THE PAUL WELLSTONE MENTAL HEALTH AND ADDICTION EQUITY ACT OF 2007

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

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H.R. 1424, THE PAUL WELLSTONE MENTAL HEALTH AND ADDICTION EQUITY ACT OF 2007

FRIDAY, JUNE 15, 2007

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 12:13 p.m., in room 2123, Rayburn House Office Building, Hon. Frank Pallone, Jr., (chairman) presiding.

Present: Representatives Green, Capps, Allen, Schakowsky, Solis, Matheson, Deal, Wilson, Ferguson, Myrick, Sullivan, Murphy, Burgess, and Blackburn.

Staff present: Carrie Annand, Yvette Fontenot, Christie Houlihan, Purvee Kempf, Jodi Seth, Bridgett Taylor, Lauren Bloomberg, Nandan Kenkeremath, and Chad Grant.

OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. I call the hearing of the subcommittee to order.

Good morning. Today, we are holding a hearing on H.R. 1424, the Paul Wellstone Mental Health and Addiction Equity Act of 2007. My colleagues and the chief sponsors of H.R. 1424, Congressman Patrick Kennedy of Rhode Island and Jim Ramstad of Minnesota, are here with us this morning. Thank you for being here.

To their great credit, they have been the most vocal proponents in Congress for requiring parity in insurance coverage of mental health conditions; and together they have crisscrossed the country to bring national attention to their cause and develop support for the legislation. To date, they have garnered 268 cosponsors and have demonstrated that this is not a partisan issue; and I want to thank them again for all they have done.

To establish the pressing need for this legislation, we will be hearing from witnesses about the current problems individuals confront when they seek insurance coverage for mental health and addiction treatment services. It will be made clear that, in spite of widespread recognition that mental illness and substance abuse are treatable illnesses, there exists glaring inequities between health insurance coverage for mental health and that for other medical conditions.

Health insurance plans often impose stricter treatment limits and higher out-of-pocket expenses on mental health care than on care for other illnesses. This discrimination prevents many from getting the treatment they need to function normally. As a Nation, we can no longer afford to ignore this disparity in coverage, because the cost to families and to society in general is simply too high.

On February 26 I hosted a forum in Trenton, NJ, on mental health parity with Congressman Kennedy, mental health professionals, advocates and individuals who experienced discrimination when they sought mental health services for themselves or their families. Their stories demonstrated to me the pain and anguish that accompanies mental illness when it goes untreated. Their personal accounts reveal that denying treatment for a mental illness can be just as life threatening as denying surgery to a cancer or heart patient.

The inequities extend across all age groups. For instance, it is estimated that over two-thirds of children with mental health conditions do not get the treatments they need.

In my own State of New Jersey, we have what is considered a limited mental health insurance parity statute. It requires that all biologically based mental illnesses be covered on a par with all other illnesses. It does not provide parity for what have been called nonbiological-based such as post-traumatic stress disorder, substance abuse, and eating disorders. Fortunately, thanks to the efforts of advocates and enlightened legislators, a measure for full parity has cleared many hurdles and is making its way towards passage in the New Jersey State Legislature.

But many other States are moving on their own towards more comprehensive coverage and now 26 mandate mental health coverage with full parity. I believe that any legislation we pass on the Federal level should recognize the value of these stronger State laws and serve as a Federal floor of covered benefits, beneath which no State law should sink.

The Kennedy-Ramstad bill recognizes this by not preempting existing State laws with greater protections. This sets that legislation apart from the Senate bill sponsored by Senators Kennedy and Enzi, legislation that is certainly a major step forward but not quite as comprehensive. Of course, I haven't figured out yet, there are two Kennedys here on two sides of the aisle, but we won't get into that too much.

The Kennedy-Ramstad bill also sets a high standard by requiring coverage of disorders offered to Members of Congress and their staffs through the Federal Employees Health Benefits Program. Our witnesses today will report on the costs associated with providing this more comprehensive mental health parity.

Employers have experienced cost increases of less than 1 percent as a result of implementing full parity laws. In fact, it appears that the cost of doing nothing is far greater for individuals, families, our health care system, and economy; and this will also be discussed in more detail by our witnesses.

In conclusion, it seems that almost every day a major news story breaks that has as its root an untreated mental health problem. A college student shoots his classmates, a mother drowns her own

children, kidnapping, suicides, drug and alcohol addiction. The next day's story is about the State's deteriorated mental condition—I should say about the subject's deteriorated mental condition, which many people knew about, and the failure or inability of that person to get mental health counseling and treatment.

By putting mental health on a par with other conditions, we will be improving the availability and affordability of health care for those with mental health and substance abuse conditions. This will not only reduce these horrific public incidents but also the everyday pain and anguish of many of our constituents and their families who suffer in silence.

I want to thank our witnesses and our Members for coming today and look forward to their comments. But I really couldn't conclude without thanking both of you. I saw when I—I know Jim wasn't able to come that day in Trenton. He tried, but he wasn't able to. But Patrick was there, and it was—the fact that Patrick was willing to tell his own story so effectively, the fact that so many other people were there to back him up. If I could just use that Trenton example of how Patrick and Jim have been going around the country, raising attention, both media and otherwise, to this. It is really because of your efforts and your willingness to do that and spend so much time, that we are at the point I think where we are going to be able to pass this and send it to the President. You really should be very proud, both of you, of what you have done; and I mean that sincerely. Thank you.

I will yield now to the ranking member, Mr. Deal.

OPENING STATEMENT OF HON. NATHAN DEAL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

Mr. DEAL. Thank you, Mr. Chairman.

I want to thank our colleagues for taking time out of their schedules to be with us. I realize this is a piece of legislation both of you have worked on for a very long time, and we appreciate your presence.

During last year we had hearings in the subcommittee on mental illness, and we discussed not only the prevalence of the problem and the treatment for mental illness but also the difficulty some patients had in accessing care. We heard compelling testimony about the debilitating effects of some of these illnesses, in addition to the advances in research. It became clear to me that improvements should be made to increase the access to mental health services, and I am glad we are taking the opportunity to today to explore that issue.

While I do believe people suffering from mental health disorders do need access to the appropriate type and level of treatment, legislation should be balanced in how it addresses this serious problem. I have always been concerned about the impact of insurance coverage requirements on the cost of health insurance. While no one mandate may increase the cost of insurance in a sizable way, they can have a cumulative effect of making coverage prohibitively expensive. I am sure this will be a point of discussion in the testimony of our witnesses, and I certainly look forward to hearing your thoughts on this issue.

I would also be concerned with any legislation which had the unintended consequence of employers not providing any coverage for all for other serious mental illnesses. Another troubling consequence could be, because employer-sponsored insurance is voluntary, increasing mandates could lead employers to stop offering benefits altogether. I realize these are reservations often raised in regards to legislation like the bill before us, and I hope that the witnesses can shed some light on these issues.

Improving access to mental health treatment is certainly a worthy goal. However, as we seek this target, there are a number of questions which must be addressed, such as what diseases and disorders ought to be covered in legislation and the broader impact of these changes on the insurance market. For this reason, I think this will be a good hearing, and we will give the opportunity to the committee to explore these issues in more detail.

My son happens to be a superior court judge in our State and handles the drug court for the two counties that our circuit is composed of. He was in town yesterday, along with mental health court advocates and family courts and drug courts from our State; and one of the things that they obviously all face is not only funding problems to keep those alternatives, which are very, very successful—in fact, the recidivism rate coming through the drug court has been 5 percent or less for a number of years now.

We are attempting and have begun the process of a mental health court, but it has huge problems of being able to obtain necessary funding. So it is a very broad picture, and I thank both of you for your time and efforts to be here today.

Thank you, Mr. Chairman.

Mr. PALLONE. Thank you.

I recognize the gentlewoman from California, Mrs. Capps.

OPENING STATEMENT OF HON. LOIS CAPPS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mrs. CAPPS. Thank you, Chairman Pallone.

The ranking member just made a comment about mental health court that prompted my interest, so I am going to be contacting him.

Thank you, Chairman, for holding this important hearing. I am very proud to be a cosponsor of the Paul Wellstone Mental Health and Addiction Equity Act of 2007, and I will be even prouder when it is passed by Congress and signed into law. That is when we will truly honor the memory of its namesake.

It is so fitting today that our first two witnesses are the bill's coauthors. Last month, it was also encouraging to take part in Mental Health Parity Day and meet with the men and women across the country who dedicate themselves to improving the lives of others. Really at the heart of this bill and this discussion today is the fact that there exists an unreasonable difference in the way we treat mental health conditions as opposed to all other health conditions. To a health professional—and there are a few of us in this subcommittee and many across the country that know that there should be no distinction in the importance of treating any state of ill health, whether it be heart disease, kidney disease, brain disease or a mental health disease. All parts of the body, including the

mind and the brain, are vital to our ability to function; and it is so sad that there has existed this distinction for mental health because of stigma and misunderstanding.

H.R. 1424 will begin to finally break down barriers for accessing life-saving mental health treatment. And I say life-saving deliberately, because as we are going to hear from these witnesses today, mental health conditions can indeed be just as life-threatening as other health conditions. We must put an end to the discrimination being practiced by insurers when they offer coverage for some health conditions and not others. And I know that some people today might refer to the Senate compromise on mental health parity. But frankly, I don't feel it goes far enough.

I strongly support the passage of language in H.R. 1424, which our dedicated colleagues and champions for mental health, Patrick Kennedy and Jim Ramstad, have worked so hard for so long to perfect.

Many employees aren't as fortunate as Members of Congress and our staff, who have access to Federal health benefits. Many employees have no choice at all which insurance plan they may access. They are lucky to have one, and so they take it without questioning. When someone gets a job and is offered health insurance, they pretty much have to take what the company has chosen for them. And it is not fair, I believe, to say, well, we are going to cover some parts of your health care, but we will pick and choose which parts of your body to cover. I believe that is bad for business. I know it is bad health care.

So again, I look forward to discussing the bill before us, and I am excited for the prospects of finally passing this legislation during this session of Congress. I yield back.

Mr. PALLONE. Thank you. The gentlewoman from New Mexico, Mrs. Wilson.

OPENING STATEMENT OF HON. HEATHER WILSON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW MEXICO

Mrs. WILSON. Thank you, Mr. Chairman. And I also wanted to thank my colleagues, Mr. Kennedy and Mr. Ramstad, for your leadership on this issue, and for being willing to take up the charge over such a long period of time and make it personal to people, as I think that getting beyond the stigma of mental illness is part of what we need to do to make sure that we achieve parity, so that diseases of the brain are treated in the same way and thought of in the same way as diseases of the heart or the lungs or the kidneys or anything else.

I come to this debate, and I have been a supporter in the past, a cosponsor in the past of the mental health parity legislation here in the House really based on my experience as the former cabinet secretary for child welfare in the State of New Mexico, where on any night we had about 1,600 kids in foster care. And generally, they were physically healthy and emotionally a wreck. And we aren't talking about kids who are a little bit depressed on the bus on the way to school. We are talking about severe mental illness among children. And getting those children adopted is hard enough, but making sure that they still have access to the nec-

essary medical and insurance coverage is certainly a challenge. And mental health parity would go a long way to helping families be able to get the care that they need for their children.

There is a different version of this bill, and Mrs. Capps just mentioned it, that was introduced in the Senate. It was introduced and has been supported for a long time by my colleague, the senior Senator from New Mexico, Pete Domenici. And that bill does represent I think—it is an agreement—represents an agreement that was developed over a period of about 2 years between—again in negotiations with various stakeholders in the mental health community and so on. I actually have a slight preference for the Senate bill, but I would like to see this bill get to conference so that we can get something done and move forward.

Again, I thank my colleagues from Rhode Island and Minnesota for your leadership on this issue, and I thank the chairman for holding this hearing today. Thank you.

Mr. PALLONE. Thank you. Ms. Baldwin of Wisconsin.

OPENING STATEMENT OF HON. TAMMY BALDWIN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WISCONSIN

Ms. BALDWIN. Thank you, Mr. Chairman. And I am very, very encouraged by the fact that we are holding this hearing today. I am proud to be an original cosponsor of H.R. 1424, the House Mental Health Parity bill, and I am delighted that this committee is holding this hearing and the bill's two main sponsors are here with us today. Congressmen Kennedy and Ramstad, you have shown such tremendous leadership on this issue, and I thank you both for that.

All Americans deserve access to affordable, comprehensive health care to meet both their physical and mental needs, and I believe that Americans should be provided with comprehensive coverage for mental health services. Mental illness and substance abuse are tangible, treatable health problems, just like hypertension, cancer, heart disease. Yet millions of hardworking men and women still find that their health plans place strict limits on coverage for mental health benefits.

I am very much looking forward to our discussion with our witnesses today, and I hope that we can take this opportunity to dispel some misconceptions about mental health parity. Often we hear those opposed to parity say that requiring mental health parity will increase utilization of mental health benefits and mental health costs. But we know from experience in States which already have mental health parity laws that this is not the case. And I look forward to hearing our witnesses talk more about that.

Lastly, I wanted to share an excerpt from a letter that I recently received from a constituent. Her name is Lisa, and she is from Madison, Wisconsin. Lisa is a registered nurse and a survivor of mental illness. Specifically, she has an eating disorder. And she writes, and I quote, "I strongly believe I would not have suffered from a severe eating disorder for 7 years, putting myself, my friends, and my family through hell had I had parity of insurance coverage." There are many causes and contributing factors to each sufferer's eating disorder, and it does not develop overnight. I was

one of the lucky ones to have even some health insurance for treatment of my serious eating disorder. However, it was grossly inadequate, geared more towards stabilizing the resultant physical consequences, and not the underlying cause. Only those who themselves can afford or whose families can afford this great expense have a good chance of recovery.

Unfortunately, Lisa's story is not unique. As we will hear today, millions of Americans face horribly restrictive barriers when they seek care for mental illness. This is not right, and this is why we need to ensure that every American has access to adequate mental health care by ensuring mental health parity.

And again, thank you to the witnesses today. I look forward to the testimony. Thank you, Mr. Chairman.

Mr. PALLONE. Thank you. Mr. Ferguson.

OPENING STATEMENT OF HON. MIKE FERGUSON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. FERGUSON. Thank you, Mr. Chairman. Thanks for convening this hearing and for your leadership on this issue. This legislation will undoubtedly deliver much needed treatment and care to thousands and thousands of people for which it is long overdue. I particularly want to thank Mr. Ramstad and Mr. Kennedy, our colleagues and friends, for joining us. There are few people in this body who don't have enormous respect and have noticed the incredible leadership and sacrifices that you have both made on behalf of this cause. I have had an opportunity to work with you on many different issues, but on this issue you two have no equal, except maybe each other, in your leadership and the work and devotion that you have made toward this issue. And you have our admiration for that.

Addiction and mental illness are afflictions that have long been stigmatized and brushed aside by our society and our institutions. And I would submit that every family, every family has been touched by mental illness in some way, large or small, in some way or another. And for too long people have been told that they must fend for themselves while battling these diseases. Those battling their debilitating effects have not been able to receive the stability of care that is available when adequate insurance coverage is in place. And the Paul Wellstone Mental Health and Addiction Equity Act is an idea whose time had come a long time ago. And it is time to deliver what people battling addiction and mental illness have long needed and wanted, and that is help.

I have been a cosponsor of mental health parity efforts in the past. I am happy to be here today to add my support as a cosponsor during this Congress. And I look forward to the testimony of our witnesses and both of our panels today, and certainly look forward to working with my colleagues on this committee on both sides of the aisle to pass this important legislation.

I yield back. Thank you, Mr. Chairman.

Mr. PALLONE. Thank you. The gentlewoman from Illinois.

OPENING STATEMENT OF HON. JAN SCHAKOWSKY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

Ms. SCHAKOWSKY. Thank you, Mr.Chairman. I too want to thank our wonderful panel of witnesses for sharing their experience and expertise with us, particularly those witnesses who are willing to share their personal experience, including of course Representatives Kennedy and Ramstad, whose leadership has been informed by personal experience. And you do honor to our friend Paul Wellstone. He and his wife Sheila were great personal friends of mine, and I know he will be very proud when this bill is signed—or would have been very proud when this bill is signed into law.

The courage that you two demonstrate telling your personal stories of struggle and hope will serve as models for others who have been touched by mental illness. And what family has not been? Each of you serve as proof that with adequate support and appropriate treatment people with mental illness can live to their full potential and make unique contributions to society.

Your stories also point to the tremendous value of mental health treatment. We have come a long way in our understanding and treatment of mental illness, but the barriers to obtaining coverage remain. Approximately 15 percent of Americans are affected by a clinically significant mental disorder in any given year, with 2 to 3 percent experiencing a severe mental illness. Many of them are struggling to access effective treatment that could greatly reduce their suffering and increase their participation in occupational, educational, social and civic realms.

Science has dispelled several myths that have been used to justify unequal coverage of mental disorders and mental health treatments. The arguments that mental illnesses are not real illnesses and mental health treatments are not real treatments have been dispelled by research into mental disorders and their treatment. Growing evidence also suggests that the myth that if mental health care were available as a standard benefit then everyone would use it and it would bankrupt the system, and that has been dispelled by economic analyses and actual experience.

Today we know that mental disorders are real and complex, with biological, psychological, and social contributors. Rigorous scientific evaluations have found a range of mental health treatments to be effective, including numerous medications and psychotherapies sometimes showing greater effectiveness than many medical treatments. For example, there is a 90 percent cure rate for panic disorder, which is a very debilitating condition. A variety of mental disorders actually have a number of effective treatment options available, making cost-effective choices possible.

Several studies and the experience of numerous States have demonstrated that the provision of mental health parity results in only modest cost increases. Illnesses such as schizophrenia, bipolar disease, major depression, anorexia nervosa, alcohol dependence, and many other disorders are potentially life-threatening conditions that can cause serious impairment and tremendous suffering for affected individuals and their families and friends. These illnesses are not moral or personal failures, and affected individuals should not be punished for suffering from them.

The time has long passed that we do this. I am so proud to be a supporter of H.R. 1424, and look forward to its passage and this discussion of it today. Thank you.

Mr. PALLONE. Thank you. Mrs. Myrick of North Carolina.

OPENING STATEMENT OF HON. SUE WILKINS MYRICK, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NORTH CAROLINA

Mrs. MYRICK. Thank you, Mr. Chairman, for holding the hearing today. And I also thank our colleagues for all their hard work and their willingness to speak out. This issue of mental health insurance parity is not a new one, and I think this hearing is a good opportunity for members to have questions answered about how it will impact of course the insurance market, but also the lives of the patients who have the brain disease.

For some time I have emphasized the need for Americans to realize that severe mental illnesses are really brain diseases, diseases that impact your brain rather than your heart or your kidneys. They are diagnosable, treatable, and biological in nature.

There are several fronts in the battle to recognize and treat these diseases. There is the awareness fight, which has been very difficult, to help people realize that diseases like bipolar, schizophrenia, depression aren't moral failings; they are diseases that can be treated once they are diagnosed. There is a scientific fight in which experts attempt to map the different changes in the brain and the genome and that impact the onset and the severity of the illnesses, and there is the treatment fight. These diseases are expensive and frustrating and often difficult to diagnose and treat. Doctors don't always have the latest scientific treatment standards at hand to treat each patient with the right dose or the right medicine or the cocktail or the right therapy. And from personal experience, we have had that experience in our family of trying to find the right way to do it. Patients with a mental illness aren't always willing to seek help from professionals. And then of course there is always the question of insurance and how much does it cost.

Untreated mental illness costs our country billions of dollars each year. It costs patients the ability to work, function in society. It costs our families a lot of heartache, and bleeds so much from our public system in the forms of homelessness, incarceration, illegal drug use. The list goes on.

It should also be noted that those who have health insurance, but lack sufficient mental health coverage, sometimes bankrupt themselves and their families, and they eventually end up on Medicaid. And we know that that costs us a lot over the long run.

In many ways, having a severe mental illness is no less serious than having cancer, and oftentimes it poses a more serious threat to the patient's life and ability to function. But let's not underestimate the gravity of the decision to create a Federal mental health parity structure. The health insurance market is notoriously complicated, and those who have a brain disease and don't have insurance don't benefit from mental health parity mandates. That is a whole 'nother issue. And if there is any incentive for insurance providers to drop coverage based upon the perceived expense or imposition of parity laws, those who have some mental health coverage

may eventually find themselves without it. And that is why I am glad we are having the hearing today to discuss all these options.

It is also important to note States have control over their benefits as well and a lot of employee plans under their jurisdiction, and we need to look into that as well. I know the agreement that is reached on the Senate side. I think it is very important they have that kind of agreement, especially with the problems that we have today. And so I want to hear from people relative to the House bill and what that brings as well. And again I thank the gentlemen from Rhode Island and Minnesota for all your years of dedication.

Thank you, Mr. Chairman.

Mr. PALLONE. Thank you. Ms. Solis.

OPENING STATEMENT OF HON. HILDA L. SOLIS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Ms. SOLIS. Thank you, Mr. Chairman. And I really appreciate the fact that you are having this hearing, and want to welcome Congressman Kennedy and Congressman Ramstad also. I know you guys, both of you, have worked so tirelessly on this issue, at least in the last 7 years that I have been here in the House, and I want to thank you for continuing the fight that Senator Wellstone began. And I did have the pleasure of working with him shortly. But as a State legislator, because even in the State of California back in 1999, we passed a mental health parity bill for this same reason that you are here today. And I would just say that it works, it works well, it is something that is proven. And for a district like mine, where we have so many young people that we are finding in the juvenile justice system and then eventually leading into the county jail system, and I know Congressman Kennedy knows fully well what that means. And in many terms our sheriff there, Lee Baca, has said that he is really not a caretaker for criminals, but more of a caretaker of the mentally ill. And it is unfortunate, but that is a fact and it is a reality, and we as a country need to do something about it.

And I am particularly concerned because of communities of color. Because the ratio of suicide for Latinos, Latinas, and Asian American women is very high, and we are not doing enough to detect that early on and providing tools for their families, and also for school districts, where I think intervention really needs to take place as well.

So I am very happy to be a cosponsor of the bill, and look forward to hearing from both of you, and can't wait to see a signature from the President on the bill. Thank you, and I will yield back the balance of my time.

Mr. PALLONE. Thank you. Mr. Sullivan of Oklahoma.

OPENING STATEMENT OF HON. JOHN SULLIVAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OKLAHOMA

Mr. SULLIVAN. Thank you, Mr. Chairman. And I would like to thank Congressman Kennedy and Congressman Ramstad for testifying today on H.R. 1424, the Mental Health Addiction Equity Act

of 2007, and I am pleased to be an original cosponsor of this very important legislation. At the end of March, Congressman Kennedy and I held a field hearing in Tulsa, Ok, to examine the effects of mental health disorders on Tulsans and the need for mental health and addiction parity. Hearing from families, scientific experts, businesses in Tulsa, all of whom have been affected by mental health disorders, drove home the point that mental illness touches many lives and the need for mental health parity could not be more important.

My home State of Oklahoma currently ranks No. 1 in the Nation in the number of people struggling with mental illness and addiction disorders, almost one-fourth of the population of the State. While many States, including Oklahoma, already have mental health parity laws in place, it is vital that Congress enact Federal legislation which levels the playing field for the 54 million Americans suffering from mental illnesses. The simple fact is mental illnesses are biologically-based brain disorders, and need to be treated by insurance companies like any other physical illness.

According to the Government Accountability Office, nearly 90 percent of health plans impose financial limitations and treatment restrictions on mental health and addiction care. This legislation, which would help an estimated 113 million Americans receive fair mental health and addiction treatment, requires group health plans that offer mental health and addiction benefits to do so on the same terms as they do for other diseases. This means closing the loopholes in the past laws that have allowed insurance companies to continue to charge higher copayments and deductibles to individuals seeking mental health treatment, and eliminating annual caps on inpatient/outpatient care.

One of the most important aspects of this bill is that it ensures that the health plans must cover the same range of mental illnesses and addictions that Members of Congress and other Federal employees and their dependents receive under the Federal Employee Health Benefit Plan.

And a lot of people talk about this as costing a lot of money, which is not true. The economic cost of untreated mental illness in America is more than $100 billion each year, and the cost of addiction is $400 billion each year. Mental health parity will bring these costs down and offer new hope to millions of Americans suffering from mental illness.

I look forward to hearing your testimony, and also I want to say that you two are doing something that really is going to help people's lives. We vote on a lot of stuff around here, and this is truly going to have an impact on millions of people's lives. You guys are heroes. You are doing a great job. Thank you.

I yield back.

Mr. PALLONE. Thank you. I recognize our vice chairman, Mr. Green.

OPENING STATEMENT OF HON. GENE GREEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. GREEN. Thank you, Mr. Chairman. I would like to ask unanimous consent to place a full statement into the record, and I will just paraphrase it to save time.

One, like my colleagues, I want to thank our colleagues from Rhode Island and Minnesota for being so diligent in working on this bill for so many years. I am proud to be a cosponsor of it. And I will just briefly talk about the need for it.

Sixty percent of employers in my district that provide insurance come under Federal law and not State law. We have 26 States who have full mental health coverage, but a number of other ones only have partial, which includes the State of Texas. And I was proud as a State senator to even get that much in the late 1980s.

I am glad the bill uses a DSM-IV, so that doctors and not insurance companies will make the decision on illnesses. In our experience in the Houston area, with the Katrina evacuees traumatized, it is so needed to make sure we have mental health services available, whether you are in New Orleans or Houston or anywhere else in the country, particularly in a disaster.

And I will say a caveat, in an earlier career, before I ran for Congress, I did mental health work as an attorney. And it is half mental health work and half counseling to find reasonable placement and family for my clients. And seeing the clients who were in the public system, as opposed to the few who had private insurance, it was so amazing.

And so that is why this bill is so important, and I yield back my time.

