficiaries access to mental health and addiction specialists. This requirement is particularly important to the severely and persistently mentally ill geriatric patients, whose complex medical, psychiatric, and cognitive impairments are frequently left poorly attended to.

Last of all, it must be emphasized that the treatment of serious brain disorders continues to require the availability of inpatient care. The decision to admit or to refuse a psychiatric hospital admission to a patient in distress can have grave and even life-threatening consequences. Thus, these decisions must be made in close consultation with the physician who wishes to admit a patient with serious symptoms to a hospital setting.

I urge my colleagues to join me in co-sponsoring this important and straightforward legislation. For too long, discussions of mental health and addictive disorders have been lost

in the Medicare debate. The elderly and disabled Medicare beneficiaries with mental health needs are a vulnerable population. They deserve our attention and our commitment to provide them with the best care we possibly can.

WHO WILL WIN THE SECOND
BATTLE OF SAIPAN?

HON. GEORGE MILLER

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, June 3, 1998

Mr. MILLER of California. Mr. Speaker, the following column by the highly respected writer Mark Shields appeared in the Seattle Post-Intelligencer on May 18, 1998 and describes the debate in Congress to reform the outrageous practices in the U.S. territory of the Commonwealth of the Northern Mariana Islands that conflict with core American ethics and values.

"Made in the USA Is at Heart of the Second Battle of Saipan" describes the continuing, widespread labor abuses and problematic immigration policies in the US/CNMI that have prompted a bipartisan group in Congress to support legislation to bring these local laws in conformity with those that apply throughout the rest of our country.

Like the battle of Saipan during World War II when American troops fought for 25 days to capture the island chain, the clash in Congress is an uphill battle between those who are working to instill humanitarian reforms in the island's labor and immigration policies and those who hail the existing policies as a cornerstone of "free enterprise."

At the root of this "second battle of Saipan" is the local control over minimum wage and immigration policies that was temporarily granted to local authorities over twenty years ago when the US/CNMI first became a part of the United States. However, since this local control was granted, the US/CNMI has not made any serious attempts to either increase the local minimum wage to the federal level or closely control its borders to prevent an influx of immigrants as it had promised. Rather, the US/CNMI maintains an artificially low minimum wage of \$3.05 per hour and has opened its borders to a flood of foreigners who provide the labor pool for menial, labor-intensive jobs.

Currently, foreign workers compose 91% of the private sector workforce and significantly outnumber U.S. citizens in the US/CNMI. Local labor controls and law enforcement are severely lacking, company housing is squalid, abuse is common and this low-cost foreign workforce is easy prey for exploitation. And the nearly \$1 billion in garments produced in these conditions by foreign workers bears the "Made in USA" label, although the labor protections normally associated with this label are nonexistent. Foreign workers in the US/CNMI can be deported at a moment's notice if they complain about conditions and are forbidden from changing jobs if they have a problem

• This "bullet" symbol identifies statements or insertions which are not spoken by a Member of the Senate on the floor.

Matter set in this typeface indicates words inserted or appended, rather than spoken, by a Member of the House on the floor.