Mr. PALLONE. Thank you. Mr. Burgess.

Mr. BURGESS. Thank you, Mr. Chairman. I want to welcome our colleagues, thank them for being here. In the interests of time, I am going to submit my statement for the record, reserve time for questions.

Mr. PALLONE. Thank you. The gentleman from Utah.

OPENING STATEMENT OF HON. JIM MATHESON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF UTAH

Mr. MATHESON. Well, thanks, Mr. Chairman, and I am so glad you are holding this hearing today. And I really want to first just extend my appreciation to our colleagues, Mr. Ramstad and Mr. Kennedy. I appreciate your leadership on this issue and your commitment, and I hope we can make progress. I know you do, too. I look forward to hearing from both panels, actually, and I hope we can get some insight that will help this committee move forward. I also hope that we hear recommendations on how best to achieve a balance between the important goal of mental health parity, and also assuring that we continue to improve access for all Americans to affordable and comprehensive health care.

As you know, Mr. Chairman, I am an original cosponsor of this bill, and have been a cosponsor in previous Congresses as well. I look forward to seeing if this committee can pass legislation in this area. I believe the provision of mental health care is an important responsibility of health care plans. And mental health care should not be treated in a significantly different manner than other illness, and those who suffer from mental illness should be able to obtain necessary services and medications.

It was in 1999 the Surgeon General reported mental health illnesses are largely biologically based disorders, similar to other medical conditions. And the Surgeon General has reported that

mental health treatments are highly effective. It is simply common sense to cover these treatments so that those who suffer from these illnesses can return to being fully productive members of our society.

It is my hope this committee will work on this tough legislation. I think it is a crucial step forward in the fight to assure every American's access to high quality health care. And I appreciate the time, Mr. Chairman, and I will yield back.

Mr. PALLONE. Thank you. The gentlewoman from Tennessee.

OPENING STATEMENT OF HON. MARSHA BLACKBURN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TENNESSEE

Mrs. BLACKBURN. Thank you, Mr. Chairman. Thanks for holding the hearing, and welcome to all of our witnesses that are here with us today. And I do want to thank our colleagues for their willingness to work on the legislation and to come before us today.

When I was in the State senate and dealing with issues that came before us in judiciary committee, I started to look at some of the root causes for teen violence, for gangs, for abusiveness, for the drug court problems that we had. And repeatedly as I delved into that root cause it came back to some form of mental illness and mental health. And as I studied a little bit more on the issue and I moved on to Congress I certainly became aware of the cost to our health care system. When you look at it in aggregate of what it costs the American health care system with emergency room visits, and days lost from work, and additional costs to the criminal justice system, we are talking hundreds of billions of dollars.

This is not an isolated problem. It is not a segmented problem. Many times it is the basis for other forms of health and wellness. And currently 46 States have some type of mental health coverage that is enacted into law. And they vary considerably, including equal coverage or a minimum mandated mental health benefit, depending upon the State. And 26 States have laws that require some type of mental health parity or something that is broader than the Mental Health Parity Act passed in 1996. And some laws apply primarily to serious mental illness and may not assure coverage for current circumstance. Many private market health plans also include some type of mental health benefit on a voluntary commercial basis, not necessarily required by State or Federal laws.

Now while this seems like a patchwork, indeed what it does show is an awareness over the past couple of decades that there is a connection between the physical and the mental health. As we move forward on this discussion, I hope that we are going to keep an eye toward what happens in the free market and look for a decision of how to cover mental health benefits as we can leave options to the insurer and the insured. So I am looking forward to discussing how a Federal mandate requiring that mental health coverage be given parity does not usurp personal freedom and unnecessarily trump State laws that are currently in existence.

Thank you again to our witnesses and to our Chairman, and I yield back.

Mr. PALLONE. Thank you. Mr. Allen of Maine.

OPENING STATEMENT OF HON. TOM ALLEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MAINE

Mr. ALLEN. Mr. Chairman, thank you for calling this important hearing on mental health parity. And to our colleagues, Patrick Kennedy and Jim Ramstad, thank you for your courage and your determination to drive this issue. You are doing it extraordinarily well.

Through this piece of legislation, we have an opportunity to improve the lives of millions of Americans suffering from mental illness and addictions, and I believe we must work together to strengthen current law to improve access to mental health treatment and services.

The effects and implications of mental illness are broad. Poor mental health manifests itself as more than an emotional condition. It can also cause or exacerbate physical conditions, such as substance abuse, obesity, and heart disease. If our goal is to reduce health care spending and improve health care outcomes, covering treatment for mental illness differently than physical illness is illogical and ineffective.

Mental illness and addictions left untreated increase indirect societal costs. Lack of access to mental health treatment due to lack of insurance coverage costs our economy more than $100 billion a year through absenteeism, turnover and retraining expenses, lower productivity, and increased medical costs.

Treatment of mental illness has come a long way. Mental health providers deliver better care for patients through use of evidence-based practices and, as we have heard and will hear today, improved coverage for mental health does not greatly increase total health care spending.

Many States, including my home State of Maine, have acted independently to provide individuals with more comprehensive mental health benefits. The Paul Wellstone Mental Health and Addiction Equity Act appropriately allows States to continue to provide exemplary care to their citizens. States that go above and beyond Federal requirements should not be held back.

I look forward to working with my colleagues to create a strong mental health parity bill that truly ensures equal coverage for physical and mental illness. I thank our witnesses and, Mr. Chairman, yield back the balance of our time.

Mr. PALLONE. Thank you. Mr. Murphy,

OPENING STATEMENT OF HON. TIM MURPHY, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. MURPHY. Thank you, Mr. Chairman, for holding this important meeting. And I appreciate Mr. Kennedy and Mr. Ramstad for being here, too, for through this issue we have developed real friendships and respect for the work you have done. I speak here also as the co-chair of the Mental Health Caucus and as the only child and family psychologist serving in Congress, and as a person who has held in my arms those patients who have tried to commit suicide while waiting for an ambulance or have gone to their funerals. But I have also gone to their graduations and received notes from them when they have had their children as their life has

turned around. And it is important to know that these are very real instances, despite what those who may oppose this bill continue to send out false information that it is not treatable, it is a matter of fantasy and pretend, or that its costs outweigh the benefits.

I tell you from a person who has studied this throughout my life, and as a practicing psychologist for over 25 years, and has written books and published articles on the subject, mental illness is real. It is debilitating. It costs money. And it can cause health care costs to double when it is untreated.

Mental illness can be treated successfully, oftentimes better than many other medical problems. And to do so is cost-effective. When a factory looks at buying a machine for its assembly line, it doesn't just look at the direct costs of what that machine is, but it also looks at what it would cost to buy a cheaper machine when it is less effective, less efficient, less safe. We also need to put this same sort of reasoning when it comes to buying health care plans. We can all buy something cheaper up front, but it will cost more in the long run for employee training, absenteeism, presenteeism, workers comp costs, injuries, and deaths.

We also need to know that mental illness is not something that one treats just by encouraging one to pull themselves up by their bootstraps on one extreme, nor is it something where a person is doomed to victimhood all their life with some sad lifelong sentence. Indeed, it is something that we can treat, but we cannot treat it if we remain mired in the Salem witch trials mentality of centuries gone by where we think if we ignore something or torture something that somehow it will get better.

This is an opportunity to change the direction of health care to save money and to save lives. It is both cost-effective and compassionate. I can think of no better marriage of ideas from all levels than looking at an issue of mental health parity. Many Fortune 500 companies have examined it, have concluded that it saves money for them, and we need to deal with this in a rational way, finally, to help those who otherwise we place behind the shadows of victimhood. And it is time that we stop ignoring them. To all of those people we need to reach out our hearts, we need to understand this carefully, and we need to pass this bill.

Thank you, Mr. Chairman.

Mr. PALLONE. Thank you. I believe that concludes the members' opening statements.

Any other statements for the record will be accepted at this time.

[The prepared statements of Mr. Dingell and Ms. Eshoo follow:]

PREPARED STATEMENT OF HON. JOHN D. DINGELL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

I welcome all of our witnesses here today to help shed light on the issue of Mental Health Parity and specifically H.R. 2414 introduced by Representatives Patrick Kennedy and Jim Ramstad. The devotion and passion that they have shown on this issue is truly impressive.

More than 54 million Americans, about 20 percent of Americans, have a mental disorder in any given year. And 22 million Americans struggled with drug and alcohol dependence in 2005. Fewer than 8 million, however, sought treatment for their mental disorders and less than 10 percent of Americans sought treatment for their substance abuse problems.

Part of the reason for this is the lack of health insurance or an absence of coverage for mental health or substance abuse disorders. People cannot afford to pay the costs associated with seeking medical care without insurance so they forgo necessary treatment. Not only does this lack of treatment have detrimental effect on the individual but it also has ripple effects on their families, our community and economy.

Inadequately-treated mental illness and substance abuse not only harm a person's mental and emotional health, but it can also lead to other serious chronic and acute medical conditions. For example, studies indicate depression greatly increases the risk of developing heart disease and makes a person four times more likely to have a heart attack. And untreated alcoholism can lead to chronic diabetes. At the economic level, employees who are depressed are twice as likely to miss work for health reasons as employees who are not depressed, and be less productive when on the job. In addition, there is a 23 percent unemployment rate among American adults with depression, compared to 6 percent of the general population.

Despite the effects of mental illness and substance abuse, these disorders can be addressed with treatment. Eighty percent of those who seek treatment for clinical depression are successful. Behavioral healthcare treatments and psycho-pharmacological treatments for panic and bipolar disorders range in the 80 percent success rate, while treatments for schizophrenia, depression, and obsessive-compulsive disorders range in the 60 percent success rate.

When one considers all of this information, we understand how important it is that people have access to the same health care coverage to treat their mental health problems as they do to treat their physical health problems.

I applaud this legislation for taking the simple step of requiring health plans to impose no more restrictive treatment limitations and financial requirements in its mental health and substance abuse benefits than are applied in its medical and surgical benefits. In addition, this legislation ensures the right of States to further protect their citizens. It's a question of fairness.

PREPARED STATEMENT OF HON. ANNA G. ESHOO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. Chairman, thank you for holding this important hearing on H.R. 1424, the Paul Wellstone Mental Health and Addiction Equity Act. The fact that this bill has 268 bipartisan cosponsors in the House is a testament to the wide support and need for mental health parity legislation.

Representatives Patrick Kennedy and Jim Ramstad are our Nation's champions of this legislation and I thank them for their extraordinary leadership. I was proud to host them in my congressional district this year for a field hearing on the need for mental health and addiction parity. This issue is critically important to my constituents and I'm proud to be an original cosponsor of H.R. 1424.

Mental health and addiction disorders touch nearly every family in America. They account for over one-fifth of all lost days of work or school productivity, and they affect children, teenagers, adults and seniors. Approximately 54 million Americans suffer from mental illnesses, and 26 million from addictions. A high percentage of Americans are battling co-occurring mental illnesses and addictions.

Mental illnesses and addictions have historically not been well understood. Because their visible symptoms are changes in personality and behavior, mental health disorders have often been perceived as personal or moral failings. New technologies developed in the last few decades such as MRI's and PET scans have allowed scientists to peer inside the brain and clearly establish the physiological and biological basis of these diseases. The mapping of the human genome has also illustrated that strong genetic markers for mental disorders and addictions exist. In spite of these facts, public health policy has not kept up with science.

Most Americans face barriers to mental health care and addiction treatment not encountered in accessing other forms of health care. According to a 2000 report published by the Government Accountability Office, most employer-sponsored health plans include more expensive financial requirements (such as copayments and deductibles), treatment limitations (such as limits on the number of covered outpatient visits or days in the hospital), or excluded diagnoses related to mental health or addiction disorders.

H.R. 1424 will improve the health of Americans by granting greater access to mental health and addiction treatment and prohibit health insurers from placing discriminatory restrictions on treatment. Specifically, the bill prohibits treatment limits or the imposition of financial requirements on mental health and substance-related disorder benefits in group health plans which are not similarly imposed on

substantially all medical and surgical benefits in any category of items or services under such plans.

The legislation also requires the Comptroller General to study the effect of the bill on various aspects of the health care system, including the cost of and access to health insurance coverage, the quality of health care, Medicare, Medicaid, and State and local mental health and substance abuse treatment spending, as well as spending on public services.

I look forward to the testimony of our witnesses.

Mr. PALLONE. So we will now turn to our panel, with our two Congressmen and sponsors of this legislation, and we will begin with Mr. Kennedy.

STATEMENT OF HON. PATRICK J. KENNEDY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF RHODE ISLAND

Mr. KENNEDY. Thank you, Mr. Chairman. First, thank you, Mr. Chairman, and Ranking Member Deal, and all the committee members for your very, very generous comments regarding myself and Mr. Ramstad. They were very generous, and believe me, are reciprocated many times over for many of you who we worked with on the hearings that we did around the country. We couldn't have done those hearings without your support and the work that you did in organizing them for us as we traveled the country. And as evidenced by your opening statements, you basically stole our thunder, because you basically told the story of why we need this bill better than we could really say it ourselves.

Each of you laid out in your own statements very effectively why we need this legislation, and I think it is very poignant that you all addressed this in very different ways, from economic arguments, to how it affects the criminal justice system, to how it affects our health care system, how it affects a whole panoply of areas in our society.

I thought Mrs. Blackburn's comment that this is not an issue that can be isolated and segmented, but it affects all of society was right on target. Ranking Member Deal's point, with his son running the drug courts, was right on target.

The fact of the matter is this is a public health issue that we have criminalized. And our court system has become the—we have basically—as Sheriff Baca said in the words of Ms. Solis, I run the largest mental health clinic in the country. I run the Los Angeles County jails. That was in the words of Sheriff Baca.

In our health care system, as was mentioned by Mr. Murphy, in terms of the costs, we had the head of our emergency rooms often talk about up to 80 percent of the costs on any given weekend in our Trauma 1 centers, the costs of those patients, where those patients were there because of drugs and alcohol. But they were never transparently there for drugs and alcohol, they were there because of auto accidents that were as a result of drugs and alcohol. They were there as a result of gun shootings and fights, all of which were the result of drugs and alcohol. They were there as a result of other accidents that were a result of drugs and alcohol. And all of those accidents, and so forth, were written up as contusions, lacerations, concussions and intubations, all of which get reimbursed by insurance. And of course they are all symptoms of a deeper problem which doesn't get covered by insurance. And that

brings us back to why we need prevention. And that is why we need this bill passed. Because if we had the real issue covered, we could avoid those other costs that are so acute and end up bringing people to the emergency room far too often, adding so much cost to our health care system.

And then of course I think Mr. Murphy said it so well in terms of the costs to our business community. He made the analogy with the machine in a business. Making that same analogy, someone may say, well, it will cost more to implement parity. Of course we have here today someone who will testify to the fact that it won't. But the fact is even if it does, as Mrs. Blackburn said, we haven't taken it into account in terms of the overall savings in the aggregate, how it will save us money in the aggregate. And he said, well, if you put in a machine in a business that turns out more widgets, but it costs more to put it in, but in the net of the business you make more money, do you ask how much it cost to put the machine in if at the end of the day you make more money? No. Because you are looking at the bottom line. And so if it costs more to put these benefits in but at the end of the day you get a better return on your investment because you get better productivity from your workers, isn't that worth the investment? And that is what we heard in Pittsburgh, from Alberto Colombi from PPG in Pittsburgh.

And then we heard, from those out in San Francisco, we heard from Kevin Hines, who has survived a jump from the Golden Gate Bridge. Every year we have 34,000 Americans, twice the number of Americans that are murdered, twice the number of Americans that are murdered attempt—or actually successfully take their lives. To think that we see the news every night and see the number of people that are murdered, to think that twice that number actually successfully take their lives every year. And this was one gentleman who actually tried but failed. He is getting married this fall, Kevin Hines is. And he is happy now because he is getting treatment. And he is a sign of success.

And you know what, 90 percent of the people who attempt suicide are suffering from a mental disorder that is treatable. That is treatable. We could avoid those suicides in 90 percent of the cases where the mental illness is treatable. And that is an avoidable cost that could be addressed if we had mental health parity.

And finally, this is an issue fundamentally of civil rights. Nobody chooses to be born with a particular genetic makeup or a brain anatomy any more than they choose to be born with a particular skin color or gender. And so nobody deserves to be denied opportunities based upon such immutable characteristics.

And so when everyone here starts to talk about the cost of extending this coverage, let me just tell you about the story of Amy Smith. She is a young woman who said that for 40 years she was wandering the streets, muttering to herself, in and out of jails, because she suffered from schizophrenia and addiction. She said finally one day she got access to treatment. Now she holds down a job and she pays taxes. But she says I lost the opportunity to live my life, to live out my dreams as an American because I didn't get access to treatment. And that is a cost of our current system that you can't measure when you consider the costs of not having parity.

You can't measure that in financial terms. But that is a cost that you have to consider when you are taking it into account. You also have to consider the cost in the loss of lives. And when you think about cost-effectiveness you have to think about telling people like Amy Smith and millions like her when you think about keeping health care costs down, are they going to have to pay with their lives to keep the health care costs down? Because that is what you are essentially going to have to say if you say we don't want mental health parity because it costs too much. If you do that, you might as well say to cancer patients why not roll back coverage for cancer patients because that will also bring down costs. And I don't think any of you up there would want to roll back coverage for cancer. Because essentially you would have to be doing the same thing for cancer as you would do for mental health if you were to decide that you don't want to cover mental health parity. Because effectively you would be asking to be doing the same thing.

Jim and I have both been the beneficiary of mental health treatment, and we are both here because of it. And we are fortunate to be covered under the Federal Employees Health Benefit Plan. And if it is good enough for Members of Congress, it ought to be good enough for the rest of the country. And that is what this legislation says. And I hope that you have a chance to pass it out of this committee in the near future.

Thank you.

[The prepared statement of Mr. Kennedy follows:]

TESTIMONY OF HON. PATRICK J. KENNEDY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF RHODE ISLAND

Chairman Pallone, Ranking Member Deal, and my distinguished colleagues, thank you for inviting me to testify today, and, especially, for your commitment to ending insurance discrimination.

And of course, I must single out my great friend and the strongest champion for Americans with mental illnesses and addictions, Jim Ramstad. For years he has led this fight, leaning into the stiff wind of his own leadership without regard for the political consequences, speaking up for what he knows is right. We all owe him a debt of gratitude, nobody more than I. Jim, it has been an honor to stand with you in these efforts, and a greater privilege to be your friend.

This issue is first and foremost one of fundamental fairness. Marley Prunty-Lara, who you will hear from, paid her health insurance premiums just like everyone else. But when she got sick and needed her insurance coverage, she didn't get it. That is just not fair. And it nearly cost Marley her life.

There is no way to justify denying Marley, and millions of others, the full benefit of the health insurance they pay for.

In the attached exhibit, you can see the visual evidence that these diseases are physiological brain disorders. Some brain diseases, like Parkinson's, affect the motor cortex, the basal ganglia, the sensory cortex, and the thalamus. Other brain diseases, like depression, affect the limbic cortex, hypothalamus, frontal cortex, and hippocampus.

There is no way to justify providing full coverage to treat certain structures of the brain, but to erect barriers to the treatment of other structures.

This discrimination is not only unjustifiable, it is enormously costly. Representative Ramstad and I have traveled across this country holding informal field hearings on this subject—14 in total.

We've heard from chiefs of police, like Sheriff Baca in Los Angeles who says he runs the largest mental health provider in the United States: the L.A. County Jail. According to the Justice Department, more than half of inmates in jails and prisons in this country have symptoms of a mental health problem. Two-thirds of arrestees test positive for one of five illegal drugs at the time of arrest, according to the National Institutes of Health.

That's a cost of our insurance discrimination.

We've heard from hospital presidents and emergency room doctors, like Dr. Victor Pincus. He said that 80 percent of the trauma admissions at Rhode Island Hospital, a level-one trauma center, were alcohol and drug related. Eighty percent.

The physical health care costs go beyond the emergency room. Research shows, for example, that a person with depression is four times more likely to have a heart attack than a person with no history of depression. Health care use and health care costs are up to twice as high among diabetes and heart disease patients with comorbid depression, compared to those without depression, even when accounting for other factors such as age, gender, and other illnesses. Not surprisingly then, one study found that limiting employer-sponsored specialty behavioral health services increased the direct medical costs of beneficiaries who used behavioral healthcare services by as much as 37 percent.

These are costs of our insurance discrimination.

In our field hearings, we've heard from enlightened business leaders and insurance executives who understand that skimping on mental health and addiction treatment only winds up driving up other costs. That's why Bob Hulsey from the Williams Companies in Tulsa, Rep. Sullivan's district, said of parity, "I absolutely believe that it helps the business."

Rick Calhoun, an executive in the Denver office of CB Richard Ellis, a Fortune 500 company, made a similar point. Mr. Calhoun said that the cost of treating mental illness is 50 percent of the cost of not treating it. As he said, "This is a no-brainer. How could we not cover it?"

Untreated mental health and addiction cost employers and society hundreds of billions of dollars in lost productivity. The World Health Organization has found that these diseases are far and away the most disabling diseases, accounting for more than a fifth of all lost days of productive life. Depressed workers miss 5.6 hours per week of productivity due to absenteeism and presenteeism, compared to 1.5 hours for non-depressed workers. Alcohol-related illness and premature death cost over $129.5 billion in lost productivity per year.

These are the costs of our insurance discrimination.

All of these costs are preventable, and wasteful. But none are as tragic as the individual costs. We heard testimony from anguished parents like Kitty Westin and Tom O'Clair, who had to bury their children because their mental illnesses and addictions went untreated.

We heard testimony from people like Amy Smith, who said when she runs into people she knew 25 years ago, they're stunned she's still alive. She was in and out of jail and emergency rooms, unable to connect with other people, muttering to herself on the street, and unemployed. For 45 years, she says, she was a drain on society. Then she finally got the treatment she needed and now she's a taxpayer, holding down a good job.

Amy Smith lost decades of her life because she didn't get treatment. If you want to know the costs of our insurance discrimination, Amy Smith can describe them: "I would have been able to pursue my dreams for my life, which were things like driving a car, or holding down a real job, or getting married, or volunteering in the community, any of those things. I think my life would have been a lot different if I had had those services a lot earlier."

So many Americans have lost their dreams, lost years, and even lost their lives—unnecessarily. In Palo Alto we met Kevin Hines. He is a gregarious, outgoing person and is engaged to be married this summer. In 2001 he jumped off the Golden Gate Bridge, one of very few to survive that fall. Thirty-thousand people succeed where Kevin fortunately failed and take their own lives each year. How many of them would, like Kevin, be starting families, contributing to their communities, holding jobs, and realizing their potential if only they had access to treatment?

Mr. Chairman, I'm happy to provide the transcripts from the field hearings I have referenced to be included in the record of this hearing, as well as our report, "Ending Insurance Discrimination: Fairness and Equality for Americans with Mental Health and Addictive Disorders."

We will hear arguments that, even if worthwhile, equalizing benefits is just too costly. The truth, however, is that the cost of doing the right thing and equalizing benefits between mental health and addiction care on the one hand and other physical illnesses on the other hand is negligible. This is not speculation.

In 2001, we brought equity to mental health and addiction care in the Federal Employees Health Benefits Program (FEHBP), which covers 9 million lives, including ours as Members of Congress. A detailed, peer-reviewed analysis found that implementing parity did not raise mental health and addiction treatment costs in the FEHBP. Since our bill specifically references the FEHBP to define the scope of our bill, this analysis provides strong evidence that our legislation will similarly have

negligible impact on costs. This finding is consistent with virtually every study of state parity laws as well.

But frankly, the very fact that we need to debate how much it costs to end insurance discrimination is offensive. Nobody is asked to justify the cost-effectiveness of care for diabetes or heart disease or cancer. Tell Marley Prunty-Lara, Kitty Westin, Tom O'Clair, Amy Smith, or Kevin Hines, or the millions of others who live with these diseases that to keep health care costs down for everyone else, they will not have to pay with their lives. Why them?

People might say that there is a component of personal responsibility here, especially with addiction. That's true. I'm working hard every day at my recovery, and it's reasonable to ask of me. But it's also true that we don't deny insurance coverage to people genetically predisposed to high cholesterol who eat fatty foods. We don't deny insurance coverage to diabetics who fail to control their blood sugar.

At the end of the day, this is about human dignity and whether we deliver on the promise of equal opportunity that is at the heart of what it means to be American. Nobody chooses to be born with particular genetics and anatomy, any more than they choose to be born with a particular skin color or gender. And nobody should be denied opportunities on the basis of such immutable characteristics. Anybody who pays their health insurance premiums is entitled to expect their plan to be there when they get sick, whether the disease is in their heart, their kidneys, or their brain.

Unlike any other country in the world, this one was founded on principles—the ideas of equality and freedom and opportunity. The history of America is the history of a country striving to live up to those self-evident truths. In pursuit of those values we've fought a civil war, chipped away at glass ceilings, expanded the vote, renounced immigration exclusion laws, and recognized that disabilities need not be barriers. Led by one of our own colleagues, a generation of peaceful warriors forced America to look in a mirror and ask itself whether its actions matched its promise, and they changed history.

It is time, once again, to ask that question: are our actions matching our promises? And once asked, the answer is clear. Jim and I know, personally, the power of treatment and recovery. We are able to serve in Congress because we have been given the opportunity to manage our chronic diseases. Every American deserves the same chance to succeed or fail on the basis of talent and industriousness. That's the American Dream, and it shouldn't be rationed by diagnosis.

Thank you.

Mr. PALLONE. Thank you so much. Mr. Ramstad.

STATEMENT OF HON. JIM RAMSTAD, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MINNESOTA

Mr. RAMSTAD. Thank you, Chairman Pallone, Ranking Member Deal, distinguished committee members and friends all. Thank you for holding this important hearing, and thank you for your kind and supportive comments.

On July 31, 1981, I woke up from my last alcoholic blackout under arrest for a variety of offenses, woke up in a jail cell in Sioux Falls, SD, and I am alive and sober today only because of the access that I had to treatment. Too many people don't have that access to treatment that Patrick Kennedy and I had. It is a national disgrace that 270,000 Americans had the doors slammed shut to the treatment centers last year alone. It is a national tragedy that last year alone 150,000 of our fellow Americans died as a direct result, as a direct result of chemical addiction. Nobody knows as an indirect result how many heart failures, how many liver failures, how many other causes, how many accidents that weren't documented.

It is also a national tragedy that 34,000 Americans, as Patrick mentioned, committed suicide last year as a direct result of depression. And it is a national crisis, really a crisis that untreated addic-

tion and mental illness, according to SAMHSA, cost our economy over $550 billion last year alone.

When you think of the costs, as I know you all do, that can't be measured in dollars and cents, the human suffering, the broken families, the shattered dreams, the ruined careers, destroyed lives and so on. It is time to end the discrimination against people suffering the ravages of mental illness and chemical addiction. It is time to end the higher copayments, higher deductibles, out-of-pocket costs, and limited treatment stays, discriminatory barriers to treatment that don't exist for other diseases.

According to the GAO, 90 percent of health plans currently impose financial limitations and treatment restrictions on mental health and addiction care that are not imposed on other illnesses. Ninety percent of plans impose these discriminatory barriers that they don't impose on other illnesses. It is really time to treat mental illness and chemical addiction under the same rules as other medical illnesses. Because if you believe what the American Medical Association espoused back in 1956, that addiction and mental illnesses are a disease, then you can't justify discriminating against those diseases.

The Paul Wellstone Mental Health and Addiction Equity Act will give Americans suffering from addiction and mental illness greater access to treatment by prohibiting health insurers from putting discriminatory restrictions on treatment. It will end the discrimination against people who need treatment for mental illness or chemical addiction. And we have all the empirical data in the world to show that increasing access to treatment is not only the right thing to do, but it is a cost-effective thing to do. And I would be happy to share any of the 20-some studies that we have that independently corroborate the fact that parity, where it has been employed, with respect to the Federal Employees Benefit Plan, for example, and you are going to hear testimony, I believe, in the second panel, actually saves dollars. This doesn't cost dollars, as those critics would maintain. We have got the proof, the empirical data, including all the actuarial studies, to prove that equity for mental health and addiction treatment will save billions of dollars nationally, while not raising anyone's premiums not more than one-half of 1 percent.

Let me put it to you this way. For the price of a cheap cup of coffee a month, 16 million people in health plans could receive treatment for their mental illness or chemical addiction. That is right from the Milliman & Roberts study, an independent actuarial firm. Furthermore, it is well documented that every dollar spent on treatment saves $12 in health care and criminal justice costs alone. And that study doesn't even take into account savings in social services, lost productivity, absenteeism, injuries in the workplace, and so forth. And you are going to hear from a CEO today how much money was saved and how cost-effective parity was in his experience. And we heard that at hearing after hearing across the country from employers, enlightened employers who have already enacted parity and who have already brought parity into their plans and who are saving money.

Let me conclude by repeating as strongly as I can, it is time to end the discrimination against people who need treatment for men-

tal illness and addiction. It is time to prohibit health insurances from placing discriminatory restrictions on treatment. It is time to provide greater access to treatment. It is time to get this bill to the President who, by the way, endorsed parity in 2002 in Albuquerque, NM, in a speech there when he was with Senator Domenici.

It is time to pass the Paul Wellstone Mental Health and Addiction Equity Act. The American people really can't afford to wait any longer.

Thank you again, Mr. Chairman.

[The prepared statement of Mr. Ramstad follows:]

STATEMENT OF HON. JIM RAMSTAD, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MINNESOTA

Chairman Pallone, Ranking Member Deal, thank you for holding this important hearing.

On July 31, 1981, I woke up in a jail cell in Sioux Falls, SD, under arrest as the result of my last alcoholic blackout.

I'm alive and sober today only because of the access I had to treatment, as well as the grace of God and support of many recovering people the past 25 years. I'm living proof that treatment works and recovery is possible.

But too many people don't have access to treatment. It's a national disgrace that 270,000 Americans were denied addiction treatment last year. It's a national tragedy that last year alone, 150,000 of our fellow Americans died from chemical addiction and 30,000 Americans committed suicide from depression. And it's a national crisis that untreated addiction and mental illness cost our economy over $550 billion last year.

And think of the costs that can't be measured in dollars and cents—human suffering, broken families, shattered dreams, ruined careers and destroyed lives.

It's time to end the discrimination against people suffering the ravages of mental illness and chemical addiction. It's time to end the higher copayments, deductibles, out-of-pocket costs, and limited treatment stays—discriminatory barriers to treatment that don't exist for other diseases. It's time to treat mental illness and chemical addiction under the same rules as physical illness.

The Paul Wellstone Mental Health and Addiction Equity Act will give Americans suffering from addiction greater access to treatment by prohibiting health insurers from placing discriminatory restrictions on treatment.

It will end the discrimination against people who need treatment for mental illness or chemical addiction.

Expanding access to treatment is not only the right thing to do; it's also the cost-effective thing to do. We have all the empirical data, including actuarial studies, to prove that equity for mental health and addiction treatment will save billions of dollars nationally while not raising premiums more than one half of one percent. In other words, for the price of a cheap cup of coffee per month, 16 million people in health plans could receive treatment for their mental illness or chemical addiction.

Furthermore, it's well-documented that every dollar spent on treatment saves up to $12 in health care and criminal justice costs alone. That does not even take into account savings in social services, lost productivity, absenteeism and injuries in the workplace.

Let me conclude by repeating as strongly as I can: It's time to end the discrimination against people who need treatment for mental illness and addiction. It's time to prohibit health insurers from placing discriminatory restrictions on treatment. It's time to provide greater access to treatment. It's time to pass the Paul Wellstone Mental Health and Addiction Equity Act.

The American people cannot afford to wait any longer for Congress to act.

Mr. PALLONE. I want to thank you again. You explained everything so well why we need to pass this bill. It certainly is our intention to move on it as quickly as we can. And my understanding is, we don't have any questions because I don't think there is anything we can ask you. You basically said it all.

Mr. KENNEDY. If I could say the sooner that you can move on it, I know the Senate is going to be moving on unanimous consent. Obviously, we have an opportunity to set the bar if we move on it before they do.

There has—many of you on both sides of the aisle have made the point on State's rights which I think is a really strong point. States ought to have the opportunity to experiment and certainly should not be preempted by the Federal Government, and we would have a much stronger position going into it if we were to pass our bill first, I think.

Mr. PALLONE. I know it has got to go to several committees, but it is already out of two of them, right, is my understanding.

OK. We are going to try our best, and I agree with you on the preemption. That was certainly brought home to me when we had the hearing in Trenton. That was maybe 50 percent of the debate that day, if I remember. So really, thank you again; we appreciate it.

Mr. BURGESS. I would ask unanimous consent if Mr. Ramstad would make that Millerman & Roberts study available to the committee.

Mr. RAMSTAD. Thank you. I would be happy to.

Mr. PALLONE. Welcome. Thank you for being here. Starting from my left is Mr. James Purcell, who is president and chief executive officer of Blue Cross and Blue Shield of Rhode Island.

Ms. Edwina Rogers, who is vice president of health policy for the ERISA Industry Committee. Then we have Ms. Marley Prunty-Lara; I don't know if I am pronouncing it properly. And then we have Mr. James Klein, who is president of the American Benefits Council. And, finally, Dr. Howard H. Goldman, who is a professor of psychiatry at the University of Maryland School of Medicine.

As you know, we have 5-minute opening statements. We will put your statements in the record. If you would like to give us some additional material later, you can do that as well, and then we will take some questions.

So we will start with Mr. Purcell.

STATEMENT OF JAMES E. PURCELL, PRESIDENT AND CHIEF EXECUTIVE OFFICER, BLUE CROSS & BLUE SHIELD OF RHODE ISLAND

Mr. PURCELL. Thank you very much. It is a pleasure to be here, Chairman Pallone, Ranking Member Deal and members of the committee.

Representing the health insurer at hearings like this, we are usually the skunk at the lawn party. Typically, we are testifying against mandates for a variety of reasons, most often because they increase the cost of health insurance; and many times, they are anecdotally driven and they, quite frankly, sometimes don't improve the quality of care that is rendered.

Here, I believe this to be an exceptional case, and that is why I am here testifying in favor of this legislation.

My comments here today reflect my experience and the experience of my Blue Cross plan in the State of Rhode Island. This experience involves both behavioral and physical health. The two are

inextricably inclined. You can't separate one from the other and think that you are providing good health care, because you are not.

My statement, I will say, only reflects the position of Blue Cross and Blue Shield of Rhode Island. It does not reflect the other positions of other Blue Cross plans nor does it affect the position of Blue Cross Association.

We are an independent local nonprofit plan closely regulated by the State of Rhode Island, and our vision is to improve the lives of our members by improving their health. That is our bottom line. On our members' behalf and in recognition of the leadership of our senior Congressman, Patrick Kennedy, and your invitation, I am here today about a simple message.

Unlike most mandates, this doesn't cost much, if anything. Even if you just look at the cost of the claims expense associated with behavioral health care that we cover, it is 3.6 percent of the total bill, and that doesn't even take into account the savings on the physical side associated with early intervention for all of the reasons that we have heard from the other witnesses.

I am of the passionate view that without full integration of behavioral and physical health, we cannot fully achieve our vision of improving our members' lives by improving their health; and unfortunately, without a meaningful behavioral health parity bill on a Federal level, I think we demonstrate to ourselves that it is just not going to happen.

I submit this testimony mindful of the insurers' special role in all of this.

We have a very difficult balance between maximizing coverage for our members, improving reimbursement to providers and trying to keep health insurance premiums at a reasonable level. Some could argue, it is not at a reasonable level anymore, but we do everything that we can to try to minimize the increases associated with this. This is a very delicate, very difficult balance, and we are in the middle of it. So that is our job. That is what we do.

Like most insurers, we are not generally supportive of mandates with regard to coverage. But here I quite frankly think, given what we have observed in the State of Rhode Island with our mental health parity law and what we have observed in our own plan, we can demonstrate to you that this has dramatically improved the quality of care that our members get, and it has not significantly increased the cost of that care.

One of the things I would strongly urge the committee is with regard to the effective date of the bill. Six months is too little time. If we want to do it and do it right, you have to give plans time to do the system changes. Some plans are going to have to create networks, negotiate contracts.

It took a long time to implement the FEP program parity. So here, please, I would ask you first of all, you might want to consider extending the effective date to 11/09. I think that would allow plans to do a good job and, still, you would implement the parity.

Second, I would be less than candid if I didn't address two issues that I have some concerns about. And I think these are details that it looks like you wish to cover. I just want to make sure it does. And those are the issues with regard to medical management and out-of-network coverage.

One of the things that we can do to ensure quality-of-care access and do something about costs, medical management and network, the network gives us the contractual right to do these things. And if we have an adequate network so that we have adequate access, there should be no reason to have complete open access to added network coverage. I can't guarantee to my members that they are receiving quality of care if they can go anywhere that they want to.

So somewhere within this we have to ensure that if there is adequate access to care within the network, if members choose to go out of the network, they pay an additional amount for that so that there is an incentive to say that we can guarantee their quality.

Since the initial passage of Rhode Island's partial mental parity in 1994, we have continued to ratchet up our coverage. We have done many things with regard to coverage as set forth in my testimony. I will not go through that here, but in essence, through the combination of State statute and how we have changed—voluntarily changed our coverage, we have, in essence, de facto parity in our State.

And in 2006, we increased office visits from a maximum of 30 to a maximum of 50. We voluntarily did that. Why on earth would we do that? Because those very few people that need in excess of 30 office visits really, really need it. And when do they run out of the 30? Right at the——

Mr. PALLONE. I have got to tell you are over by a minute so you are going to have to summarize.

Mr. PURCELL. I will summarize it. It doesn't break the bank. I think it gives better care. I think the experience in Rhode Island demonstrates that, and I would urge its passage.

The prepared statement of Mr. Purcell follows:]

STATEMENT OF JAMES E. PURCELL

Chairman Pallone and Members of the Committee…

My name is James E. Purcell. I'm the President and CEO of Blue Cross & Blue Shield of Rhode Island ("BCBSRI"). Prior to joining BCBSRI, I was an attorney by profession.

My comments here today reflect our experience in the area of behavioral and physical health. The two are inextricably intertwined for reasons that I will address later. My statement reflects only the position of BCBSRI and not the BlueCross BlueShield Association, nor any other Blue Cross Blue Shield Plan.

Established in 1939, BCBSRI serves approximately 700,000 members and collects nearly $2 Billion in premiums. We're a small insurer by national standards, but a good size for Rhode Island. We are an independent, local, non-profit insurer, closely regulated by the State of Rhode Island. Our vision is to improve the lives of our members and all Rhode Islanders by improving their health.

On their behalf, and in recognition of the leadership demonstrated by Rhode Island's Senior Congressman Patrick Kennedy, and at the gracious invitation of Chairman Pallone, I am here with a simple message:

I am of the passionate view that without full integration of physical and behavioral healthcare, we cannot fully realize our vision. And unfortunately, without meaningful behavioral health parity, that will not happen on a national level.

I submit this testimony mindful of an insurer's special role: that is, balancing the members' interests in receiving high-quality care with optimal coverage; the providers'

interests in higher reimbursement; and the employers' and subscribers' interests in affordable premiums. That is a contentious and delicate balance, but that's our job.

Like most insurers, BCBSRI is not generally supportive of coverage mandates as they tend to increase premiums. Many are anecdotally driven, and some do not improve the quality of care ultimately given. This is different. Back in 1994, we took a pro-active approach to this issue and worked with the regulator, the behavioral health provider community, and our State legislature to craft a law that accomplished an important milestone in mental health, while protecting our ability to use appropriate medical management techniques to achieve the delicate balance I described earlier.

Given our Company's experience in the implementation of these mandates and modifications, I would strongly encourage the Committee to include in the legislation a provision that allows adequate time, at least a year, for plans to implement these changes. We appreciate the fact that the House bill's intention is not to preclude an insurer's ability to use reasonable medical management tools and network quality oversight. I would urge that the final bill preserve an insurer's ability to do so.

Since the initial passage of Rhode Island's partial mental health parity state mandate in 1994, we have continued to modify our behavioral health coverage to reflect additional changes in state and federal law. But more than that, in a number of instances, we voluntarily went beyond the letter of the law, instituting policies that achieve *de facto* parity.

Some definitions: When I refer to mental health, I mean traditional diagnoses of recognized forms such as depression or schizophrenia. When I refer to behavioral health, I mean mental health plus substance abuse problems and combinations of the two. And

when I refer to parity, there is coverage parity and payment parity (what we pay providers). I am in favor of both.

In 2001, BCBSRI eliminated prior authorization for standard outpatient treatment; at the time a bold step, which has proven successful.

In 2002, the company allowed payments to behavioral health providers for the treatment of the behavioral and emotional components of medical illnesses without a psychiatric diagnosis.

In 2004, we began reimbursing professional behavioral health services at the same level as professional medical services for physical ailments. That achieved *de facto* payment parity.

In 2005, we eliminated prior authorization at admission for higher levels of care at participating providers, including inpatient services – again, at the forefront of the industry.

In 2006, we increased standard outpatient behavioral health service coverage (office visits) from a maximum of 30 per year to 50 for our fully insured members.

Why on earth would we do this when we weren't forced to do it by law? Because it was the right thing to do from the perspective of our members, which this should be all about. It's good care and good business. As a non-profit insurer in Rhode Island, we have the ability and indeed the will not only to look at our bottom line, but also the impact on the community when we make decisions like these. And here, it was definitively in the best interests of our members to do this.

I mentioned integration of behavioral and physical health. This truly is the future, and is so fundamental to complete care. Where is the line separating behavioral health

and physical health for an obese diabetic suffering from depression and eating disorders? Treating just the physical symptoms without treating the behavioral issues is less than adequate care.

Not only is this the right way to care for our members; it also is cost effective. BCBSRI has *de facto* coverage and payment parity. We've seen the results. Yes, it adds some up front costs, but it provides better care to people who desperately need it. And the price tag is not that big.

Typically, the bulk of behavioral services are, for many people and in many places, delivered by medical providers. Behavioral health parity improves access to more appropriate treatment by breaking down the barriers to obtaining the right care.

For BCBSRI commercial business, non-drug behavioral healthcare benefits are 3.6% of premium expense. These costs are distributed about 32% for inpatient care, 12% for facility out-patient care, and 56% for professional services (mostly office visits).

About 1 out of 10 of our members received professional behavioral healthcare services in 2006. Of those members, 71% had 10 or fewer office visits, and 90% had 20 or fewer office visits.

The impact on claims costs of limiting annual coverage to 15 visits rather than 30 would have been about 0.3% of total claims. Our increase from 30 to 50 costs us significantly less, but imagine how that helps our members. The big problem is to get people to see their behavioral health provider. Very few need more than 30 visits a year, but those who do, really, really need them. And with a maximum of 30 visits, they usually run out around the holiday season. And where do they end up? Right; the emergency room, for a much bigger bill. This is more humane care, at a lower cost.

When Congressmen Kennedy and Ramstad held their hearing on this issue in Providence earlier this year, the testimony was overwhelmingly positive on parity. Not surprising. But what might surprise you was the testimony of the human resources director of one of our local banks. She said, and I'm paraphrasing here, that the reason her bank chose BCBSRI to provide health insurance for their employees and their families over the competition was the comprehensive behavioral healthcare coverage offered by our plan. She noted improved worker productivity and lower absenteeism. And in the end, this is all about taking care of people the right way, isn't it?

Your decision comes back to balancing the interests of members, providers, and employers with benefits, costs, and affordability. I would like to close by stating that we have found behavioral health parity strikes the right balance in Rhode Island.

Mr. PALLONE. Ms. Rogers.

STATEMENT OF EDWINA ROGERS, VICE PRESIDENT, HEALTH POLICY, THE ERISA INDUSTRY COMMITTEE (ERIC)

Ms. ROGERS. Good afternoon, Chairman Pallone and Ranking Member Deal. Thank you for the opportunity to testify today.

I am going to speak from the plan sponsor perspective representing companies that pay for health coverage for tens of millions of Americans. My testimony will focus on concerns about the Kennedy-Ramstad Mental Health Parity bill, H.R. 1424.

ERISA members are in favor of expanding coverage, but this bill's approach is fundamentally flawed, we believe. The bill fails to incent better coverage options. It creates mandates, micromanaging the distribution of benefits, creating costly administrative quagmires and failing to keep up with integrations and demands widely accepted in the market.

Today, major employers offer benefits to the employees on a voluntary basis to attract and keep employees, improve morale and productivity, and because they take pride in providing for the employees' life security.

Congress developed ERISA so that major employers could create uniform national plans that fit the needs of their employees regardless of where they live, work or receive their health care. ERISA was created as a floor upon which States could create—was not created as a floor. ERISA was meant to be the ceiling.

As Congress considers a bill that would burden employers by forcing them to increase coverage and dissolving their plan flexibility, look to ERISA for guidance. Rather than leaving plan sponsors at the mercy of various State laws, Congress could make a parity law that preempts conflicting State laws, giving employers clear guidance on how to become compliant on a national level.

Plan sponsors are concerned about the accreditation of mental health providers and facilities, as well as their accountability and transparency, and must be able to designate which facilities and treatments are bona fide and which should not be covered.

Plan sponsors are moving away from a system of trust, don't verify in demanding metrics in transparency for all medical providers, data that lets employers and patients know the cost of an episode of care and make informed decisions on where to get quality treatment. A bill to promote mental health and substance abuse treatment would fail in its mission if it did not include such provisions for the mental health community.

Proponents of the mental health mandate claim it would lower health care costs, but the bill includes provisions anticipating cost increases. New ERISA members stated that simply implementing this bill, ignoring the costs associated with actually covering the benefits, would cost millions of dollars. One member company cited preexisting contracts with more than 150 plans, all of which would require amendment or renegotiation.

Other major employers mentioned that a 2 percent increase would be more than $10 million for them and that every 1 percent of health care costs shifted to employees translates to about $70 annual costs per employee.

Historically, it was employers who developed consumeristic strategies, demanded transparency, urged adoption of health IT and evidence-based medicine, proposed paying for performance, initiated patient-centered medical homes and began sponsoring disease management and drug therapy programs, and the list goes on.

The current health care systematic actively discourages employers from participation with the regulatory structure so burdensome that it effectively requires them to operate two businesses, One to operate their core business and one to administer benefits. As employers are moving to simplify the system and leveling the playing field, this bill moves in the wrong direction complicating coverage and increasing financial burdens.

The bottom line is that legislation, this legislation will likely reduce coverage and not improve quality for major employers. Plan sponsors have to reduce coverage or further shift costs. In mandating how plan designs and how they offer their voluntary benefits, this legislation will hurt plan sponsor flexibility and force one-size-fits-all policies.

The bill will open floodgates of State mandates and substance abuse mandates which will be extremely costly and burdensome, if not impossible, to comply with. The scope of benefits being managed is clearly written in favor of mental health groups.

Those pushing for legislation are not taking into account the extremely volatile financial situation of current voluntary benefit plans. Further, the bill does not even approach the issue of mental health providers and facilities keeping up with the necessities and innovations of today's health care markets—transparency of quality and pricing data, use of health information technology and performance-based reimbursement systems.

If Congress wants to increase mental health and substance abuse coverage, it should address the transparency, accountability, and affordability and the education issues, not create new mandates.

Thank you, Mr. Chairman.

[The prepared statement of Ms. Rogers follows:]

TESTIMONY OF EDWINA ROGERS

Good morning, and thank you Chairman Pallone and Ranking Member Deal for the opportunity to testify at this hearing.

I am Edwina Rogers, vice president for health policy at The ERISA Industry Committee (ERIC). ERIC is a non-profit trade association committed to the advancement of employee health, retirement, and compensation plans of America's largest employers. We represent exclusively the employee benefits interests of major employers. ERIC is engaged in policy affecting our members' ability to deliver benefits, their cost and their effectiveness, as well as the role of employee benefits in America's economy.

Today I will speak from a plan-sponsor perspective, representing companies that pay for health coverage for tens of millions of Americans. My testimony will focus on issues of concern in the Kennedy-Ramstad Mental Health Parity bill, H.R. 1424.

ERIC members are broadly in favor of expanding coverage, but the approach contained within H.R. 1424 is fundamentally flawed. The bill fails to incentivize better coverage options, instead injecting government into the world of voluntary benefits, creating mandates, micromanaging the distribution of benefits, failing to protect plan sponsors from burdensome and costly administrative quagmires, and failing to keep up with innovations and demands already widely accepted in the private health benefits marketplace.

VOLUNTARY BENEFITS AND ERISA PREEMPTION

Today major employers offer health, pension, and other benefits to their employees on a voluntary basis. They pay the exorbitant costs associated with these benefits in order to attract and keep employees, to improve morale and productivity, and because major employers take pride in providing for their employees' life security.

Major employers operate in multiple states—some in all 50—and their employees have common needs that are often not shared with arbitrarily-drawn regions, states, or localities. Congress developed the Employee Retirement Income Security Act of 1974 (ERISA) so that major employers could create uniform national plans that fit the needs of their employees, regardless of where the employees lived, worked, or received healthcare. ERISA was not created as a "floor" upon which states could create differing, conflicting laws; this would have made voluntarily sponsoring a plan extremely expensive and burdensome. ERISA is meant to be the ceiling—the Department of Labor regulates the operations of employer-sponsored benefit plans in every state, regardless of the laws various states create.

As Congress considers a bill that would burden those employers who have chosen voluntarily to offer mental health and/or substance abuse benefits by forcing them to increase coverage and dissolving their plan flexibility, they should look to ERISA for guidance. Rather than leaving plan sponsors at the mercy of various state laws, Congress could choose to pass a mental health parity law that preempts conflicting state laws, giving employers clear guidance on how to be compliant on a national level. We should all be moving to support a uniform national system. Instead, by allowing states to craft their own laws, and not including preemption language, the Kennedy-Ramstad bill would further disincentivize plan sponsors from offering any mental health coverage at all. Further, there is no indication that legislators will not simply continue to expand on employer healthcare mandates, for mental and medical care, continuing to drive up costs and push employers closer to one-size-fits-all plans.

PLAN FLEXIBILITY AND ACCOUNTABILITY

Major employers have used logic, experience, and experimentation to create plans that offer affordable coverage that works for their employees. Many plans have determined that certain conditions should be covered, while other conditions (particularly some that are listed in that mental illness handbook authored by the mental health lobby, the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV) are not valid. Because plan sponsors were able to make these judgments, engage in medical management, and design plans that covered the conditions they chose, many plan sponsors currently offer extremely generous mental health and substance abuse coverage.

The soundness of some conditions endorsed by the mental health lobby is not the only issue plan sponsors are wary of when purchasing mental health care—plan sponsors are also concerned about the accreditation of mental health providers and facilities, as well as their accountability and transparency. Must employers pay preposterously high rates to treat imagined detriments like jet lag, shyness, or other ailments treated with "folk" remedies or possibly unnecessary medications from unaccredited professionals? Plan sponsors need the flexibility to define which treatments, focusing on evidence-based medicine, should be covered. They must be able to define a network of providers within (and outside) their preferred network. Plan sponsors must be able to designate which mental health facilities are bona fide and which should not be covered under their plan offerings.

If mental health and substance abuse treatment are mandated to have the same financial and treatment rules as medical coverage, they should also have the same accountability standards. Plan sponsors are moving away from a system of "trust, don't verify," and beginning to demand metrics and transparency from all medical providers—data that lets employers and patients know the costs of an episode of care, and helps them make informed decisions on where to get treatment through reporting on quality measures. A bill to promote mental health and substance abuse treatment would fail in its mission if it did not include accountability and transparency provisions for the mental health community, if not also including value-based purchasing language and urging these providers, facilities, and programs to begin using health information technology. It would be a mistake to impose a host of new elements into the healthcare coverage equation without also requiring those elements to comply with the innovations and advances (in both quality and cost efficiency) already made standard in the rest of the healthcare community. ERIC members overwhelmingly reject the one-way street of information from the mental health community—while the bill demands plan design details and claims information from ERISA plans, it does not require any transparency from the mental health and sub-

stance abuse community. A balanced bill must include accountability provisions that include transparency of price and quality data.

OUT OF CONTROL COSTS

Proponents of the mental health mandate claim that it will lower healthcare costs, but the bill includes very clear provisions anticipating cost increases. No doubt the bill's backers believe that they are making a concession in offering a one-year exemption if, six months into a compliant program, a plan sponsor finds that costs are rising at more than an additional two percent in the initial year or one percent in subsequent years due to the mandate. This demonstrates a critical lack of understanding of the financial strains US employers are currently facing. While trying to stay globally competitive, employers have been burdened with double-digit healthcare inflation costs, and are under severe pressure to curb these costs—or to cut benefits. Employers have gone to great lengths to lower costs by one or two percent, and any instant infusion of greater costs could be catastrophic for workers' coverage. Numerous ERIC members have stated that simply implementing this change in their plans administratively, ignoring the costs associated with actually covering this benefit, would cost millions of dollars, requiring extensive revision to pre-existing plans. One member company cited pre-existing contracts with more than 150 plans, all of which would require amendment or renegotiation. Other major employers mentioned that a two percent increase would be more than $10 million, and that every one percent of healthcare costs shifted to employees translated to about $70 annual cost per employee.

If the Federal Government steps in, fencing off mental health benefits and mandating that employers provide them, the prices of mental health services are sure to rise. Creating an instant, massive increase in demand will certainly dry up the supply, making mental health providers and facilities an even rarer commodity than they already are. It is highly probable that this legislation will lead to an unnecessary rise of utilization, which will in turn lead to a lack of mental health and substance abuse services, denying care to those who need it most. Creating an artificial demand will disrupt the market, drive up prices, and lead to shortages.

Employers, not government, started all the major healthcare quality and efficiency improvement innovations in the past decade. Employers developed consumerist strategies, demanded transparency, urged adoption of health IT and evidence-based medicine, proposed paying for performance, initiated patient centered medical homes, began sponsoring disease management and drug therapy programs, and the list goes on. It took the government ten years just to decide that plan sponsors who offer more coverage to early retirees than to those eligible for Medicare are not engaging in age-discrimination. Now the government, at the urging of a lobby that has specific financial interests in the outcome, is purporting to dictate to the business community how to offer health benefits and save money—something is certainly amiss here. If in fact proponents of mental health parity can prove that it lowers plan costs and improves employee health, they do not need to force this "reform" by legislative fiat. Rather, this would be an issue of education and advocacy, not government interference and employer mandates.

Just this week the employer community proposed a new platform for life security that could serve to expand all manner of health coverage to many more individuals and small businesses, without harming the current employer-sponsored system. ERIC's New Benefit Platform for Life Security envisions competing expert third-party administrators who manage employers' voluntary contributions, as well as individuals' contributions, and provide affordable, effective, and innovative retirement and healthcare security benefits. These administrators will allow major employers, small businesses, and individuals all to purchase fully portable coverage at equal rates. This private market system, coupled with tax parity, an individual mandate, and subsidies for low-income individuals, embodies a revolutionary step forward in expanding access and coverage to all Americans, while improving our global competitiveness.

The current healthcare system actively discourages employers from participation with a regulatory structure so burdensome that it effectively requires an employer to operate two businesses, in which one operates the employer's core business and the other provides and administers benefits. As employers are moving to simplify the system and build a level playing field, this bill moves in the wrong direction, complicating providing coverage and increasing financial burdens on plan sponsors and beneficiaries.

The government specializes in micro-mismanagement and reducing coverage; between crowd-out by entitlement programs, ill-conceived healthcare mandates, and other botched attempts, the government has failed to address with any real success

the more than 40 million uninsured Americans. This is partially because government has failed to address costs before pushing for coverage—instead of deregulating and making the individual and small business healthcare market more affordable, they have continued to pile on cost-drivers. Instead of enacting tort reform, allowing small businesses to band together for purchasing clout, or allowing insurance to be purchased over state lines, government continues to regulate how voluntary benefits are provided, further incentivizing plan sponsors to cut back coverage. If this bill is enacted, some ERIC members have stated they will reduce coverage, increase employee contributions, and implement treatment limits on medical care.

WHAT TREATMENT IS COVERED?

In defining the minimum scope of the new mandated benefits, this legislation works in a very round-about way. The bill reads that if a plan offers any related benefit, it must cover all the mental health and substance abuse benefits (with significant enrollment) covered by the Federal Employees Health Benefit (FEHB). The FEHB implemented mental health parity in 2001—and according to a 2005 study by HHS, has seen cost increases due to it. More than 56 percent of FEHB beneficiaries are enrolled in Blue Cross Blue Shield plans. This, in essence, means that Blue Cross plans will always be in compliance, while other plans will be forced to conform to the models adopted by Blue Cross. This has serious implications for plan competition and flexibility, and may lead to increased costs (and decreased participation and coverage).

The legislation does not clearly define how much enrollment in FEHB is necessary such that a condition or substance is mandated to be covered. It also does not designate which conditions or substances might require "emergency care" that would surely incur substantially increased costs. These facets of the legislation leave the door wide open for price-fixing, as any mental health or substance abuse group that can convince a particular plan to adopt coverage for a particular condition or substance can thus force all other plans to adopt it—and can charge vastly different rates to Blue Cross than to other plans.

It is doubtful that this was the intention of the legislation—in the rush to legislate, the bill's backers may have been attempting to avoid the pitfalls of using the overtly lobbyist-driven DSM IV. However, the option selected is only slightly better—perhaps an omen to alert Congress that plan design is best left to plan sponsors, not outside actors who have financial incentives to overcharge ERISA plans.

The bottom line is that this legislation will very likely reduce coverage, not improve quality or increase coverage. Plan sponsors, already stretched thin, will have no avenue to deal with their increased costs other than to reduce coverage or to further shift costs to employees. In mandating how plans design and offer their voluntary benefits, this legislation will reduce plan sponsors' flexibility and force one-size-fits all policies on diverse and varying pools of workers. The bill will open floodgates of state mental health and substance abuse mandates, which will be extremely costly and burdensome, if not impossible, to comply with. The scope of benefits being mandated is hazy, but clearly written in favor of mental health interest groups, and leaves room for serious vice. Those pushing this legislation are not taking into account the extremely volatile financial situations of current voluntary benefit plans. Further, the bill does not even approach the issue of mental health and substance abuse treatment providers and facilities keeping up with the necessities and innovations of today's healthcare market—transparency of quality and pricing data, use of information technology, and performance-based reimbursement systems. If Congress wants to increase mental health and substance abuse coverage, it should address transparency, accountability, and affordability and education issues, rather than creating a new mandate.

Mr. PALLONE. Thank you. Ms. Prunty-Lara.

STATEMENT OF MARLEY PRUNTY-LARA, BOARD MEMBER, MENTAL HEALTH AMERICA

Ms. PRUNTY-LARA. Thank you very much for this invitation.

I am here before you for one simple reason: because I am dedicated to the proposition that mental health matters. It matters because many lose their dignity and sometimes their lives in the struggle for mental wellness. It matters to me because mental ill-

nesses compromised my mental health so profoundly that it put my life and dreams in jeopardy.

My name is Marley Prunty-Lara, and today I am here to testify in support of a bill to establish simple fairness in insurance coverage for people with mental health conditions.

I serve on the National Board of Directors for Mental Health America, formerly the National Mental Health Association. I work to improve mental health care policies, not simply because I have a mental illness, but because I know treatment works.

I have passionately lived within the prison of mental illness and have experienced the incalculable emancipation that accompanies wellness. I am here today because effective treatment saved my life. I am also here because the opportunity of health should not be something granted only to the lucky and privileged few.

When I was diagnosed with bipolar disorder at the age of 15, I never imagined the pain I would endure as a result of my illness. Before adequate treatment, I intimately knew the harrowing, sinister suicidal depression no one likes to talk about. I knew the mania that could obscure the world and deprive me of sleep for days. It would fill my mind with racing thoughts and grandiose ideas, most of them unfeasible and left abandoned, incomplete.

Living with this disease has meant not only enduring the disabling lows and exhilarating highs, but also fighting for insurance coverage, educational accommodations and appropriate health care. I have experienced firsthand the narrow mindedness insurance companies and some in the business industry show toward mental illness.

During my teen years, as my mom searched for a psychiatrist available to treat me in South Dakota, a rural State with limited mental health resources, we were told we would have to wait 4 to 5 months before I could get an initial appointment. I did not have that long to live.

We found help 350 miles away in another State. And I was hospitalized for 2 months. However, the treatment facility was not covered by my mother's insurance, forcing my parents to take a second mortgage out on their home in order for me to receive the care that I urgently needed.

Had I suffered a spinal cord injury requiring long-term hospitalization, my insurance company would have paid for my care, but because my hospitalization involved a disease of the mind, my insurance company deemed it unworthy of equitable coverage.

I am one of the lucky ones. My family was able to take out a mortgage to afford my inpatient care. However, many in this country currently face a question with no easy answer. What happens when the insurance benefits run out and you are not better yet?

My family did everything we were supposed to. My mother, a CPA, an ardent advocate on behalf of her daughter, had a good paying job and health insurance. She was adept at handling our insurance claims, and we exhausted our efforts to receive treatment within the coverage system.

I did not chose my disease.

I ask those who oppose this legislation what are people to do when they don't have the options my family had, when parents must choose between watching their children deteriorate or giving

up custody to obtain insurance benefits? At what point do we decide collectively to end the suffering of millions?

For children struggling to cope with a mental illnesses, wellness should not depend on luck, on whether a family's particular health plan provides ample and equitable mental health coverage. In my case, it has proven far cheaper to treat my mental illnesses with medication and proper psychiatric care than to have me in and out of hospitals and emergency rooms. I understand the power of successful treatment because I am living it.

Congress enacted a parity law in 1996, but it requires only partial parity. Current law still permits discrimination based on mental health conditions, and it is routine in practice. Both current law and practice are untenable. Americans agree that partial fairness is unacceptable. In a survey conducted by International Communications Research, an independent research company, and paid for by Mental Health America——

Mr. PALLONE. I hate to interrupt you because I am—you are really telling an important story—because you are over a minute.

Ms. PRUNTY-LARA. Let me just conclude.

I implore this committee to act soon to adopt H.R. 1424. I urge you further to reject amendments that would weaken it. Kay Jamison once said this gap between what we know and what we do is lethal.

The time is right and the time is now to enact comprehensive Federal parity. I leave with you that charge and hope today. Please remember my name, my face, and my story as you work and decide to pass this vital legislation.

America is waiting. Thank you.

Mr. PALLONE. Thank you, and I wanted you all to know that we do put your entire statement in the record even if I ask you to summarize at the end.

Thank you.

[The prepared statement of Ms. Prunty-Lara follows:]

TESTIMONY OF MARLEY PRUNTY-LARA

Good morning. I am here before you for one simple reason—because I am dedicated to the proposition that mental health matters. It matters because many lose their dignity, and sometimes their lives, in the struggle for mental wellness; it matters to me because illness compromised my mental health so profoundly that it put my life and dreams in jeopardy.

My name is Marley Prunty-Lara and today I am here to testify in support of a bill to establish simple fairness in insurance coverage for people with mental health conditions. I serve on the national Board of Directors for Mental Health America, formerly the National Mental Health Association. I work to improve mental health care policies, not simply because I have a mental illness, but because I know that treatment works. I have passionately lived within the prison of mental illness and have experienced the incalculable emancipation that accompanies wellness. I am here today because effective treatment saved my life. I am here today because the opportunity of health should not be something granted only to the lucky and privileged few.

When I was diagnosed with bipolar disorder at the age of 15, I never imagined the pain I would endure as a result of my illness. Before adequate treatment, I intimately knew the harrowing, sinister, suicidal depression no one talks about. I knew the mania that would obscure the world and deprive me of sleep for days. It would fill my mind with racing thoughts and grandiose ideas; most of them unfeasible and left abandoned incomplete. Living with this disease has meant not only enduring the disabling lows and exhilarating highs but also fighting for insurance coverage, educational accommodations, and appropriate health care.

I have experienced first hand the narrow-mindedness insurance companies and some in the business community show toward mental illness. During my teen years, as my mom searched for a psychiatrist available to treat me in South Dakota, a rural state with limited mental health resources, we were told we would have to wait four to five months before I could get an initial appointment. I did not have that long to live. We found help, 350 miles away, in another state, and I was hospitalized for two months. However, the treatment facility was not covered by my mother's insurance; forcing my parents to take a second mortgage out on their home in order for me to receive the care that I urgently needed. Had I suffered a spinal cord injury requiring long-term hospitalization, my insurance company would have paid for my care; but because my hospitalization involved a disease of the mind, my insurance company deemed it unworthy of equitable coverage.

I am one of the lucky ones; my family was able to take out a mortgage to afford my in-patient care. However, many in this country currently face a question with no easy answer: What happens when the insurance benefits run out and you're not better yet? My family did everything we were supposed to; my mother, a C.P.A., had a good-paying job and health insurance. She was adept at handling our insurance claims and we exhausted our efforts to receive treatment within the coverage system. I did not choose my disease. I ask those who oppose this legislation: what are people to do when they don't have the options my family had; when parents must choose between watching their children deteriorate and giving up custody to obtain insurance benefits? At what point to we decide collectively to end the suffering of millions?

For children struggling to cope with a mental illness, wellness should not depend on luck, on whether a family's particular health plan provides ample and equitable mental health coverage. In my case, it has proven far cheaper to treat my mental illness with medication and proper psychiatric care, than to have me in and out of hospitals and emergency rooms. I understand the power of successful treatment because I am living it.

We live in a time where discrimination ought not be tolerated, in any form, against any people. Having a mental illness should neither determine one's fate nor limit one's potential. As our country faces the challenges of war, of returning veterans changed forever by the trauma of combat, Congress must reaffirm its commitment to the principles of justice and the pursuit of happiness by enacting comprehensive mental health parity legislation. It is not enough to simply continue to say, "We must change," veterans, active-duty military personnel, and their families; employers; teachers; doctors; and those that are struggling—are all counting on Congress to be the difference, to make prevention, treatment, and recovery believable realities.

The costs of mental health and substance use conditions are unavoidable. Our only decision is how we pay for them. Society can either invest in treating mental health and substance use conditions or pay a greater price through homelessness, lost productivity, suicide, and an increased reliance on the criminal justice system. Enacting a comprehensive mental health parity law sends a strong message to people across this country that mental health is fundamental to overall good health. It sends a message to those living with a mental illness that their disease is just as real as cancer and diabetes. Enacting mental health parity sends a message to the business community that we value the health of their employees and their bottom line. I believe that treatment access follows dollars; by eliminating a barrier to treatment, we provide an incentive for providers to enter the mental health field.

Congress enacted a parity law in 1996. However, that law required only partial parity. Current law still permits discrimination based on mental health conditions, and it is routine in practice. Both current law and practice are untenable. Federal law must demand fairness in health coverage on behalf of people with or at risk of mental health conditions. Americans agree that "partial" fairness is unacceptable. In a survey conducted by International Communications Research, an independent research company, and paid for by Mental Health America, 89 percent of Americans asserted that insurance plans should cover mental health treatments at the same level as treatments for general health problems. 74 percent believe that insurance plans should cover substance abuse treatments at the same levels as treatments for general health issues and 89 percent of employees and employers want health insurance coverage for mental health treatments to be equitable to general health treatments. [1]

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1 Interviews were conducted via telephone and the Internet from October 10 to November 1, 2006 among a nationally representative sample of 3,040 respondents age 18 and older. *<http:/*

Continued

I implore this committee to act soon and adopt H.R. 1424. I urge you further to reject amendments that would weaken it. I ask you to consider my testimony not solely as one person's story, but as a microcosm of millions of Americans. We are people whose treatment has been cut short by arbitrary treatment limits, not only annual, day, and visit limits, but even lifetime caps on outpatient visits. Consider your son or daughter, with health insurance, being told that their treatment for cancer would not be covered because their diagnosis required more chemotherapy treatments than their plan allowed. Imagine finding out that your broken leg, which could be healed with appropriate care, would have to fester un-cast because your insurance provider denied your claim on the basis that a broken leg could be managed on its own. Many with mental health conditions face these realities every day. The Paul Wellstone Mental Health and Addiction Equity Act seeks to remedy the incorrigible and nonsensical practices of the insurance industry. The industry has failed to act alone. The time has come for accountability and justice.

It is imperative that help be available to those that seek it. Sanctioned discrimination toward those with mental illness must end. H.R. 1424 provides fundamental protections against the range of discrimination experienced by people like me. Please do not dilute it. Please adopt it with utmost expediency. Insurance must not stand in the way of goals and dreams and normalcy; rather it should be the means by which one achieves health. Kay Jamison once said, "The gap between what we know and what we do is lethal." The time is right and the time is now to enact comprehensive Federal parity. I leave with you that charge today. Remember my name; remember my face; remember my story. America is waiting. Thank you.

Mr. PALLONE. Mr. Klein.

STATEMENT OF JAMES A. KLEIN, PRESIDENT, AMERICAN BENEFITS COUNCIL

Mr. KLEIN. Thank you very much, Mr. Chairman.

I am testifying today on behalf of the American Benefits Council. Our member companies are primarily very large national employers, as well as health plans and other organizations that design and administer health coverage of all sizes, 100 million Americans overall, in health and retirement plans.

Today, I would like to pose and then answer four questions.

The first question is: why are mental health benefits so important? The second is: can employers, insurers, mental health providers and patient advocates reach consensus on mental health parity? Third, does H.R. 1424, the Kennedy-Ramstad bill which is the topic of today's hearing, meet the criteria needed for consensus? And fourth, if parity is so vital, why doesn't the proposed legislation apply to numerous federally sponsored health plans?

The answer to the first question, why are mental health benefits so important, is quite obvious. There probably is not a single person in this hearing room who has not been affected by mental illness either personally, or as we heard from the compelling witnesses today, Ms. Prunty-Lara, Congressman Kennedy and Congressman Ramstad, or through a family member or a friend.

For me personally, just a few months ago, a young woman who was a friend of my teenage daughter took her own life after struggling with mental illness. Ms. Prunty-Lara is one of the happy cases. My daughter's friend was not. This issue touches us all.

U.S. employers believe in the value of mental health coverage and spend vast sums to provide it to their workers and family members. Employer opposition over the past decade to expanding current parity law does not reflect lack of support for mental

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/www.mentalhealthamerica.net/index.cfm?objectid=2BCEA7D2–1372–4D20-C8A54A26522099D8>

health benefits for all of the reasons noted earlier that providing mental health benefits can save employers money.

Rather, the concern and opposition is based on concern over a highly prescriptive legislation that dictates the details of health plans that denies employers the opportunity to manage plans in ways that are permitted for medical and surgical benefits, and that it allows States to impose varying standards.

Mr. Chairman and members of the subcommittee, that is not parity. That is a proposed set of rules that treats mental health benefits vastly differently than health coverage for other conditions.

This raises the second question: Can employers and insurers, mental health providers and patient advocates reach consensus on parity? The answer is an emphatic "yes," and it has already been done.

Over the past several months, Senators Kennedy, Enzi and Domenici brought together the major stakeholders on this issue on a process that addressed all parties' primary concerns. The American Benefits Council was privileged to work on behalf of employers during this effort. The resulting bill, which passed the Senate Health Committee by a strong, bipartisan 18 to 3 vote, may not be anyone's ideal, but it resolves the mental health debate in a way that patients, providers, employers and insurers can all be proud and satisfied.

The Senate bill retains private employers' flexibility to design the plans they pay for, just like the Federal Government does for the plan it sponsors. It protects medical management and ensures uniformity between Federal and State parity requirements. Even more important than what the collaborative process means for achieving mental health parity legislation is that it can serve as a model to be emulated as Congress seeks consensus on much broader health care reform challenges.

With that in mind, let me pose the third question: Does H.R. 1424 meet the criteria for consensus? Regrettably, my answer must be "no." My written statement describes more fully the deficiencies of the House bill, but the essence of our concern is that it approaches for employers—employer and health plan priorities in exactly the opposite way that the Senate bill resolves this.

First, H.R. 1424 requires that if a health plan covers any mental health or substance-related disorder benefits, that it must cover all conditions described in this DSM-IV volume that identifies such disorders. My point here is not to make a value judgment as to whether some health conditions are more worthy of coverage than others. My point is to say that Congress should not do so either. Wisely, Federal law does not impose such prescriptive rules on coverage for other physical conditions, and it is not justified for mental health benefits either.

Second, unlike the Senate bill, the House bill does not protect medical management practices to ensure that patients are receiving appropriate care. Health care providers, consumer groups and purchasers are actively promoting evidence-based measures of quality care. The House bill would stymie these efforts as it relates to mental health conditions.

I will quickly sum up.

Third, the House bill mandates coverage for mental health disorders by out-of-network providers if the plan covers out-of-network coverage for certain categories of medical and surgical services. This goes even disposing beyond the rules governing the Federal employers' benefit plans.

Fourth, the House bill authorizes States to expand enforcement and remedy schemes, either creating special rules applicable only to mental health benefits, which seems patently unfair, or arguably creating a whole new set of State-by-State enforcement-of-remedy standards for all types of health benefits, which is clearly beyond the scope of the mental health parity bill.

ERISA's uniform framework should not be dismantled and certainly not as an afterthought on the mental health parity bill.

And finally, the American Benefits Council asks why, if parity is so vital, does the proposed legislation treat people different depending on the plan from which they receive coverage. More specifically, why impose parity requirements on health plans sponsored by private employers and State and local governments when full parity is not required in Medicare, Medicaid, veterans health care and TRICARE for active and retired military personnel.

I cannot answer that question. Only Congress can explain why there is already parity in FEHBP, which covers Federal employees, including Members of Congress and their staff, but the proposed legislation completely ignores these other vital health programs. Surely the elderly, the poor, and those who have bravely put their lives at risk for this Nation should not be overlooked.

Basic fairness, not to mention leadership by example, dictates that Congress should not impose requirements on private employers and State and local governments when it has not yet extended the same requirements to all health plans that the Federal Government itself designs and pays for.

Thank you very much for the opportunity to testify.

[The prepared statement of Mr. Klein follows:]

TESTIMONY OF JAMES A. KLEIN

Mr. Chairman and members of the Health Subcommittee, thank you for the opportunity to share our views with you today on the Paul Wellstone Mental Health and Addiction Equity Act of 2007. My name is James Klein and I am president of the American Benefits Council.

The American Benefits Council's members are primarily major employers and other organizations that collectively sponsor or administer health and retirement benefits covering more than 100 million Americans. Most of the Council's members are very large companies that have employees in most or all 50 states and provide extensive health coverage to active employees and retirees. Our membership also includes organizations that provide benefits services to employers of all sizes, including small employers who often face the greatest challenges in providing health coverage for their workers.

EMPLOYERS RECOGNIZE THE IMPORTANCE OF BEHAVIORAL HEALTH CARE

The American Benefits Council's members highly value and have long recognized the importance of effective health coverage for the treatment of both physical and behavioral disorders. Indeed, because of the importance our members place on these services, we have repeatedly urged Congress that the current Federal parity requirements not be expanded in a way that would add to plan costs or increase the complexity of plan administration. Doing so could unintentionally risk a reduction in coverage for these or other benefits provided to employees and their families.

We also recognize that much has changed in the behavior health care field over the past decade since the enactment of the current Federal mental health parity re-

quirements in 1996. Better medical evidence on behavioral health conditions has become available and better treatment options have advanced during this period. In a great many cases, the way in which behavioral health conditions are covered by health plans has also changed, particularly with the emergence of health plan administrators that specialize in the management of behavioral health care services in a wide range of outpatient and inpatient settings.

As the field of behavioral health care has changed during this time, it has become increasingly clear that the ability of employers to provide access to affordable and appropriate health care services, including for behavioral health conditions, depends on the ability of health plans to do an effective job in the medical management of health benefits. This involves often challenging tasks to try to ensure that plan participants get the right care and effective care under the terms of their plans and for the health conditions they have. Employers have a strong interest and an enormous stake in seeing that these tasks are performed well, not only because employers are the primary payers for the health care coverage for millions of American workers, but also because of the importance they place in maintaining a healthy and productive workforce.

SENATE PARITY LEGISLATION DEVELOPED THROUGH INCLUSIVE PROCESS

Before I address the concerns we have with the House mental health parity bill, H.R. 1424, let me see if I can dispel the myth that employers are simply irrevocably opposed to any legislation in this area or that employers somehow do not understand or appreciate how vitally important effective behavioral health care is for millions of Americans.

Over the past several months, the three Senate sponsors of mental health parity legislation—Senate HELP Committee Chairman Edward Kennedy, HELP Committee ranking member Senator Mike Enzi and Senator Pete Domenici, who is a longtime champion of mental health parity and an author of the original legislation enacted a decade ago—have taken a fresh approach to trying to resolve the difficult and important issue of changing the current law Federal parity requirements. Under their joint leadership, a new bill was developed, S. 558, through a balanced, candid and extensive process that has given all the major stakeholders on this issue—employers, health plans, behavioral health care providers and patient advocates—the opportunity to have their priority concerns addressed.

The American Benefits Council has been privileged to have participated in this process with the three Senate sponsors as a representative of employer interests. While these discussions have been demanding and have required much give and take on all sides, we also think that it has unquestionably resulted in a bill that is a bipartisan in the best sense of the term. In fact, we believe it could serve as a model for how Congress might be able to tackle other similarly challenging health policy issues, ones which members of this subcommittee must frequently work to resolve, too.

The Senate parity measure is not perfect. No true compromise proposal ever is. But the Senate parity measure is the only one of its kind which includes among its supporters a leading coalition of mental health parity proponents as well as a broad range of organizations representing employers and insurers. We hope this good faith effort sends an important message that employers will support legislation where their priority concerns are addressed in a thoughtful manner and with a careful attention to details, even when our preferred outcome would be no new legislation or an even better bill.

Unlike previous parity measures considered by the Senate or the parity bill which has been introduced here in the House of Representatives, the Senate proposal does not mandate that plans cover specific mental health benefits. It leaves those decisions up to employers and, in the case of fully insured health plans, the Senate bill permits States to continue to determine whether to require any particular benefits. In addition, the Senate bill includes a provision making clear that medical management of these important benefits may not be prohibited and preserves flexibility for employers and health plans in the formation of networks of health care providers who deliver these services. These provisions are vitally important because they allow employers to appropriately design and manage the health coverage they offer to meet their employees' needs.

Finally, and most importantly, several of the key provisions of the Senate parity bill are subject to a rule which is intended to ensure uniformity between the Federal parity requirements and those established by the States, while maintaining the traditional role of the States to regulate the business of insurance in all other respects. Major, multi-state employers, in particular, rely upon the uniform Federal framework established by the Employee Retirement Income Security Act (ERISA). It is

crucial to these employers, who provide health coverage to over 70 million Americans, that this framework not be eroded.

EMPLOYER CONCERNS WITH THE HOUSE MENTAL HEALTH PARITY BILL

Unfortunately, we do not see the same balanced approach in the House parity bill to the issues of key concern to employers and we would urge that several changes be made to the legislation as it is considered further by this subcommittee and the other committees of jurisdiction in the House of Representatives. The primary issues which we believe need to be addressed are the following:

FLEXIBILITY NEEDED IN COVERED BENEFITS

Under the House parity bill, if a health plan provides "any" mental health or substance-related disorder benefits, then the plan must cover all of the same mental health and substance disorder benefits as are provided to Federal employees under the Blue Cross and Blue Shield standard option health plan (the most heavily enrolled health plan offering under the Federal Employee Health Benefits Program). Plans offered to Federal employees are required to cover all conditions listed in the so-called DSM-IV manual, the diagnostic manual used by mental health care professionals to identify and categorize all disorders in this area. So, while the benefit mandate is stated somewhat differently than it has been in previous mental health parity bills, the basic requirement in the House bill is to cover all mental health and substance-related disorders if a plan covers any services at all in this area. Of course, the vast majority of plans do provide such services.

Employers have several concerns about this sort of requirement. First, it is not necessary to achieve the purposes of the legislation, which is to provide parity in any financial requirements and treatment limits which a plan applies to the benefits it covers. Requiring a plan to provide coverage for all of the conditions which are identified in the diagnostic manual used by health care providers is not "parity", it is simply a benefits mandate. It also requires much more specificity of coverage than is required for any non-behavioral health conditions. Such a requirement would send an immediate message to employers that they no longer have any discretion over decisions about what benefits they cover for their employees in this area of their plan, except the decision to provide no coverage for these conditions at all, which is an unacceptable alternative.

In addition, state laws currently govern which benefits are required to be covered for fully insured health coverage, so this is a matter that can be, and often is, decided by the states for the health plans which they regulate. In terms of self-insured health plans which are regulated under Federal law, there are no similar requirements applied to any other broad category of health conditions or services which are typically covered by employer-sponsored health plans, in recognition that this is an important area of discretion for employers when they voluntarily choose to provide health coverage to their employees.

PROTECTION REQUIRED FOR MEDICAL MANAGEMENT PRACTICES

Another major concern with the House bill is that, unlike previous mental health parity bills considered by Congress or the current Senate measure, there is no specific protection for plan medical management practices. It is very important to protect the ability of plans to appropriately manage coverage for mental health conditions and substance-related disorders as part of any Federal parity legislation. Proposed treatments for these conditions should, whenever possible, be consistent with standards for evidence-based care. Ultimately, to quote the conclusion of an April 11, 2007 op-ed column in the New York Times by Maia Szalavitz, "we need parity in evidence-based treatment, not just in coverage—for mental health conditions.

One of the most important developments now occurring in the health care field is in the preparation of measures by numerous clinical specialty groups to help define appropriate care and expected outcomes for patients for a wide range of conditions. Purchasers, health care providers, consumer groups and many others are actively working in several different forums to reach consensus on evidence-based measures of quality health care. While much more needs to be done to achieve a fully transparent and more accountable health care system, there can be little doubt that the movement to achieve consistent measures of quality care is a major step in the right direction and can help drive overall health system reform.

We need to be careful to ensure that neither State nor Federal laws undercut or diminish efforts by plans to try to ensure that the health care services received by plan participants are medically necessary and appropriate for their conditions. Some health plans contract with managed behavioral health care organizations for this

purpose while others perform medical management services as part of their core plan operations. Either way, it is essential to safeguard these important activities so that plans are able to both protect themselves and their participants from unnecessary costs as well as to try to ensure that coverage is provided for quality health care services. Indeed, an August 2006 report by the Congressional Research Service on the impact of health parity laws cited evidence that there was little adverse impact in the Federal Employee Health Benefits Program in terms of access, quality or cost of care because the parity requirements for mental health benefits covered under that program were coupled with the management of care by plans offered to Federal employees.

DISCRETION NEEDED FOR OUT-OF-NETWORK COVERAGE

A third significant concern that employers have with the House bill is that it mandates coverage for mental health and substance-related disorders by out-of-network providers if a plan provides coverage for substantially all medical or surgical services on an out-of-network basis in any of three different categories (emergency services, inpatient services or outpatient services). Again, this requirement limits important plan discretion and exceeds what is required under the Federal Employee Health Benefits Program where parity is required only for services provided on an in-network basis.

We would recommend that the House bill be modified to conform to either the FEHBP requirement or the comparable provision in the Senate parity bill which includes a Federal standard that calls for parity in plan financial requirements and treatment limitations for any out-of-network mental health coverage provided by a plan, but the Senate provision does not require plans to offer out-of-network coverage. The Senate bill also preserves the traditional role of the States to regulate fully insured health plans in this area, so it does not interfere with State laws which may require insurers to offer out-of-network health coverage.

CHANGES NEEDED TO PROVISIONS RELATED TO STATE LAWS

Finally, we have significant concerns with the provisions in the House parity bill which would authorize States to provide "greater consumer protections, benefits, methods of access to benefits, rights or remedies—than those in the legislation. This is extraordinarily broad language and arguably gives States the ability to develop parity laws, at least for fully insured health plans, that could differ significantly from the Federal standards provided and that are determined to be even "greater" than those in the House bill.

More troubling, however, is that the House bill provision on the relationship to State laws would give States broad authority to enact greater "consumer protections...methods of access to benefits, rights and remedies than any applicable Federal standards. This provision appears to go far beyond a mental health parity requirement in that it opens the door for the States to develop separate enforcement and remedy schemes, a matter of frequent review by the United States Supreme Court which has ruled unanimously that the Federal remedy scheme included in ERISA is exclusive for all health benefits covered by employer-sponsored benefit plans.

Moreover, if the bill is intended to only change enforcement and remedy schemes for mental health coverage, then there is no justification for a separate set of rules for just one category of benefits. If, in fact, this provision is intended to permit states to create a new enforcement and remedy scheme for all benefits, then such a fundamental change in the law should not be an adjunct to a bill whose purpose is to address mental health parity.

The uniformity ERISA establishes for employer-sponsored coverage, including its enforcement and remedy scheme, is based on sound public policy and is something employers consider crucial to their voluntary decision to offer health coverage to their employees. Federal preemption is not unlimited, but where it does apply it fosters uniform administration of covered benefits and reduces costly burdens of complying with differing State laws which would occur in the absence of ERISA's uniformity provisions.

If Congress believes that changes are needed in this area, is should be fully debated on its own merits rather than included as one of many provisions of a mental health parity bill.

HOUSE AND SENATE PARITY BILLS FAIL TO APPLY TO MEDICARE OR MEDICAID

One of the most glaring omissions of both the House and Senate parity bills is that they fail to apply the same requirements to the mental health benefits provided

to millions of elderly and low-income Americans who are covered under Medicare and Medicaid. While we are aware that separate legislation sponsored by Rep. Pete Stark, H.R. 1663, would partially address this situation by requiring parity for benefits covered by Medicare, nearly all of the debate and focus concerning mental health parity over the past decade in Congress has been around employer-sponsored health coverage.

We believe it is simply indefensible for Congress to impose parity requirements on employer-sponsored health coverage while ignoring the same issues in the programs where it has direct responsibility. Failing to do so would mean that if either the House or Senate bills were to be enacted, mental health parity would be the law for employer-sponsored coverage and, through previous action by Executive Order, for coverage offered to Federal employees (including members of Congress), but not for those covered under Medicare or Medicaid.

This committee has jurisdiction over Medicare outpatient services covered under Part B and the Medicaid program. We would be in a very different place in this debate if the fundamental policy decision had been made long ago that mental health parity was not simply something that Congress was seeking to apply solely to employer-sponsored health coverage, but was being done as part of a more omnibus effort to achieve the same standards in all Federal health programs as well. Such an approach would send a substantially different message to employers that sponsor health benefits for their employees and it is an approach that we strongly urge be done before you compel private sector employers to make changes to their plans.

Again, I appreciate the opportunity to testify today and share our views with you on these important issues. The American Benefits Council has played a constructive and highly engaged role in the multi-stakeholder negotiations that helped shape the Senate mental health parity bill. We and our allies on this issue are prepared to do the same with the House bill if a similar approach is taken to making what we believe are important and needed changes to ensure a more balanced proposal.

Employers understand the importance of quality mental health coverage for their employees and to maintaining a productive, healthy workforce. We also fully understand the strong sentiment in Congress to change current Federal mental health parity requirements. We believe the candid discussions among all the major stakeholders which were used to develop the Senate bill have demonstrated that employers and insurers are prepared to engage seriously in resolving this longstanding issue, provided that the process is respectful of the priority needs of all the parties involved. As this legislation moves forward, we urge that you consider the merits of this approach so that a consensus measure can ultimately be considered by the House of Representatives.

Mr. PALLONE. Dr. Goldman.

STATEMENT OF HOWARD H. GOLDMAN, M.D., PROFESSOR OF PSYCHIATRY, UNIVERSITY OF MARYLAND, SCHOOL OF MEDICINE

Dr. GOLDMAN. Thank you very much for the invitation to speak here today.

I am Howard Goldman. I am a professor of psychiatry at the University of Maryland School of Medicine. I served as the senior scientific editor of the Surgeon General's report, and I was the principal investigator of the evaluation of behavioral health parity for Federal employees.

My testimony today focuses principally on that evaluation. The comments are derived from papers that were published in the New England Journal of Medicine and the Journal of Pediatrics, and they are also based on an editorial written by two health economists that accompany our paper in the New England Journal of Medicine.

The parity policy in the Federal Employees Health Benefits Program began on January 1, 2001, and it offered comprehensive insurance coverage for all mental disorders, including substance

abuse, all of the conditions in the international classification of diseases.

The terms were the same for behavioral disorders as they were for general medical conditions when the treatment was provided by in-network providers under the managed care arrangements.

Our study compared seven Federal plans with a matched set of plans that did not change benefits or management and did not have parity. We compared use and spending by enrollees in these plans for the 2 years before parity, 1999 and 2000, with the 2 years afterwards in 2001 and 2002.

We observed the proportion of Federal employees, retirees and their dependents who use behavioral health services. We looked at how much they spent and how much of this spending was out of their own pockets.

The study found, one, that the policy was implemented very smoothy and without any of the Federal plans dropping out of the Federal Employees Health Benefit Program, which is something that has been feared by some in their testimony today.

Two, there was a significant decline in out-of-pocket spending in the Federal plans compared to the nonparity plans, which indicates that parity coverage resulted in improved insurance protection against financial risks. After all, that is the principal objective of health insurance, and we have heard about this tremendous financial burden that a mental disorder can impose.

Three, the savings to Federal plan members was not associated with significant increases in use and spending attributable to parity. In fact, for the most part, increases that we did observe in use and total spending in the Federal plans were no greater than use and spending increases in the comparison plans. This was true for adults just as it was for children and adolescents.

In our published paper, we concluded that these findings suggest that parity of coverage of mental health and substance abuse services, when coupled with management of care, is feasible and can accomplish its objective of greater fairness and improved insurance protection without adverse consequences for health care costs.

In their editorial, the two health economists note that the purpose of the parity policy was to provide better financial protection to everyone who has health insurance. The coverage is not only for people who have currently a mental disorder, but any one of us who might have a mental disorder in the course of the year.

The economists state that the article by Goldman, et al, provides the first controlled study of parity in two decades. The compelling evidence presented suggests that in today's environment, parity and health insurance coverage is both economically feasible and socially desirable.

The policy performed just as insurance should. It reduced the cost of out-of-pocket payments with a small increase in plan payments. This could result in very small increases in insurance premiums without leading to an increase in use of services. The CBO estimates a premium impact for group plans of 0.4 percentage points, and that is the same increase in premium, very small, that we observed for Federal employees.

Furthermore, there is a concern raised about mandated benefits. We conclude that by reducing financial risk, parity improves the

well-being of insured people without distorting the market for mental health services. Legislation is the way to accomplish that social good because parity coverage offered by only one or two plans would result in those plans attracting a disproportionate group of people with persistent mental illness. This is referred to as adverse selection, and it is only through a parity policy such as that which is offered that we can avoid the financial risks associated with adverse selection.

For decades, advocates for parity relied only on an argument of fairness to gain support for their cause. Now they can argue that parity promotes social well-being and economic efficiency in the form of better insurance benefits for all of us.

Thank you, Mr. Chairman, Ranking Member and Members of Congress.

[The prepared statement of Dr. Goldman follows:]

TESTIMONY OF HOWARD H. GOLDMAN, M.D.

Thank you for the invitation to address you today. I am Howard H. Goldman, MD, PhD, professor of psychiatry at University of Maryland School of Medicine in Baltimore. I served as the senior scientific editor of the Surgeon General's Report on Mental Health and was the principal investigator of the evaluation of behavioral health insurance parity for Federal employees.

My testimony today focuses on that evaluation and its findings and conclusions. My comments are derived from our report posted on a Department of Health and Human Services Web site as well as from published papers. I have appended papers by our research team published in the New England Journal of Medicine (1) and pediatrics (2). I will also refer to an editorial published with our paper in the New England Journal of Medicine, written by two health economists (3) and also appended to the testimony as well.

The parity policy in the Federal Employees Health Benefits [FEHB] program began on January 1, 2001 and offered comprehensive insurance coverage for mental disorders, including substance use disorders, on terms that were identical to the coverage of general medical conditions, when the treatment was provided by in-network providers.

Our study compared 7 FEHB plans with a matched set of plans that did not change benefits or management and did not have parity. We compared use and spending by enrollees in these plans for the 2 years before parity [1999 and 2000] and for the 2 years after parity began [2001 and 2002]. We observed (i) the proportion of Federal employees, retirees and their dependents who used behavioral health services, (ii) how much they spent for behavioral health services, and (iii) how much of the spending was out of their own pockets.

The study found that:

1. The policy was implemented smoothly and without plans dropping out of the FEHB program.
2. There was a significant decline in out-of-pocket spending in the FEHB plans compared to the non-parity plans. This indicates that parity coverage resulted in improved insurance protection against financial risks—the principal objective of health insurance.
3. This savings to FEHB plan members was not associated with significant increases in use and spending attributable to parity. In fact, for the most part increases in use and total spending in the FEHB plans were no greater than use and total spending increases in the comparison plans. This was true for adults as well as for children and adolescents. (2)

In our published paper we concluded that "these findings suggest that parity of coverage of mental health and substance abuse services, when coupled with management of care, is feasible and can accomplish its objectives of greater fairness and improved insurance protection without adverse consequences for health care costs." (1; p. 1386)

In their editorial, "Better Behavioral Health Care Coverage for Everyone," in the New England Journal of Medicine, two health economists (Glied and Cuellar) note that the purpose of the parity policy was to provide better financial protection to

everyone who has health insurance. The coverage is not only for individuals who already have a mental disorder but it is for all of us. (3)

The economists state that "the article by Goldman et al.—provides the first controlled study of parity—in two decades. The compelling evidence presented suggests that in today's environment, parity in health insurance coverage is both economically feasible and socially desirable." (3; p. 1415)

The parity policy performed just as insurance should, it reduced costs from out-of-pocket payments with a small increase in plan payments. This could result in very small increases in insurance premiums, without leading to an increase in the use of services. CBO estimates a premium impact for group plans of a 0.4 percentage point increase (4), a figure which is identical to our estimate based on the FEHB experience.

Furthermore, in response to concerns raised about a mandated benefit, we conclude that by reducing financial risk parity improves the well-being of insured people, without distorting the market for mental health services.

Legislation is the way to achieve this social good, because parity coverage offered by only one or two plans would result in those plans probably attracting a disproportionate share of people with persistent mental illness. This is what is referred to as "adverse selection."

In fact, parity provides the best protection for insurers and self-insured companies from experiencing adverse selection. When they offer parity benefits at the same time, they can avoid a shift of high-cost individuals into their plans.

For decades advocates for parity relied only on an argument of fairness to gain support for their cause. Now they can argue that parity promotes social well-being and economic efficiency—in the form of better insurance benefits for all of us.

References

HH Goldman et al. "Behavioral Health Insurance Parity for Federal Employees," New England Journal of Medicine 354(13):1378–1386, March 30, 2006.

Stazrin et al. "Impact of Full Mental Health and Substance Abuse Parity for Children in the Federal Employees Health Benefits Program," pediatrics 119:452–459, 2007.

Glied and a Cuellar. "Better Behavioral Health Care Coverage for Everyone," New England Journal of Medicine 354(13):1415–1416, March 30, 2006.

Congressional Budget Office cost estimate, S. 558, Mental Health Parity Act of 2007, March 20, 2007. CBO.gov/ftpdocs/78xx/doc7894/s558.pdf.

Some additional comments and potentialquestions/answers:

Quality. We also looked at indirect measures of quality of behavioral health care in the FEHB plans during this same period. Parity was accomplished without increases in hospitalization of patients and without a decline in the measures of quality of care that we studied, such as likelihood of receiving follow-up care for depression or being referred for substance abuse treatment.

What is included in the term "behavioral health services"?This term refers to all use of health care services for any of the disorders (including substance use disorders) in the diagnostic and statistical manual or the mental disorders chapter in the International Classification of Disease (ICD). It includes specialty mental health services such as psychotherapy as well as visits to a general medical provider, when a mental disorder diagnosis is recorded. It also includes the use of all medications for which behavioral health conditions are an indication. When medications might be used for a mental disorder or a general medical condition, use and spending were included only if accompanied by a mental disorder diagnosis in the record. This is the broadest definition of use and spending, designed to capture the impact of parity.

There was no use or spending for (oft-parodied) trivial behavioral conditions under managed care plans.

It is probably worth noting that the ICD contains a wide range of general medical conditions, such as scrapes and bruises, rashes, sprains, and the common cold, just as it includes sleep disorders, mild phobias and mild learning problems. Managed care arrangements and "medical necessity" criteria control un-necessary use and spending for trivial cases of general medical conditions and mental disorders alike.

Can you say anything about the impact of parity on spending for general medical care?

Unfortunately our study did not include such analyses.

Adverse selection. Adverse selection occurs when plans offer different benefits and individuals select plans with coverage they expect to use. These plans are said to experience "adverse selection" resulting in higher costs on average than other plans that do not offer special benefits. Without a parity mandate plans that wish to offer better benefits attract to them a group of users with high costs, resulting in adverse economic consequences for the plan and its other members. If all plans offer the

same benefits (such as under a mandate) they can avoid adverse selection. Left to the incentives of market pressures, plans either offer the same extremely limited set of benefits or a few plans offer better benefits and risk selection, while the other plans have a selective advantage and lower costs. For everyone to enjoy the benefits of parity and the cost-neutral experience of parity in the FEHB program, there must be a mandate for parity coverage, and the benefits should be standardized. This is why the two health economists who commented in the New England Journal of Medicine (Glied and Cuellar) concluded that a legislative mandate was required to achieve the economic efficiency demonstrated by the FEHB experience with behavioral health insurance parity. In this instance a mandate promotes market efficiency—or at least avoids the market failure associated with adverse selection. Ironically, a mandate may help insure employers and plans against financial risks when they try to offer better benefits to their employees.

SUMMARY OF THE KEY POINTS FROM THE SUBCOMMITTEE HEARING TESTIMONY FOCUSING ON BEHAVIORAL HEALTH INSURANCE PARITY IN THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

The parity policy in the Federal employees health benefits (FEHB) program began on January 1, 2001 and offered comprehensive insurance coverage for mental disorders, including substance use disorders, on terms that were identical to the coverage of general medical conditions, when the treatment was provided by in-network providers.

The most important positive finding in the evaluation was a significant decline in out-of-pocket spending in the FEHB plans compared to the non-parity plans. This indicates that parity coverage resulted in improved insurance protection against financial risks

Furthermore, this savings to FEHB plan members was not associated with significant increases in use and spending attributable to parity. In fact, for the most part increases in use and total spending in the FEHB plans were no greater than use and total spending increases in the comparison plans.

Goldman et al. concluded: "These findings suggest that parity of coverage of mental health and substance abuse services, when coupled with management of care, is feasible and can accomplish its objectives of greater fairness and improved insurance protection without adverse consequences for health care costs." (1; p. 1386) these findings were true for children as well as adults. (2)

Glied and Cuellar, two health economists state: "the article by Goldman et al.—provides the first controlled study of parity—in two decades. The compelling evidence presented suggests that in today's environment, parity in health insurance coverage is both economically feasible and socially desirable." (3; p. 1415)

The parity policy performed just as insurance should, it reduced costs from out-of-pocket payments with a small increase in plan payments. This could result in very small increases in insurance premiums, without leading to an increase in the use of services. CBO estimates a premium impact for group plans of a 0.4 percentage point increase (4), a figure which is identical to our estimate based on the FEHB experience.

Legislation is the way to achieve the benefits of parity, because it helps to avoid "adverse selection."

References: (1). HH Goldman et al. "Behavioral Health Insurance Parity for Federal Employees," New England Journal of Medicine 354(13):1378–1386, march 30, 2006. (2). Stazrin et al. "Impact of Full Mental Health and Substance Abuse Parity for Children in the FEHB Program," Pediatrics 119:452–459, 2007. (3) Glied and Cuellar. "Better Behavioral Health Care Coverage for Everyone," New England Journal of Medicine 354(13):1415–1416, march 30, 2006. (4) Congressional Budget Office cost estimate, S. 558, Mental Health Parity Act of 2007, March 20, 2007. CBO.gov/ftpdocs/78xx/doc7894/s558.pdf.

Mr. PALLONE. Thank you very much.

We will have questions from the members, and I should point out that if you can't answer the question or you want to get back to us in writing, that is certainly permissible, but we would like you to try to answer today obviously.

I am going to start with myself for 5 minutes, and I wanted to ask of Ms. Prunty-Lara and possibly Mr. Purcell, as well; it deals with the preemption.

Let me start with Ms. Prunty-Lara.

Over the last few years, several States have enacted very strong parity laws, Rhode Island, Mr. Purcell's State, along with some others such as Washington, Oregon—I won't go through the list—have strong mental health parity laws.

Do you have concerns about legislation that would preempt States' stronger mental health parity laws and what would that mean for patients?

Ms. PRUNTY-LARA. I believe, for the 130 million people covered by health insurance plans, that they have the right and the honor and they deserve the dignity of being provided with equitable mental health coverage at the same level that a lot of people who have fully funded insurance plans at the State level are also offered.

To disregard what States have already achieved and throw that by the wayside, I think is irrefutably wrong, frankly. I think that we need to institute a baseline of sorts so that we have equitable coverage for as many people as possible in terms of mental health care.

For me personally, in the State of Minnesota we have a stronger parity law, and so we need to let that stand as it is so that we don't adversely affect those people who are currently influenced by the parity laws already in existence.

Mr. PALLONE. Let me ask, Mr. Purcell, what are your thoughts on passing a Federal law that would preempt Rhode Island's more protective mental health parity law?

Mr. PURCELL. I would be against it. I am here only because Rhode Island was innovative enough and perhaps courageous enough to pass a law, and we were able to operate under it and see the results; and hopefully, those results help you have a context in terms of understanding what may happen if you pass your law. So this is the old federalism argument, and I think it makes abundant sense to have the preemption issue handled the way the House bill does throughout the Senate bill.

Mr. PALLONE. OK.

One of the major differences between the House and the Senate bills is that while the Senate legislation allows insurers to define what they cover in terms of mental health treatment, the House bill sets the standard for coverage. In the House bill, mental health conditions must be covered to the same extent they are covered for the Federal employees and Members of Congress.

Critics of the House bill charge that this would open insurers up to paying for every problem under the sun, but the simple fact of the matter is that insurers still have many tools by which to manage the coverage and care provided to the enrollees. With medical benefits, clients don't have to provide every covered benefit to anyone who wants it; they only do so if it is medically necessary. And that would continue to apply here.

So I wanted to ask again the two of you, Mr. Purcell and Ms. Prunty-Lara, do you believe that, the way the Senate bill works, I understand, we would—we might not achieve parity because we permit insurers to cover only depression, but not autism, or cover alcoholism, but not bipolar as part of the parity law.

Is there a reason any of these illnesses is less deserving of coverage than, say, heart disease or diabetes? This is what we are trying to get to with the House version.

I will start with you.

Ms. PRUNTY-LARA. I think the problem, with not explicitly stating that we need to cover what is considered diagnosable, is that you end up with a system in which there is discrimination by diagnosis. And that is inherently wrong. My disease is no less deserving of coverage than that of a heart condition or that of a broken leg or that of autism or cerebral palsy or MS. And it is just as real and just as painful, even if you can't see it.

So my hope is that you not allow the discrimination to continue on the basis of diagnosis and on the basis that post-traumatic stress disorder or an eating disorder would not be considered medically necessary. Because I assure you, the pain is real.

Mr. PALLONE. Mr. Purcell.

Mr. PURCELL. Of course, the devil is in the details with regard to the Senate definition. It depends upon when the exception is going to be so big it can eat up the rule. I assume it would not be that big. Nonetheless, it does seem to me that using the FEP definition gives you much more context. If you are going to mandate parity, at least you have to mandate what coverages have parity.

And you have the example in FEP where you have seen, based on Dr. Goldman's study, it does not appear to have significantly increased costs, if at all. So while we can have some red herrings about some of the more fringe, V-type DSM types of diagnoses, such as jet lag or gray hair, that is beside the point.

We have got to bring it back to the middle and even though you can describe a completely unrealistic or facetious coverage, the true idea here is to get people coverage. This is all about the people, so I think you have got an example that works.

So I would be in favor of the House version on that.

Mr. PALLONE. Thank you.

Mr. Deal.

Mr. DEAL. Thank you, Mr. Chairman.

Mr. Klein, you held up the book, and I assume that is the diagnostic and statistical manual; is that correct?

Mr. KLEIN. That is right.

Mr. DEAL. Who compiled that?

Mr. KLEIN. My understanding is, that is a compilation from various health care provider groups that identified the panoply of mental health and behavioral disorders.

Mr. DEAL. I have been given some information that indicates that it does include a wide variety of things, and you can always find some things that sound ridiculous on their face. One of them that sounded a little ridiculous to me is a mathematical disorder. It may or may not be a significant mental disorder.

My concern is the breadth of coverage, if we require coverage of all of those potential manifestations.

Dr. Goldman, did you find anything, as it related to such a broad, expansive coverage, perhaps even to contrast it outside of the study you did, that you referred to, with States that have more narrowly limited their parity to biologically based or serious mental illnesses as State statutes would sometimes define it.

Could you tell us whether that is a problem or not?

Mr. GOLDMAN. In our experience, studying Federal employees parity policy, we didn't see utilization of these so-called and often parity-trivial disorders. Utilization was not governed by diagnostic criteria, but was governed by management decisions that were made about the necessity of service.

It is considered now an old-fashioned way to make the determination of who should get what care, to do it on the basis of diagnosis or diagnosis alone, that we have the tools of management that allow us to make much more precise decisions about allocating the sources based on medical necessity.

Mr. DEAL. And that is in the context of a managed care environment?

Mr. GOLDMAN. Yes. The managed care environment was the environment in which the parity policy was implemented in the Federal employees plan. And that was true of most of the State parity policies as well.

I should note that if you look within the international classification of diseases, of which the DSM has simply one chapter on mental disorders, you will see in the other chapters a wide range of conditions. Everything from scrapes and sprains and skin tags and colds to more serious conditions. And in the current health care environment, we use management of care in order to make appropriate allocation decisions.

Parity would extend that mechanism for cost containment to mental disorders without having to refer to specific conditions.

Mr. DEAL. I think the concern is that we also allow health insurance policies to further refine and define the benefits and the conditions for which those benefits attach.

Mr. Klein, in that regard, and also in regard to any, perhaps, State studies or variations among the States, do you have any comment you would like to make on that?

Mr. KLEIN. No. I read Dr. Goldman's excellent study and encourage it to everyone.

It is so crucial to keep in mind that perhaps the major reason—I will let him speak to it—that the cost increases didn't occur under the Federal Employees Health Plan was because there was this medical management that I was referring to earlier; and Mr. Purcell also spoke about how important that is. Because the issue really isn't, as I said before, making a value judgment of which of these conditions is worthy or not of being covered.

The fact of the matter is, not all treatment regimens are equally successful. And there are countless studies in the journals that show people with the same diagnosis in two different parts of the country may get radically different kinds of treatment; and in order to ensure high-quality outcomes for patients, it is absolutely essential to have these medical management tools. And that is something that is protected under the House—the Senate bill, but not under the House bill.

Mr. DEAL. Would you care to comment on that?

Ms. ROGERS. I agree with what Mr. Klein just said about best practices are extremely important, and the major employers are really forcing their providers to use best practices. And they focus

on the cost drivers and are able to manage them, and that is actually the future, it is the direction we should be doing in.

We should also be going in the direction of making health benefits more portable, and I think this is a step in the other direction where you still have all of these different State mandates. And in order to get to a system where health plans are portable, because the workers are much more mobile these days than they used to be, since we are in a global economy, you need to move closer in the direction of one system—and this moves, in the other direction. And we also need to move in the direction of simplicity, and this does not move in that direction.

Mr. DEAL. Thank you all for being here.

My time is out. I am over my time. But thank you all for being here.

Mr. PALLONE. Thank you.

Mrs. Capps.

Mrs. CAPPS. Thank you.

I want to thank you, Ms. Prunty-Lara, for very powerful testimony. It is the most eloquent statement I have ever heard by a consumer of mental health care and someone who has lived and does live with bipolar disorder. My brother does as well. And the pain and suffering that you described is also shared, as you said, by all the family members.

I am glad you are on the board of the Mental—I still call it the Mental Health Association—the national board; and there is a very active local chapter in Santa Barbara, and I am going to tell them what a good spokesperson you are for various issues as well.

You talked about the lack of equity for physical versus mental health as being a form of discrimination. And I want you to describe that connection.

It is like a revictimization, in a way, that the family really does get in on, a pain and suffering caused by the denial of treatment, sometimes over and over again. And I think for our part here, that this stigma of bias becomes systemic when it is promoted; and the status quo, we here in the Government are kind of perpetuating as well. That is why I think it is so timely that we have this legislation before us.

Talk a little bit more, if you would.

But I also want to turn to Mr. Purcell, you were cut off, and I think you had some more things to say, and I will give you a minute or so to complete that.

Ms. PRUNTY-LARA. First of all, I want to comment that there is nothing in the Kennedy-Ramstad version of this bill that precludes medical management. So I want to make that perfectly clear. That is in this legislation. There is nothing to preclude it.

I also want to submit some comments from James T. Hackett, who testified before this committee in 2002. And he talked about the Federal law that currently allows health insurance discrimination against people with mental illness, discrimination in duration of needed treatment, discrimination in cost-sharing burdens and discrimination by diagnosis, as I said.

There is also a discrimination in ideals, a discrimination that says that your illness isn't good enough, that we somehow stigmatize the treatment of mental health conditions and we say that

it is not equitable, that it is not real enough as a broken leg. And as some Members of Congress have commented, there is a disparity, there is a difference in how we are going to treat them. And I am sorry, there is not. It hurts the same, it feels the same, it deserves the same principal of equality and justice and accountability to your employees and their beneficiaries.

Mrs. CAPPS. Thank you very much.

Mr. Purcell, I really—I am going to remember it the way you distinguished between mental and physical health. You call it behavioral and physical health. That is very clear, health covering both of them, or disease, a lack of health, as evidenced in different ways.

I also was struck by your description, and I want you to expand on this in whatever time I have, but the relationship between mental health problems and their spillover, the correlation between mental and physical health, because I think that is one way that we can help to document the cost of not treating mental health.

Mr. PURCELL. I have an example in my written testimony about how gray the line is between an obese diabetic who has depression and an eating disorder. Where does the physical health component end and the behavioral component begins? And of course nobody knows.

What we are trying in Rhode Island, we have a pilot program to achieve integration of behavioral and physical health by collocating and integrating behavioral and physical health. The whole idea here is to get people in early for office visits. Office visits don't cost anything in the greater scheme of things. When we increase from 30 visits to 50 visits a year, it costs almost nothing. But as I was going to say, the few people that run out of 30 really need the care. And when do they run out? Right around the holidays. And where do they go? They go to the emergency room. Is that cost-effective? Never.

We have more trouble getting people to go to office visits than having them abuse it. And the key here is if you can get them to office visits, you keep them from becoming chronically ill for the most part. And it is tremendously cost-effective both on the behavioral and physical side.

I hope that answers your question.

Mrs. CAPPS. If I had more time, I would get into how do you get them in earlier, because that means someone has to refer; or there used to be an acknowledgment—I used to work in the school district, and I know that is a good place for young people to get started.

Mr. PURCELL. Collocation for primary care doctors. That is the way to do it.

Mrs. CAPPS. Collocation for primary care?

Mr. PURCELL. That is right.

Mrs. CAPPS. Excellent. Thank you.

Mr. PALLONE. Mrs. Myrick.

Mrs. MYRICK. Thank you, Mr. Chairman, and thank all of you for being here.

Ms. Rogers, I wanted to ask you a question. You said that one of your objections to the House bill is that the nature of psychiatric medical care requires flexibility in benefit design. Do you see what you call trust, don't verify, that culture of psychiatric care, chang-

ing as it becomes more obvious that these are biological-treated illnesses? And then how do you see the status changing in the future—and aren't there professional societies like APA that have treatment and quality standards that could, A, benefit design plans for companies so that they end up paying for quality care?

Ms. ROGERS. Thank you for the question. In our opinion, it appears that on the physical side that they are much further down the road with regard to having best practices that have been pushed out to the primary care physicians and also the specialists. And they are starting to get used to the idea of reporting on quality measures. I know that Medicare is pushing it with the hospitals and also with the physicians.

Mrs. MYRICK. Right.

Ms. ROGERS. And also with transparency of their costs, efficiency measures. And we just think that that is key for the future, coupled with health information technology. And we see the mental health community much further behind on that side. So it just seems like they need a push or a nudge, and that they need to be included in the fold with regard to those advancements.

Mrs. MYRICK. Don't you think that would actually come if working together with the companies and the different groups to incorporate that type of thing? Because they haven't had the same length of experience in doing this that you have with the other physical illnesses. Am I making sense?

Ms. ROGERS. Yes, you are making sense. Well, remember, the majority of our members have stigma-free mental health. They don't have "parity" according to this bill, but they have very generous benefits. But they do feel like that there are quite a few providers, more so on the mental health side than they see on the physical side, that are less willing to provide the information that they would like to see.

Mrs. MYRICK. So it is less willing.

Ms. ROGERS. Yes.

Mrs. MYRICK. That is why there needs to be more cooperation.

Ms. ROGERS. And we just look at this as an education issue. We don't see this as a big legislative, regulatory issue.

Mrs. MYRICK. I see.

Ms. ROGERS. But more of an education issue that the private sector has been pushing for for quite a while. And especially our members on both sides, on the mental health side and also on the physical health side. It just seems like on the mental health side they are further behind, and they are not as well organized and represented.

Mrs. MYRICK. OK. Thank you.

Marley?

Ms. PRUNTY-LARA. If I may just respond, as an organization, Mental Health America is working to further evidence-based practices, but it is very hard to do when you don't have parity, because you don't have the same number of providers, and you don't have the same access to treatment to formulate those evidence-based practices.

I would also like to respond about Government interference into parity regulation. It is not a question of education, because the private sector has failed. They have not implemented parity. And it

has been 11 years since Paul Wellstone stood on the floor of the Senate with Pete Domenici and called for the enactment of the 1996 partial parity law. These discriminatory practices are, for the best interests of the American people, to be eliminated. Federal law subsidizes employers through the Federal Tax Code for providing health insurance to employees, allowing the cost of insurance as an ordinary business expense. It is wholly appropriate for Congress to condition entitlement to such benefits on employers providing health benefits in a nondiscriminatory manner. This Congress has the right to demand that mental health be covered equally.

Mrs. MYRICK. Yes. Go ahead. Pardon me, I am almost out of time, but quickly go ahead.

Mr. KLEIN. No, I was just going to say that I don't believe that—I think we are beyond the issue of parity. I mean, the Senate bill has already embraced it. The point is you don't need such tightly prescriptive type of parity that is called for in the House bill in order to encourage the type of quality improvement outcomes that we are looking for.

Mrs. MYRICK. Very good. I appreciate that. Thank you all.

Mr. PALLONE. Thank you.

Ms. Baldwin.

Ms. BALDWIN. Thank you, Mr. Chairman.

There has already been some discussion, considerable discussion, about differences between the House bill and the Senate bill and use of the DSM-IV definitions in the House bill. But I want to probe for some additional clarity on that. So at the risk of being redundant, I do want to pursue that subject a little bit more.

Dr. Goldman, I want to discuss how mental illness should be defined in a model mental health parity law. And as I hinted, I have serious concerns about the Senate bill, which allows insurers basically to pick and choose which illnesses they want to cover, and I don't think that is right. In the House bill, mental illness is defined based on DSM-IV. And it is my understanding that this is the diagnostic manual used by mental health and addiction professionals, and that it is widely accepted. Is this correct?

Mr. GOLDMAN. That is correct.

Ms. BALDWIN. Do you think that there is any medical basis for allowing insurers to decide what is a mental health illness and what is not?

Mr. GOLDMAN. I think, as I said before, we have other mechanisms to make sure that we allocate resources efficiently and effectively according to need, and that we don't use diagnosis as a way of excluding care on the general medical side. And the spirit of parity is to do the same for the behavioral disorders. So it is really a matter of not needing to focus on diagnosis for purposes of exclusion, but allowing management to deal with the cost concerns.

Ms. BALDWIN. So I am concerned that allowing insurers the type of discretion that I described earlier would lead to discrimination based on diagnosis. For example, an insurer might decide that one mental illness or another is simply too costly, too therapy-intensive or too complex, and they won't cover it. We know that insurers use nonmedical criteria to make their coverage determinations now, and so what is to stop them from doing the same thing if we were

to pass a very weak mental health parity law? Do you think that this would pose a potential threat to patient health?

Mr. GOLDMAN. If I base my remarks entirely on the experience that we had with the Federal Employees Health Benefit Program, we showed that all of the upside benefits that you want in terms of the social good, avoiding discrimination, and doing so by improving insurance protection can be done without reference to restrictions on the basis of disorders, I would have to substantially agree with your point.

Ms. BALDWIN. Thanks.

Mr. Purcell, I thank you for testifying today and sharing the experiences of Blue Cross/Blue Shield of Rhode Island in providing mental health parity. It is also useful to have the data about how things work, and we appreciate you sharing that with us.

Under Rhode Island's mental health parity law, are insurers required to provide parity for conditions which are not medically necessary?

Mr. PURCELL. No.

Ms. BALDWIN. I have certainly heard arguments from those opposed to this bill that insurers would be forced to provide parity for a whole host of conditions which are not necessarily medically necessary. And it is my understanding that H.R. 1424 also includes language that says that there will be parity only for medically necessary treatment. Is that your understanding of the bill as well?

Mr. PURCELL. That is what I have been told, and that is the tie-in with medical management.

Ms. BALDWIN. Yes.

Mr. PURCELL. Just because there is coverage for a condition does not necessarily mean it is medically necessary, because there has to be a linkage here. And you can come up—again, labels don't help here. If somebody comes in because they are excessively shy, that may not necessarily in and of itself be a behavioral disorder, but there may be an underlying function, there may be an underlying depression that causes that. And an office visit that is covered will allow a practitioner, using medical necessity means, to determine if that is so or not. And if there is, it deserves treatment, because down the road that patient is going to be healthier, their life is going to be better. And that is what this is all about.

So I think as long as we are able to use traditional medical management tools for utilization review for medical necessity, we can take care of that problem using a little common sense. I don't have a problem with it.

Ms. BALDWIN. Thank you.

Mr. Chairman, I yield back my remaining 16 seconds.

Mr. PALLONE. Mr. Sullivan.

Mr. SULLIVAN. Thank you, Mr. Chairman. And I guess my questions will be towards Ms. Rogers and Mr. Klein. And we had a hearing in Tulsa, we had a company—Williams Company has 4,000 employees, and they said that they felt that having parity in their plans reduced costs, and it was good for their business.

I have three questions for you. Do you—for both of you. Do you know any companies that have dropped mental health benefits in response to State requirements that they equalize benefits? If so,

what percentage of covered lives in that State lost their benefits as a result?

Mr. KLEIN. Congressman, I am not aware of specific companies. I am sure logic would seem to indicate that there would be some, but I don't know of any. And certainly among my member companies, which are primarily large ones, that hasn't happened. But, of course, it is possible any time costs go up in one area, other changes may be made to the health plan.

I also think, and I am so glad that you posed the question the way you did, about that there is actually cost savings relative to parity, because I think that it is inconsistent for people to argue, as several have done today, that insurers and employers will save money by providing mental health benefits, which is correct, if done properly, but then argue that employers and insurers are excluding certain coverages in order to save money. I mean, employers and insurers have every financial incentive to make sure that people are getting the appropriate coverages. So those two comments that have been made seem to me at complete odds with one another.

Ms. ROGERS. Thank you for the question.

I have talked to members of our trade association that did drop coverage, and the way they explained it to me was that they are mainly self-insured plans, but even though they are large self-insured, they have large pockets of employees in various States, and so they might have some insured plans, especially HMOs. And I have been told by numerous companies that when they are subject to State mandates that they feel that are too burdensome, like, for example, they also mentioned the issue of raising the mandatory age where you have to keep a dependent child on in some States, like New Jersey to 26, and I think maybe Colorado might be close to 30, that they did get out of their more managed care plans in those States that subject them to the State mandates, and they just fell back on their ERISA preemption.

Mr. SULLIVAN. Thank you.

I have another question for both of you. Members of Congress and Federal employees have full equity for mental health and addiction treatment in our health insurance plans. As we heard from Dr. Goldman, a thorough study found that equalizing benefits did not increase costs. Why then would you suggest that covering the same diseases would be a big cost increase for your members?

Mr. KLEIN. Well, I will take that one. First of all, the Federal Employees Health Benefit Plan only provides parity for in-network services, and it doesn't require it for out-of-network services.

The second part of that, again, gets back to this issue of medical management. And I think we can actually resolve something here today, because there is a little disagreement between Ms. Prunty-Lara and me on this question of whether or not the House bill interferes with that medical management. The Senate bill explicitly prohibits interference with medical management. The House bill is simply silent on the issue. So if the intention—and I am getting the sense that the intention is, amongst the supporters of the House bill, that it should not interfere with medical management, which everyone has indicated is so crucial—then I think a wonderful amendment, when this bill comes to be marked up here, would be

to make that very clear, as the Senate bill does. That would go a long way toward encouraging, giving greater confidence that this very important practice that ensures quality outcomes will be protected.

Mr. SULLIVAN. And then a final question, I guess, Ms. Rogers, I guess. Why do you think that passing this bill will somehow result in major cost increases, even though parity did not increase costs to the Federal employee program, or in several States, including mine, Oklahoma, Vermont, Maine, New Hampshire, Maryland, Texas, Minnesota, Connecticut or Rhode Island or any other State studied?

Ms. ROGERS. I think that because we surveyed our member companies, and their responses were—some of them were quite specific. Some of them said that their estimates are close to $2 million just to implement all the changes that they need to do to comply with the House bill. And then others said even though they have very generous mental health benefits, they are not identical to what would be mandated, and they feel like that they can't——

Mr. SULLIVAN. Have you ever surveyed them about lost productivity in the workforce or anything like that? We lost $100 billion last year in America. That is pretty significant.

Ms. ROGERS. Yes. No, that is usually an issue in our surveys, but, remember, I keep saying that our members have very generous mental health benefits. They all do. And they call them stigma-free mental health benefits. But they are not financial parity on the medical side. There is not the same system. And they do have the ability to medically manage them, and they want to be able to keep that ability.

Mr. SULLIVAN. I guess we all have to have someone to fight.

Mr. Purcell, I really appreciated your comments. And you are very thoughtful. And you, as a CEO of Blue Cross and Blue Shield, I learned something from what you said, and I appreciate it. Thank you.

Mr. PURCELL. Hopefully it is not inconsistent with a CEO to be thoughtful.

Mr. SULLIVAN. No, I think it is well thought out. Thank you. I yield back.

Mr. PURCELL. Thank you.

Mr. Matheson.

Mr. MATHESON. Thank you, Mr. Chairman, and thanks to the panel.

It has been an interesting discussion. To follow up on the line of questioning Mr. Sullivan led with, Dr. Goldman, you talk about your study with how the cost was affected in the Federal Employee Health Benefit Plan when mental health parity was implemented. We have also heard about the HHS study that found increased costs. Can you talk about the differences in the findings and give us some insight into that?

Mr. GOLDMAN. I am not sure I know about the HHS study that is different from our study. Ours was the HHS-sponsored study, and what they did find was that there was a small premium increase of less than one-half of 1 percentage point of total premium impact, and that resulted not from an increase of utilization, but a shift of costs onto the plan and away from the out-of-pocket costs

of people who used services. So it was just due to an improved insurance coverage, the financial protection associated with the parity benefit. That is a very small increase in premium.

And I believe that that is what you will find on the HHS Web site, and it is very similar to the CBO estimate for the Senate bill, and it is similar to our estimate for the Federal Employees Health Benefit Program.

Mr. MATHESON. Can you also provide insight into that discussion on the past set of questions on how I think Mr. Klein indicated the Federal Employee Benefit Plan, that the savings were not necessarily as realistic for the rest of the marketplace because of the way the plan is structured?

Mr. GOLDMAN. If I understand, and of course Mr. Klein can answer for himself, but I think the point was that for Federal employees parity applied to in-network benefits only where care was managed. Now, we saw people move from out-of-network providers to in-network providers in order to follow their financial incentive. People do behave rationally with respect to their insurance coverage. And so where they had the option, they moved. Many of them chose to move to get the parity coverage by going in network and having managed care, but they did have the choice. You all still have the choice, as Federal employees under this plan, to go out of network. Usually out-of-network benefits are unmanaged, but the coverage is usually inferior; that is, the cost-sharing arrangements are much higher.

Mr. MATHESON. Right.

Mr. GOLDMAN. And the issue is whether if you mandate parity on out of network, whether the cost controls will be sufficient, and that is one of the hardest things. Our study can only speak to a situation in which in-network benefits are on a par.

Mr. MATHESON. OK. That is helpful.

Mr. GOLDMAN. Is that also with you?

Mr. KLEIN. Yes.

Mr. MATHESON. Mr. Purcell, I was going to ask you, I am from a State where we have partial parity at this point, and since you have been involved in the transition that took place in your State, do you have advice you could give to insurers in other States who have not yet made that transition about how to most effectively have a smooth transition toward full parity?

Mr. PURCELL. Well, I think most often the characterization is that insurers are standing in the way of this. Quite frankly, the more business we get, the better it is for us. So in some respects, this is good business. But what you have to do is you have to get out to the business community and bring the word, with some backup, because they expect some proof, that this is not going to dramatically increase your costs.

And why is it good business for you? And it is good business for you, exactly what Mr. Sullivan said. You can really track the increase in productivity, the lowering of absenteeism, and the biggest monster in the corner, which is presenteeism in which you have people who are depressed or suffering from other behavioral disorders coming to work, and maybe they are being there a quarter of the time. And there are ways you can measure this. And if you can bring that measure to the employer, the business community,

and say this will actually help, I think that is your key, because once you have got them convinced, they won't have to pay any more premium, but they also won't viscerally react, oh, no, another mandate, this is enough, I have had enough. Because Ranking Member Deal had a great point. How many ornaments do you hang on the tree before you weigh the tree down? And that is always the issue with mandates. Each mandate is just a little bit, but you die by a thousand cuts. Here this one, I think, is substantively different. So that is why I think if you do that, I think you stand your best chance of getting it done.

Mr. MATHESON. Thanks.

Mr. Chairman, I yield back.

Mr. PALLONE. Thank you.

Mr. Burgess.

Mr. BURGESS. Thank you, Mr. Chairman.

Mr. Purcell, let me ask you a little bit about the medical management issue, and I guess you also referred to utilization review. Now, you made the comment that that was not in the House bill that is before us, but that language is in the Senate bill.

Mr. PURCELL. What I understand——

Mr. BURGESS. You had three things that would improve the bill before us. One was date of implementation, second was medical management, and the third was the out of network.

Mr. PURCELL. My understanding is that the House bill is silent on the issue. Whether it does provide the medically necessary, and therefore by implication that allows medical management, I suppose I could make that argument as a good lawyer. I would much prefer that it affirmatively say that you can employ appropriate medical management techniques in order to assure medical necessity.

Mr. BURGESS. Do you think this is important for the overall performance of the program?

Mr. PURCELL. I very much do.

Mr. BURGESS. Dr. Goldman, let me ask you, in your paper from the New England Journal, in the abstract under the conclusion line, it says, when coupled with management of care, implementation of parity in insurance benefits for behavioral health care can improve insurance protection without increasing costs. Is that phrase, "when coupled with the management of care," is that the same thing that Mr. Purcell is referring to as far as the medical management that he would like to see incorporated in the legislation?

Mr. GOLDMAN. It is.

Mr. BURGESS. And so would you agree with that statement, that perhaps the bill could be improved by incorporating either language like the Senate or an amendment that would incorporate the concept of medical management utilization review?

Mr. GOLDMAN. You are the experts on draft language, but our study indicates that you want to have the care managed if you want to have the same experience.

Mr. BURGESS. You want to have the care management as part of the total program?

Mr. GOLDMAN. If you wish to have the same financial impact.

Mr. BURGESS. And I would assume that—and, Dr. Goldman, I guess in full disclosure, I am a simple country doctor, so I have done this only for the past couple of years.

Mr. GOLDMAN. I am a complicated urban man.

Mr. BURGESS. Let me ask you this, because this is something that has bothered me for some time. When managed care really burst upon the scene in the mid–1990's, my perception as a practicing OB-GYN in suburban Dallas, TX, was it didn't do a thing for the practice of psychiatry, at least in my world. And Ranking Member Deal also kind of implied that the health insurance policies sometimes kind of defined the conditions of the world in which we live. Do you see a potential for some problems here?

Mr. GOLDMAN. For many professionals managed care is a mixed blessing. There are down sides in terms of having your work observed by other people. Some people don't like to have their professional judgments second-guessed by other professionals. But when it comes to this issue of whether the allocation decisions should be made on the basis of arbitrary diagnostic criteria versus individualized management, I think we have learned that we can improve people's insurance protection if we rely on managed care rather than on arbitrary diagnostic criteria and our nominal benefits. So there are problems.

Mr. BURGESS. Right.

Mr. GOLDMAN. But they are the same problems that occur in general medicine. I don't know very many providers of general medical care that don't have their problems as well with managed care.

Mr. BURGESS. And we could talk about that at length, but we don't have time.

Mr. GOLDMAN. Yes, we could. We want it to be just as unpleasant perhaps —for some on both sides of this issue.

Mr. BURGESS. Perhaps.

Let me ask you this, and I appreciate your position as well, but, as you kind of look at the evolution of insurance and insurance benefits, at least over the time I was in clinical practice, I mean, we had the time when all of obstetric benefits weren't covered, and then slowly those were incorporated in. There have been other things that have been slowly incorporated into the insurance world. Would you see this as just part of the—perhaps the normal evolution of insurance benefits that we just might otherwise expect to see happen?

Ms. ROGERS. Yes, I do agree with that. As people learn more, and there is more information out about mental health issues, I think that you will see more and more issues being covered.

Now, I never said that we were against mental health parity. Our issues lie with having one Federal system for major multinational employers who are trying to compete globally. That is our main concern. And so that gives us a lot of heartache, this particular bill does, because of that.

Mr. BURGESS. Let me just interrupt you. Does the Senate bill give you less heartache?

Ms. ROGERS. Far less; yes, it does.

Mr. BURGESS. Let me move to one last thing, because I just have to get this out. Mr. Klein, you said it is just an issue of fundamen-

tal fairness that Medicare and Medicaid, I presume SCHIP, veterans benefits, should provide the same parity that we are talking about imposing upon the private sector. Did I grasp that concept correctly?

Mr. KLEIN. That is correct.

Mr. BURGESS. And, Dr. Goldman, your contention would be should we take that step, we would, in fact, save money for Medicare, Medicaid, SCHIP, veterans health care. Is that correct?

Mr. GOLDMAN. I think what I would say is we could improve insurance coverage and not have a big cost impact.

Mr. BURGESS. Has anyone—we have to live and die by the CBO here, and the Congressional Budget Office refuses to allow us to dynamically score things. We always used to have to score things on what the direct cost is. Have any of you looked at that to any degree?

Mr. KLEIN. Congressman, I have not looked at it lately, but memory seems to serve me that back in 1996, when the initial parity law was enacted, that there was, I think, some CBO calculation around that issue. I would be happy to check into that. And it obviously would need to be updated, but I think there might have been some sometime back.

Mr. PALLONE. Mr. Burgess, you are over.

Mr. Murphy.

Mr. MURPHY. Thank you, Mr. Chairman.

Ms. Rogers, let us say you are the CEO of a company, or maybe even vice president of a division, and one of your employees who has been around for a while has just been promoted himself to maybe high-level executive of sales. And you notice, you hear reports that what is happening is his performance is beginning to deteriorate pretty significantly, restless, perhaps falling asleep in meetings, absent-minded, distractable, moody, irritable, perhaps even leading to loss of sales and productivity. Would you want to have him evaluated?

Ms. ROGERS. Well, I don't know if I would require that this person be evaluated.

Mr. MURPHY. You spent a lot of money over the years training this person.

Ms. ROGERS. I think that I would—most of our members have counselors on staff, and it would be more appropriate for that type of person to talk to this senior salesperson.

Mr. MURPHY. Like an employee assistance person or something?

Ms. ROGERS. Yes.

Mr. MURPHY. Let us say they recommended this person have some medical evaluation, and there is a lot of things that could relate to that. It could be a tumor, it could be narcolepsy, could be a diabetic, could be depressed.

Ms. ROGERS. That is true.

Mr. MURPHY. It could be jet lag. What do you do if there is a diagnosis of jet lag? You specifically referred to that in your——

Ms. ROGERS. Yes, I do.

Mr. MURPHY. Do you know what the treatment is for jet lag?

Ms. ROGERS. I would assume that it would be make sure that you are hydrated, because flying dehydrates——

Mr. MURPHY. You adjust your flight schedule. It is not a psychiatric treatment. But the DSM-IV—I am trying to help you understand, because it comes up so much among some people trying to be a little psychiatric diagnosis. They use that one, or shyness, et cetera. Just because it is in the DSM-IV doesn't mean it is a psychiatric treatment. You have to label everything. If a person shows up and they say, well, the good news is we don't have to spend hundreds of thousands on other things for you, it is jet lag, instead of talking to a psychiatrist, you talk to the person who books their flights.

Here is another thing, too, I want you to know, because this is so important when it comes to providing things for mental health services, and that has to do with a lot of times people are not providing mental health services, but they will have like—they are screened by a general practitioner or someone. And a good example of where this can break down is I think in the use of Paxil, psychiatric medication for depression. Tragically, it is associated with a higher risk of suicide and other complications. But I know when I have talked to students in medical school and other things, the highest risk for suicide comes when the patient starts to get better. They lose their social supports, they start to get better, they feel energized. And what happens so often is that 75 percent of psychiatric drugs are prescribed by nonpsychiatrists. When you have heart disease, you double the chance of depression. If you don't treat the depression, you double the cost of the treatment, the illness. And many times cardiologists say, all right, looks like you have a terrible heart disease, I am going to describe Prozac for you, too. But that person never goes on to get the treatment they need where you can really reduce costs.

And the point being made by Mr. Purcell, et cetera, is when this is done—I wouldn't say managed care, I would say care management, because I hate that word "managed care." it really is helping to manage a person. It is making sure the right things get done. And I would hope that as you look at some of the studies that you refer to, it is so important to look at who is doing the treatment and how it is done. It could be a big cost if it is done wrong. But when we look at these things, shyness and other things like that caffeine withdrawal, those are simply labels to say if you have caffeine withdrawal, the treatment is stop drinking so much coffee; jet lag, talk to the person who books your flights.

But when you are dealing with depression and bipolar illness and other things, you got to keep this in mind. I think that, and I hope the business community pays attention, too, and that is that these are real employees they invest thousands of dollars in training and all these other things for, and if we look at this in the big picture, what is the proper treatment and the proper diagnosis, it is as important as saying if someone else had some other medical problems, you want to get the proper treatment.

I would go back to this. If that great sales manager did have a tumor, and you only sent him to the employee assistance program that says, Joe's just kind of moody, he has been a bad employee, get rid of him, I don't think we would want that. If he did have narcolepsy or diabetes or something, we would want that treatment.

And so I see us looking at mental health parity as something where you are really bringing the experts in to make decision. You manage that case so they just aren't going off somewhere and making sure, for example, they don't get some folk treatment. Someday I would like to find out what you mean by that, too. But I think the idea is you get the experts together to get more effective and cost-effective treatment. And that is part of that, so——

Ms. ROGERS. Yes. And I think we agree more so than disagree. And personally, I am a big advocate of mental health benefits, and I spend a lot of money on them myself. My dad has psychosis. I have two children that are premature. And none of the experts I have been to even take insurance. So you might want to look at that issue.

Mr. MURPHY. Probably not covered.

Ms. ROGERS. Well, I do have mental health benefits through Blue Cross, but they don't take my insurance, so I just have to pay for it personally. So, that is an issue, too.

But, remember, I mentioned that our members have very generous mental health benefits. In all of our surveys we couldn't find complaints from employees that felt like they were not covered for everything that they needed to be covered. These are America's largest employers, 25,000 employees and up.

Mr. MURPHY. Well, then there is a lot of those employers who really say they have a cost savings, and not a loss.

Thank you, Mr. Chairman.

Mr. PALLONE. Thank you. And let me thank all of you. I know this is such an important issue, and we do really want to deal with it effectively, and your testimony was very helpful to us as we proceed.

I would also mention that the members have the option of submitting additional questions to you within the next 10 days or so, and the clerk would notify you of that. So just keep that in mind and respond in writing if you get those requests.

And without further ado, again I want to thank you. And I hope that we can move in an expedited fashion on the legislation. This hearing is adjourned.

[Whereupon, at 2:34 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

HENRY A. WAXMAN, CALIFORNIA
EDWARD J. MARKEY, MASSACHUSETTS
RICK BOUCHER, VIRGINIA
EDOLPHUS TOWNS, NEW YORK
FRANK PALLONE, Jr., NEW JERSEY
BART GORDON, TENNESSEE
BOBBY L. RUSH, ILLINOIS
ANNA G. ESHOO, CALIFORNIA
BART STUPAK, MICHIGAN
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October 9, 2007

Howard H. Goldman, M.D., Ph.D.
Professor of Psychiatry
University of Maryland School of Medicine
10600 Trotters Trail
Potomac, MD 20854

Dear Dr. Goldman:

Thank you for appearing before the Subcommittee on Health on Friday, June 15, 2007, at the hearing entitled "H.R. 1424, the Paul Wellstone Mental Health and Addiction Equity Act of 2007." We appreciate the time and effort you gave as a witness before the Subcommittee on Health.

Under the Rules of the Committee on Energy and Commerce, the hearing record remains open to permit Members to submit additional questions to the witnesses. Attached are questions directed to you from the Honorable Nathan Deal, Ranking Member to the Subcommittee on Health. In preparing your answers to these questions, please address your response to the Member who has submitted the questions and include the text of the Member's questions along with your responses.

Because the Committee is expected to consider this legislation in full Committee markup next week, we are asking that you please respond to these questions as soon as possible but by no later than the close of business **Friday, October 12, 2007**. When your written responses are available, the Committee will arrange to have your responses returned by messenger to the Committee on Energy and Commerce, Attention: Sharon Davis, Chief Clerk, 2125 Rayburn House Office Building, Washington, DC 20515.

We also ask if you would please both fax your response to (202) 225-2125, as well as e-mail the electronic version of your written response to Sharon Davis at sharon.davis@mail.house.gov. We would request that the response be in a single Word formatted document. The electronic version will be used to facilitate its inclusion in the hearing record.

Thank you for your prompt attention to this request. If you need additional information or have other questions, please contact Sharon Davis at (202) 225-2927.

Sincerely,

JOHN D. DINGELL
CHAIRMAN

Attachment

cc: The Honorable Joe Barton, Ranking Member
Committee on Energy and Commerce

The Honorable Frank Pallone, Jr., Chairman
Subcommittee on Health

The Honorable Nathan Deal, Ranking Member
Subcommittee on Health

Subcommittee on Health
Hearing on H.R. 1424, the Paul Wellstone Mental Health and Addiction Equity Act
June 15, 2007

Additional Questions from the Honorable Nathan Deal (R-GA) to
Howard H. Goldman, M.D., Ph.D.
Professor of Psychiatry, University of Maryland School of Medicine

General Response to Questions:

I would like to take the opportunity to answer the questions of the Honorable Nathan Deal (R-GA) by beginning with an omnibus response.

Most health insurance is designed to cover all health conditions, including mental disorders.

The matter is not whether health insurance policies *require* the coverage of specific conditions but whether it is appropriate or necessary to *exclude* specific categories of health conditions, in particular specific mental disorders, including substance use and the addictive disorders. Health insurance generally covers all of the conditions in the International Classification of Diseases (ICD), including many which are very mild, such as abrasions and contusions, mild skin rashes, moles and skin tags, insect bites, insomnia, and the cough and runny nose of the common cold. In fact, most insurance policies that cover mental illness *also* cover all of the mental disorders in the ICD, which is closely related to the Diagnostic and Statistical Manual (DSM). When insurers wish to limit coverage, they impose specific limits for *treatments* not for *conditions*. Coverage limitations for mental disorders typically involve limits on days of treatment in specific settings or outpatient visits, higher annual or lifetime expenditure limits, or higher cost-sharing arrangements – not exclusions for specific conditions.

Decisions about what services to cover are made on the basis of the appropriateness of the available treatments provided for the conditions that patients present. *Standard benefit design* refers to "medically necessary" and sometimes to "scientifically sound" treatments. So, for example, an experimental treatment for a specific cancer might not be covered if it is not found to be medically necessary or scientifically sound. The question is not whether the condition is severe or covered but whether the treatment is appropriate. Similarly, cosmetic surgery often is not covered. This is not accomplished by indicating that a particular abnormality or deformity is not covered; it is accomplished by determining the medical necessity of the treatment for a specific covered condition.

Except for the mental disorders, to my knowledge it is not common health insurance policy to exclude health conditions listed in the ICD. (The DSM is almost identical to the ICD chapter on mental disorders.) The House parity bill (H.R. 1424) would remove arbitrary limits based on diagnosis and would rely instead on "medical necessity" criteria and management techniques to control utilization and costs, as is the case for any other condition in the ICD. These management techniques are less arbitrary than limits on visits or days or using higher cost sharing arrangements. Higher co-payments and lower annual and lifetime limits place individuals with the most severe conditions at risk of financial ruin. Utilization management is designed to allocate resources to individuals receiving appropriate and effective treatments for the most severe cases of specific conditions. The FEHB program encouraged these management techniques. H.R. 1424 would follow the practice and policies of the FEHB program.

When we studied utilization of mental health and substance abuse services for federal employees in the FEHB program, we found that the plans followed the letter and spirit of the parity directive to cover all conditions in the ICD and DSM. The FEHB plans used various management techniques (including medical necessity criteria and utilization review, as well as management by a specialized vendor) to match the wide array of conditions in the DSM only with appropriate treatments. As a result, we did not observe care for extremely mild conditions. Care was managed, and as our report and papers explained, there was no increase in total expenditures in the FEHB plans above-and-beyond what we observed over the same time period for the matched set of comparison plans that did not have parity. If a plan uses management techniques, such as those used in the FEHB parity experience, there is no reason to believe that insurance payments will be used to cover inappropriate treatments for either trivial conditions or for more serious conditions.

What the FEHB parity policy did was put mental disorders on the same footing as all other health conditions. The policy covered all of the conditions in the ICD or DSM, subject to care management based on the medical necessity of services and treatments. It removed arbitrary limits and cost sharing requirements on the basis of condition and depended instead on management techniques to control un-necessary treatments of any of the covered conditions.

I would also add, speaking as the senior scientific editor of the Surgeon General's report on mental health, that the distinction between "biologically based" conditions and other conditions is not a scientific distinction. The Surgeon General's report demonstrates that mental disorders *are* physical disorders and are biologically based. Furthermore, individuals with some conditions that are covered in some state parity statutes might have less severe conditions than some individuals with excluded conditions. Diagnosis is a blunt instrument for controlling utilization. It is more efficient and fair to make insurance coverage decisions on the basis of medical necessity and scientific standards of appropriateness and effectiveness of treatment than based on arbitrary determinations of the biological basis of conditions.

I support the use of medical necessity criteria and scientific criteria for treatments for making health insurance coverage decisions. The FEHB parity experience suggests that with such care management it is possible to cover all conditions in the ICD and DSM without increasing total expenditures and without raising premium more than about 0.4 percentage points.

My reading of H.R. 1424 is that plans would be permitted to use all of the appropriate utilization review techniques (such as for determining medical necessity) to allocate scarce premium resources efficiently and to protect the interests of all beneficiaries – without needing to rely on arbitrary limits on the basis of diagnosis. All of the plans in the FEHB have this choice and followed this policy and practice with a very satisfactory result. Federal employees now enjoy better protection against financial risks associated with use of treatments for a wide array of mental disorders without arbitrary limits and without an increase in total costs attributable to the parity policy. Plans were not permitted to make decisions about coverage on the basis of diagnosis, but they were permitted and encouraged to make decisions on the basis of medically necessary treatments for any of the mental disorders in the ICD or the DSM.

I support following the experience of the FEHB parity policy, which we studied and reported in the *New England Journal of Medicine* and *Pediatrics*, among other journals and report sites. It is rare to have such precise estimates of the impact of a specific policy. In this instance, the studies support H.R. 1424 and support offering plans choices to control utilization and costs on the basis of managing care rather than setting arbitrary limits based on diagnosis.

Subcommittee on Health
Hearing on H.R. 1424, the Paul Wellstone Mental Health and Addiction Equity Act
June 15, 2007

Additional Questions from the Honorable Nathan Deal (R-GA) to
Howard H. Goldman, M.D., Ph.D.
Professor of Psychiatry, University of Maryland School of Medicine

1. Is there any precedent in current federal statutes that says, in effect, that if you provide ANY given service, such as mental health services that you must cover ALL conditions listed in a manual prepared by one group of health care professionals? For example, is there a similar federal law that says that if an insurer or employer provides coverage for some pharmaceuticals or medical procedures that you must now cover ALL pharmaceuticals or medical procedures listed in a manual prepared by a trade association of pharmacists or medical care providers?

No such federal law exists – nor is it needed, as it is common practice to cover all health conditions.

In my view, the matter is not whether health insurance policies require the coverage of specific conditions but rather whether a policy should exclude a specific set of disorders – in this case the mental disorders, including substance use disorders. Health insurance generally covers all of the conditions in the International Classification of Diseases (ICD), including the mental disorders. In practice all conditions in the ICD (which is a manual prepared by health care professionals) are covered – with the occasional exception. To be included in the Diagnostic and Statistical Manual (DSM) or the mental disorders chapter of the ICD, conditions must have substantial evidence to support their inclusion. Furthermore, the definition of a mental disorder requires that an individual experience clinically significant "distress or disability" (DSM IV, 1994, p xxi) in addition to specific signs and symptoms.

Health insurance policies usually limit coverage using a range of management techniques rather than exclude specific conditions. Managed care techniques can avoid arbitrary limits on the basis of specific disorders or visit limits, day limits, and higher cost sharing, which would not be permitted under parity. These managed care techniques have been very effective at keeping the cost impact of parity very low, as reported in our studies of the FEHB program experience with mental health and substance abuse parity. (Please see original testimony and papers provided from the *New England Journal of Medicine* and *Pediatrics*.)

2. Many states that have looked at this issue of parity provisions have chosen to limit any parity requirements to "biologically-based" or "serious" mental illness as they define them. Such states do not require coverage for all the disorders in the Diagnostic and Statistical Manual of Mental Disorders or DSM IV. There are categories of DSM IV referred to as conditions for clinical focus. These include such items as: sibling relational problem; occupational problem; academic problem; and religious or spiritual problem. The manual provides an example of V. 62.3 "Academic Problem" as "a pattern of failing grades or significant underachievement in a person with adequate intellectual capacity in the absence of a Learning or Communication Disorder or any other mental disorder that would account for this problem." Is it your reading of H.R. 1424 that it could require coverage for these conditions?

I am not sure of the intent of H.R. 1424 with respect to the V codes, conditions for clinical focus. They are not considered "mental disorders," *per* se, in the ICD or DSM. If such conditions were to be covered under parity, however, a specific treatment for a specific

condition could be disallowed as not "medically necessary" or not likely to be effective. This determination would be made on a treatment-by-treatment basis or a case-by-case basis. I think that management techniques can effectively assure that payments would go only for treatment for V codes which were medically necessary, according to a definition developed by the plan.

3. DSM IV category 315.1 is called Mathematics disorder. One of the diagnostic criteria is that mathematical ability is substantially below that expected for the person's age and intelligence. Another criterion is that it significantly interferes with academic achievement. Is it your reading that employers must have insurance to cover diagnosis and treatment for Mathematics disorder as long as Federal plans cover this and such employer is providing any mental health benefit?

My understanding of the proposed parity policy is that no plan can exclude coverage on the basis of a diagnosis of that condition *alone.* A management decision might be made to not cover specific treatments for such a condition – on a treatment-by treatment or a case-by-case basis.

4. The DSM IV manual also states criteria to describe mild, moderate, and severe disorders. Mild disorders or example are defined as "[f]ew if any symptoms in excess of those required to make the diagnosis are present, and symptoms result in no more than minor impairment in social or occupational functioning."

   Under H.R. 1424 how would and insurer or employer be able to ensure they are not paying for inappropriate treatment. Would specific evidence be required from the health professional to describe a mild version of any of the following conditions in DSM IV:

   Parent-Child Relational Problem V61.20
   Sibling Relational Problem V61.8
   Child or Adolescent Antisocial Behavior V71.02
   Borderline Intellectual Functioning V62.89
   Age-related Cognitive Decline 780.9
   Bereavement V62.82
   Academic Problem V62.3
   Occupational Problem V62.2
   Identify Problem 313.82
   Religious or Spiritual Problem V62.89
   Acculturation Problem V62.4
   Phase of Life Problem V62.89

   Plans would have the choice to review treatment decisions about such conditions and determine if treatment was medically necessary or met other standards of effectiveness of treatment. I am not sure of the intent of H.R. 1424 with respect to the V codes.

5. Could you support language that says that the diagnosis of a disorder and its treatment must be well established and supported by substantial scientific evidence?

Yes. Scientific evidence forms the basis for inclusion of conditions in the DSM IV. T Determinations of medical necessity for treatments should be supported by scientific evidence.

6. Provision 313.81 in DSM IV called "oppositional defiant disorder"? The diagnostic criteria require four among the following:

- often loses temper
- often argues with adults
- often actively defies or refuses to comply with adults request or rules
- often deliberately annoys people
- often blames others for his or her mistakes or behavior
- is often touchy or easily annoyed by others
- is often angry and resentful
- is often spiteful or vindictive

Under your reading of H.R. 1424, if there is a disagreement with the group health plan over an individual case, does the beneficiary or provider have the burden to show a clinically significant impairment?

I would expect that clinically significant impairment would be present for a diagnosis to be made by a professional, properly using the DSM or ICD. I do not have the training or experience to render an informed opinion on the legal matter of burden of proof.

7. A prior survey of Federal Employee Health Benefit Plans indicates a number of exclusions from DSM IV that seem to be not accounted for in the official Federal guidance letters. These include, but are not limited to:

- counseling or therapy for marital, educational or behavioral problems
- services provided under a federal, state or local government program
- treatment related to marital discord
- treatment for learning disabilities and mental retardation
- all charges for chemical aversion therapy, conditional reflex treatments, narcotherapy or any similar aversion treatments and all related charges (including room and board)
- services by pastoral, marital, or drug/alcohol counselors
- biofeedback, conjoint therapy, hypnotherapy, interpretation/preparation of reports
- services, drugs or supplies related to sexual transformation, sexual dysfunction and sexual inadequacy
- experimental or investigational procedures, treatments, drugs or devices

Can you comment on your understanding of whether these are or are not required under FEHBP.

I do not know the details of FEHB program policy on these matters, so I cannot answer your question directly. For the most part, these limits are based on specific treatments and not based on specific conditions.

8. In a letter to carriers dated April 11, 2001, OPM emphasizes that managed care behavioral health care organizations (MBHO) can implement mental health benefits. Where plans do not choose to use such organizations, OPM recommends approaches such as gatekeeper referrals to network providers, authorized treatment plans, and pre-certification of inpatient services. OPM states that plans may limit parity benefits when patients do not substantially follow their treatment plans. Is this consistent with your understanding of how FEHBO operates. Are these provisions set out in H.R. 1424?

This is consistent with my understanding of how the FEHB program operates within its parity policy. I do not know whether these provisions are set out in H.R. 1424.

9. Even outside of mental health benefits, health plans do not treat all categories of health benefits equally. For example, outpatient physical therapy, emergency care, specialty care, speech therapy, occupational care, chiropractic care, and preventive care often have different limitations than other categories of items or services. Prescription drugs may also have different categories of co-payments based on the kind of financial arrangements a plan can arrange with pharmaceutical companies. Do you consider differences in approach among these categories to be discrimination against the particular patients who may use these services?

These are distinctions on the basis of treatment and not on the basis of specific conditions. They do not single out an entire group of conditions for different insurance coverage. As to a legal definition of "discrimination," I do not have the specific training or experience to render an informed opinion on this matter.

10. Medical and surgical services have different reimbursement rates. For example, services required for hip replacement might include surgical fees, MRI fees, hospitalization, and rehabilitation, each of which may be reimbursed at a different level. A broken leg might require emergency room services and physical therapy in addition to physician fees, and again, each of these services might have still different reimbursement mechanisms.

If this legislation is enacted, health plans would be required to have the same cost sharing requirement for mental health services as some benchmark for medical and surgical benefits. What is your understanding under H.R. 1424, if a health plan has one deductible and coinsurance amount for physician office visits, another one for physical therapy and a third one for occupational therapy, and a fourth one for preventive services? Which one would apply for treatment of schizophrenia or treatment of sibling rivalry condition?

Cost-sharing provisions virtually never vary by type of condition, although they may vary by type of service. This would be permitted according to my reading of H.R. 1424.

11. Group health plan sometimes provide a tiered formulary to address drugs. Under such an approach there are different cost-sharing requirements because the plan was able to get certain discounts or because of different cost effectiveness. Would such a plan violate the parity rules of H.R. 1424 if the net effect of the plan made certain psychotherapy

drugs to have a higher cost-share? If so, would the determination be made on a drug-by-drug basis?

I do not think that use of a tiered pharmacy benefit would violate rules of H.R. 1424. It seems to me that there would only be a violation of the parity rule if all psychotropic drugs were placed on the tier with the highest cost sharing and few other drugs were treated in this fashion – and there was no reasonable explanation for such a differential policy. The determination would be made on a drug-by-drug basis, using similar decision-making processes.

12. Under your understanding of H.R. 1424, could plans differentiate reimbursement based on qualifications? For example, a psychiatrist may have a different reimbursement rate than a psychologist. Could this in any way violate a parity requirement? Let's assume a group health plan creates outpatient categories based on whether or not the visit was to someone with a medical degree -- not on whether it was mental illness related or not. Under H.R. 1424 could such an approach be viewed as discriminatory to psychologists and, thus, to mental health benefits? That is to say, could lawyers argue that there is a disparate impact test?

I do not have the training or experience to render an informed opinion on this matter.

13. Under H.R. 1424, treatment limitations include "limits on the duration or scope of treatment under the plan or coverage." Do you believe this means decisions to limit the duration or scope of treatment for therapeutic reasons must be held up to a parity test? If so, how would this work? If not, why are these included in the definition of treatment limitations subject to the parity requirements?

My understanding is that this means that techniques used to limit general medical treatments should be applied in the same fashion to mental disorders. This might mean that care would be subject to the same cost sharing arrangements, for example. H.R. 1424 appears to apply the parity requirement to out of network services. My understanding is that FEHBP does not do so. Can you confirm this and what type of effect this might have with respect to the analyses you performed on costs to the FEHBP system?

Parity does not apply to out of network provider services in the FEHB program. My understanding is that H.R. 1424 would require plans to use the same mechanisms and limits to control costs for mental disorders that are used for other health conditions.

15. S. 558 states in part:

In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health benefits, such plan or coverage shall not be prohibited from--

> *`(1) negotiating separate reimbursement or provider payment rates and service delivery systems for different benefits consistent with subsection (a);*
>
> *`(2) managing the provision of mental health benefits in order to provide medically necessary services for covered benefits, including through the use of any utilization review, authorization or management practices, the application of medical necessity and appropriateness criteria applicable to behavioral health, and the contracting with and use of a network of providers; ...*

These provisions appear to be consistent with the policy under FEHBP. I do not think they are prohibited by H.R. 1424.

To your knowledge are there any restrictions under FEHBP policy for negotiating separate reimbursement rates or medical management as described above?

No, these are some of the techniques used by plans in the FEHB program.

HENRY A. WAXMAN, CALIFORNIA
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October 9, 2007

Mr. James A. Klein
President
American Benefits Council
1212 New York Avenue, NW
Suite 1250
Washington, DC 20005

Dear Mr. Klein:

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Under the Rules of the Committee on Energy and Commerce, the hearing record remains open to permit Members to submit additional questions to the witnesses. Attached are questions directed to you from the Honorable Nathan Deal, Ranking Member to the Subcommittee on Health. In preparing your answers to these questions, please address your response to the Member who has submitted the questions and include the text of the Member's question along with your response.

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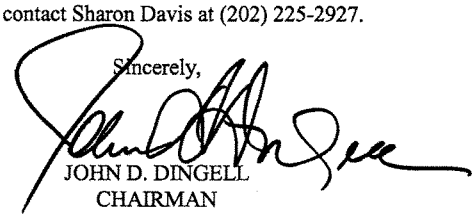
Sincerely,



JOHN D. DINGELL
CHAIRMAN

Attachment

cc: The Honorable Joe Barton, Ranking Member
Committee on Energy and Commerce

The Honorable Frank Pallone, Jr., Chairman
Subcommittee on Health

The Honorable Nathan Deal, Ranking Member
Subcommittee on Health

Subcommittee on Health
Hearing on H.R. 1424, the Paul Wellstone Mental Health and Addiction Equity Act
June 15, 2007

Additional Questions from the Honorable Nathan Deal (R-GA) to
James A. Klein
President, American Benefits Council

1. Is there any precedent in current federal statutes that says, in effect, that if you provide ANY given service, such as mental health services that you must cover ALL conditions listed in a manual prepared by one group of health care professionals? For example, is there a similar federal law that says that if an insurer or employer provides coverage for some pharmaceuticals or medical procedures that you must now cover ALL pharmaceuticals or medical procedures listed in a manual prepared by a trade association of pharmacists or medical care providers?

   Answer:
   There are no similar requirements under federal law to the provision in H.R. 1424 which states that a group health plan (or health insurance coverage offered in connection with a group health plan) that provides <u>any</u> benefits for mental health or substance-related disorders must provide coverage for <u>all</u> conditions for which benefits are provided under the highest enrollment health plan offered to federal employees (Note: The Blue Cross and Blue Shield standard option plan is the highest enrollment plan offered to federal employees and all plans under the Federal Employee Health Benefit Program are required to provide benefits for all conditions listed in the Diagnostic and statistical Manual of Mental Disorders or DSM-IV). This requirement in H.R. 1424 is extraordinary because federal law generally recognizes that employers voluntarily offer health care coverage to their employees and therefore should have considerable flexibility in determining what benefits are covered under their health plans. Further, our members strongly believe that such a requirement would be highly objectionable because it could actually have the perverse and unintended effect of leading to more restrictive health coverage under employer-sponsored plans, either by causing plans to have lower annual or lifetime limits on coverage for all covered benefits or by causing some employers to not cover mental health or substance abuse benefits entirely so that they would not be subject to such a broad mandate.

2. Many states that have looked at this issue of parity provisions have chosen to limit any parity requirements to "biologically-based" or "serious" mental illness as they define them. Such states do not require coverage for all the disorders in the Diagnostic and Statistical Manual of Mental Disorders or DSM IV. There are categories of DSM IV referred to as conditions for clinical focus. These include such items as: sibling relational problem; occupational problem; academic problem; and religious or spiritual problem. The manual provides an example of V. 62.3 "Academic Problem" as "a pattern of failing grades or significant underachievement in a person with adequate intellectual capacity in the absence of a Learning or Communication Disorder or any other mental disorder that would account for this problem." Is it your reading of H.R. 1424 that it could require coverage for these conditions?

Answer:
It is not possible to answer definitively whether H.R. 1424 would require group health plans and health insurers to cover the specific "clinical focus" conditions referenced in your question. In fact, the ambiguity around this issue is one of the main concerns of our members with this coverage mandate. As introduced, H.R. 1424 essentially requires that all employers provide benefits for the same mental health and substance abuse conditions as are provided by the Blue Cross and Blue Shield (BCBS) standard option plan offered to federal employees. It is very unlikely that employers, insurers or the Office of Personnel Management which administers the federal employee health program knows precisely which clinical focus conditions are covered by the BCBS plan and under what conditions. It is certainly possible that if this provision were enacted into law that it would be clarified by guidance issued by the Secretary of Labor or the Secretary of Health and Human Services. However, even if the this implementing guidance were to conclude that such conditions were not required to be covered, we would remain concerned that health care providers would have strong incentives to either code their patients' conditions under categories where coverage is required or to revise future editions of the DSM-IV to include these conditions in the mandatory coverage categories.

3. DSM IV category 315.1 is called Mathematics disorder. One of the diagnostic criteria is that mathematical ability is substantially below that expected for the person's age and intelligence. Another criterion is that it significantly interferes with academic achievement. Is it your reading that employers must have insurance to cover diagnosis and treatment for Mathematics disorder as long as Federal plans cover this and such employer is providing any mental health benefit?

   Answer:
   Yes, our general understanding of H.R. 1424 is that such a condition would be required to be covered if it is covered by the BCBS standard option plan and if the employer-sponsored plan provides coverage for mental health and substance abuse conditions.
   However, it is also important to note that, unlike H.R. 1424, the Office of Personnel Management (OPM) explicitly recognizes that medical management determinations may also apply to determinations of coverage. Specifically, OPM requires that health plans offered to federal employees provide benefits for all conditions listed in the DSM-IV manual as long as the treatment for these conditions is "clinically-proven" and that the covered services are "included in authorized treatment plans." OPM also recognizes that such treatment plans should be in accordance with "standard protocols" and meet the plan's medical necessity criteria. Therefore, the OPM coverage requirement also includes considerable deference to the health plans to apply appropriate medical management practices to determine the circumstances when a specific services for a health care condition are covered for a particular individual given the course of treatment proposed by a health care provider.

4. The DSM IV manual also states criteria to describe mild, moderate, and severe disorders. Mild disorders or example are defined as "[f]ew if any symptoms in excess of those required to make the diagnosis are present, and symptoms result in no more than minor impairment in social or occupational functioning."

Under H.R. 1424 how would an insurer or employer be able to ensure they are not paying for inappropriate treatment. Would specific evidence be required from the health professional to describe a mild version of any of the following conditions in DSM IV:

Parent-Child Relational Problem V61.20
Sibling Relational Problem V61.8
Child or Adolescent Antisocial Behavior V71.02
Borderline Intellectual Functioning V62.89
Age-related Cognitive Decline 780.9
Bereavement V62.82
Academic Problem V62.3
Occupational Problem V62.2
Identify Problem 313.82
Religious or Spiritual Problem V62.89
Acculturation Problem V62.4
Phase of Life Problem V62.89

Answer:
As introduced, H.R. 1424 included no provision to explicitly protect the medical management practices of group health plans and employers in order to ensure that the plan is not paying for inappropriate or medically unnecessary services. In response to Question 3 above, we noted the deliberate protection of plan medical management practices by the Office of Personnel Management as an integral part of the parity requirements which it established for health plans offered to federal employees. Also, as I noted in my testimony at the time of the subcommittee's hearing on this legislation, it is because OPM was careful to safeguard plan medical management practices that researchers concluded that the parity requirement has had only a modest impact on federal employee health plan premiums.

5. Could you support language that says that the diagnosis of a disorder and its treatment must be well established and supported by substantial scientific evidence?

Answer:
We would recommend that the Committee include the provision in the Senate mental health parity bill, S. 558, which states that plans shall not be prohibited from "managing the provision of mental health benefits in order to provide medically necessary services for covered benefits, including through the use of any utilization review, authorization of management practices, the application of medical necessity and appropriateness criteria applicable to behavioral health, and the contracting with and use of a network of providers." We believe that such a provision would clarify that plan practices intended to ensure that the diagnoses and proposed treatment of mental health and substance abuse disorders be well established and supported by solid evidence.

6. Provision 313.81 in DSM IV called "oppositional defiant disorder"? The diagnostic criteria require four among the following:

    - often loses temper
    - often argues with adults
    - often actively defies or refuses to comply with adults request or rules
    - often deliberately annoys people

- often blames others for his or her mistakes or behavior
- is often touchy or easily annoyed by others
- is often angry and resentful
- is often spiteful or vindictive

Under your reading of H.R. 1424, if there is a disagreement with the group health plan over an individual case, does the beneficiary or provider have the burden to show a clinically significant impairment?

Answer:
We are not able to respond to this question with certainty without much greater detail on how a coverage determination disagreement might arise, however, the type of situation described in your question underscores the importance of the inclusion of a provision to protect plan medical management practices, such as the Senate provision described above in response to Question 5.

7. In a letter to carriers dated April 11, 2001, OPM emphasizes that managed care behavioral health care organizations (MBHO) can implement mental health benefits. Where plans do not choose to use such organizations, OPM recommends approaches such as gatekeeper referrals to network providers, authorized treatment plans, and pre-certification of inpatient services. OPM states that plans may limit parity benefits when patients do not substantially follow their treatment plans. Is this consistent with your understanding of how FEHBO operates. Are these provisions set out in H.R. 1424?

Answer:
Yes, it is our understanding that OPM has been careful to protect a wide range of plan medical management practices, including the use of referrals to network providers, authorized treatment plans, pre-certification programs, and the use of managed behavioral health care organizations. It is very important that these vital plan practices be fully protected in any parity measure considered by the Committee.

8. Even outside of mental health benefits, health plans do not treat all categories of health benefits equally. For example, outpatient physical therapy, emergency care, specialty care, speech therapy, occupational care, chiropractic care, and preventive care often have different limitations than other categories of items or services. Prescription drugs may also have different categories of co-payments based on the kind of financial arrangements a plan can arrange with pharmaceutical companies. Do you consider differences in approach among these categories to be discrimination against the particular patients who may use these services?

Answer:
You are correct that health plans typically do not apply the same financial requirements or other limits on all categories of benefits. Our members do not consider such variations in coverage limits or financial requirements to be discrimination against patients who

may use these services; rather, this is a very common practice – including for health benefits offered under Medicare, Medicaid or the Federal Employee Health Benefits Program – which is intended to try to keep the overall cost of health benefits offered to a plan participant as affordable as possible without discouraging appropriate utilization of health care services.

9. Medical and surgical services have different reimbursement rates. For example, services required for hip replacement might include surgical fees, MRI fees, hospitalization, and rehabilitation, each of which may be reimbursed at a different level. A broken leg might require emergency room services and physical therapy in addition to physician fees, and again, each of these services might have still different reimbursement mechanisms.

   If this legislation is enacted, health plans would be required to have the same cost sharing requirement for mental health services as some benchmark for medical and surgical benefits. What is your understanding under H.R. 1424, if a health plan has one deductible and coinsurance amount for physician office visits, another one for physical therapy and a third one for occupational therapy, and a fourth one for preventive services? Which one would apply for treatment of schizophrenia or treatment of sibling rivalry condition?

   Answer:
   In the absence of implementing guidance, it is difficult to know precisely how H.R. 1424 would be interpreted, however, the legislation appears to require a two part test. First, the plan would have to make a determination that a particular financial requirement such as a deductible or a coinsurance amount applied to "substantially all" medical and surgical benefits within one of the categories of benefits prescribed in the legislation. Second, the plan would apply the "predominant" financial requirement for the category medical and surgical benefits to the mental health and substance abuse benefits within the same category. The Senate mental health parity bill takes a less prescriptive approach and states that the application of the parity rules for plan financial requirements and treatment limits for covered services should take "into consideration similar treatment settings or similar treatments." We believe this provision in the Senate bill would provide appropriate and needed flexibility to employers and insurers to apply the parity requirements to comparable categories of benefits when it is implemented.

10. Group health plan sometimes provide a tiered formulary to address drugs. Under such an approach there are different cost-sharing requirements because the plan was able to get certain discounts or because of different cost effectiveness. Would such a plan violate the parity rules of H.R. 1424 if the net effect of the plan made certain psychotherapy drugs to have a higher cost-share? If so, would the determination be made on a drug-by-drug basis?

    Answer:
    We do not believe that H.R. 1424 specifically addresses the application of the parity requirements to tiered formularies, so it is not clear whether a plan would violate the provisions of the legislation if certain drugs, including psychotherapy drugs, were subject to higher cost-sharing than others. However, we believe the appropriate policy result

should be that as long as all drugs within the same tier are subject to the same cost sharing requirements that the plan would satisfy the parity requirements.

11. Under your understanding of H.R. 1424, could plans differentiate reimbursement based on qualifications? For example, a psychiatrist may have a different reimbursement rate than a psychologist. Could this in any way violate a parity requirement? Let's assume a group health plan creates outpatient categories based on whether or not the visit was to someone with a medical degree -- not on whether it was mental illness related or not. Under H.R. 1424 could such an approach be viewed as discriminatory to psychologists and, thus, to mental health benefits? That is to say, could lawyers argue that there is a disparate impact test?

Answer:
It is not clear whether H.R. 1424 applies in any manner to differences in reimbursement amounts for provider services. We strongly believe that parity legislation should not be interpreted to apply to such differences in provider reimbursement amounts. The Senate mental health parity bill, S. 558, includes a provision that states that plans shall not be prohibited from "negotiating separate reimbursement or provider payment rates and services delivery systems for different benefits..." We would urge the Committee to include this language in H.R. 1424 also so that the legislation is not construed to apply to such payment differentials.

12. Under H.R. 1424, treatment limitations include "limits on the duration or scope of treatment under the plan or coverage." Do you believe this means decisions to limit the duration or scope of treatment for therapeutic reasons must be held up to a parity test? If so, how would this work? If not, why are these included in the definition of treatment limitations subject to the parity requirements?

Answer:
We believe it is essential that any parity legislation make clear that the term "treatment limitations" does not include determinations made under medical management programs which have the effect of limiting the duration of covered services to those appropriate to the patient's condition and are medically necessary.

As we stated in response to Question 5, we recommend that the Committee include the provision in the Senate mental health parity bill, S. 558, which states that plans shall not be prohibited from "managing the provision of mental health benefits in order to provide medically necessary services for covered benefits, including through the use of any utilization review, authorization of management practices, the application of medical necessity and appropriateness criteria applicable to behavioral health, and the contracting with and use of a network of providers." We believe that such a provision would clarify that these vitally important plan practices are protected and are not subject to the parity requirements applicable to "treatment limitations".

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Committee on Energy and Commerce
Washington, DC 20515–6115

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October 9, 2007

Mr. James E. Purcell
President and Chief Executive Officer
Blue Cross & Blue Shield of Rhode Island
444 Westminster Street
Providence, RI 02903-3279

Dear Mr. Purcell:

Thank you for appearing before the Subcommittee on Health on Friday, June 15, 2007, at the hearing entitled "H.R. 1424, the Paul Wellstone Mental Health and Addiction Equity Act of 2007." We appreciate the time and effort you gave as a witness before the Subcommittee on Health.

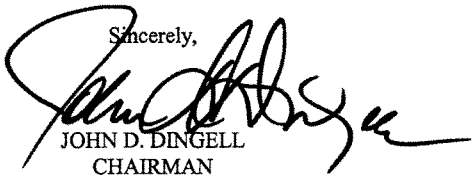
Under the Rules of the Committee on Energy and Commerce, the hearing record remains open to permit Members to submit additional questions to the witnesses. Attached are questions directed to you from the Honorable Nathan Deal, Ranking Member to the Subcommittee on Health. In preparing your answers to these questions, please address your response to the Member who has submitted the questions and include the text of the Member's questions along with your responses.

Because the Committee is expected to consider this legislation in full Committee markup next week, we are asking that you please respond to these questions as soon as possible but by no later than close of business on **Friday, October 12, 2007**. When your written responses are available, the Committee will arrange to have your responses returned by messenger to the Committee on Energy and Commerce, Attention: Sharon Davis, Chief Clerk, 2125 Rayburn House Office Building, Washington, DC 20515.

We also ask if you would please both fax your response to (202) 225-2125, as well as e-mail the electronic version of your written response to Sharon Davis at sharon.davis@mail.house.gov. We would request that the response be in a single Word formatted document. The electronic version will be used to facilitate its inclusion in the hearing record.

Thank you for your prompt attention to this request. If you need additional information or have other questions, please contact Sharon Davis at (202) 225-2927.

Sincerely,



JOHN D. DINGELL
CHAIRMAN

Attachment

cc: The Honorable Joe Barton, Ranking Member
Committee on Energy and Commerce

The Honorable Frank Pallone, Jr., Chairman
Subcommittee on Health

The Honorable Nathan Deal, Ranking Member
Subcommittee on Health

Subcommittee on Health
Hearing on H.R. 1424, the Paul Wellstone Mental Health and Addiction Equity Act
June 15, 2007

Additional Questions from the Honorable Nathan Deal (R-GA) to
James E. Purcell, President and Chief Executive Officer
Blue Cross & Blue Shield of Rhode Island

The responses that follow are submitted by James E. Purcell, President and Chief Executive Officer of Blue Cross & Blue Shield of Rhode Island. Please note these responses reflect my opinions and observations, based on Blue Cross & Blue Shield of Rhode Island's experience in the area of behavioral health. These responses are not attributable to the Blue Cross & Blue Shield Association or any other Blue Cross & Blue Shield plan.

1. Is there any precedent in current federal statutes that says, in effect, that if you provide ANY given service, such as mental health services that you must cover ALL conditions listed in a manual prepared by one group of health care professionals? For example, is there a similar federal law that says that if an insurer or employer provides coverage for some pharmaceuticals or medical procedures that you must now cover ALL pharmaceuticals or medical procedures listed in a manual prepared by a trade association of pharmacists or medical care providers?

Response:

While I am not aware of any such federal law, this question seeks a legal analysis and opinion that is not appropriate for me to offer and is beyond the scope of the testimony that I presented.

2. Many states that have looked at this issue of parity provisions have chosen to limit any parity requirements to "biologically-based" or "serious" mental illness as they define them. Such states do not require coverage for all the disorders in the Diagnostic and Statistical Manual of Mental Disorders or DSM IV. There are categories of DSM IV referred to as conditions for clinical focus. These include such items as: sibling relational problem; occupational problem; academic problem; and religious or spiritual problem. The manual provides an example of V. 62.3 "Academic Problem" as "a pattern of failing grades or significant underachievement in a person with adequate intellectual capacity in the absence of a Learning or Communication Disorder or any other mental disorder that would account for this problem." Is it your reading of H.R. 1424 that it could require coverage for these conditions?

Response:

This question seeks a legal analysis and opinion of the proposed legislation that is not appropriate for me to offer and is beyond the scope of the testimony that I presented. As indicated in Question 15 below, under Rhode Island law "V" codes are excluded from the definition of "Mental illness." Therefore, Blue Cross & Blue Shield of Rhode Island does not have any experience with "V" codes and it would be

inappropriate for me to opine on their use in the diagnosis or treatment of mental illness.

3. DSM IV category 315.1 is called Mathematics disorder. One of the diagnostic criteria is that mathematical ability is substantially below that expected for the person's age and intelligence. Another criterion is that it significantly interferes with academic achievement. Is it your reading that employers must have insurance to cover diagnosis and treatment for Mathematics disorder as long as Federal plans cover this and such employer is providing any mental health benefit?

Response:

Please see my testimony in response to a question by Chairman Pallone at page 82 of the transcript. As you have noted in subsequent questions, in Rhode Island, we have eliminated certain things such as the more obvious "red herring" items. The real issue, however, is not the diagnosis, but whether the proposed treatment is appropriate for the diagnosis (medically necessary). From a personal perspective, health insurance cannot be responsible for what the school systems are designed to do.

4. The DSM IV manual also states criteria to describe mild, moderate, and severe disorders. Mild disorders or example are defined as "[f]ew if any symptoms in excess of those required to make the diagnosis are present, and symptoms result in no more than minor impairment in social or occupational functioning."

   Under H.R. 1424 how would and insurer or employer be able to ensure they are not paying for inappropriate treatment. Would specific evidence be required from the health professional to describe a mild version of any of the following conditions in DSM IV:

   Parent-Child Relational Problem V61.20
   Sibling Relational Problem V61.8
   Child or Adolescent Antisocial Behavior V71.02
   Borderline Intellectual Functioning V62.89
   Age-related Cognitive Decline 780.9
   Bereavement V62.82
   Academic Problem V62.3
   Occupational Problem V62.2
   Identify Problem 313.82
   Religious or Spiritual Problem V62.89
   Acculturation Problem V62.4
   Phase of Life Problem V62.89

Response:

As indicated Response 2 above, "V" codes are a specific exemption under the Rhode Island parity law. It is my understanding, both the House and Senate versions allow health plans to perform "Medical Management" functions. This includes, but is not limited to, "utilization review" a function that a health plan can employ to

determine the medically necessity of services. Additionally, please see my testimony in response to a question by Chairman Pallone at page 82 of the transcript.

5. Could you support language that says that the diagnosis of a disorder and its treatment must be well established and supported by substantial scientific evidence?

Response:

This question seeks an opinion regarding the sufficiency of certain medical diagnoses as well as the quantification of scientific evidence that is beyond my field of expertise. That being said, Blue Cross & Blue Shield of Rhode Island provides coverage for mental health and substance abuse services based on the same quantum of medical necessity and appropriateness of care as is employed for medical/surgical services. While there are often differences between the types of services for behavioral care and physical care, there are also vast differences in the types of services in the physical health area (e.g., orthopedics vs. oncology). We do not seem to dwell on quantum of evidence there…just "medical necessity." It has been our experience that utilizing the same approach in the behavioral health has worked well in Rhode Island.

6. Provision 313.81 in DSM IV called "oppositional defiant disorder"? The diagnostic criteria require four among the following:

- often loses temper
- often argues with adults
- often actively defies or refuses to comply with adults request or rules
- often deliberately annoys people
- often blames others for his or her mistakes or behavior
- is often touchy or easily annoyed by others
- is often angry and resentful
- is often spiteful or vindictive

Under your reading of H.R. 1424, if there is a disagreement with the group health plan over an individual case, does the beneficiary or provider have the burden to show a clinically significant impairment?

Response:

Whether the nature of a disorder is behavioral or physical is irrelevant in terms of the answer to this question. The beneficiary/provider has the same requirements to overturn a denial of coverage in either case. The issue again is usually one of coverage or "medical necessity." In fact, Rhode Island has a regulation that clearly outlines the process when a denial has been made by a health plan for a requested service/benefit. This regulation applies to both medical and behavioral health services and is that process that must be followed. Under most circumstances it would require the provider to submit clinical information to support his or her position. Again, this would be the same for a denied medical service. Blue Cross &

Blue Shield of Rhode Island also adheres to the federal Department of Labor regulation requiring similar processes for ERISA plans.

7. In a letter to carriers dated April 11, 2001, OPM emphasizes that managed care behavioral health care organizations (MBHO) can implement mental health benefits. Where plans do not choose to use such organizations, OPM recommends approaches such as gatekeeper referrals to network providers, authorized treatment plans, and pre-certification of inpatient services. OPM states that plans may limit parity benefits when patients do not substantially follow their treatment plans. Is this consistent with your understanding of how FEHBO operates. Are these provisions set out in H.R. 1424?

Response:

This question seeks a legal analysis and opinion of the proposed legislation that is not appropriate for me to offer and is beyond the scope of the testimony that I presented. Additionally, I am not an authority on the operations of FEHBP and therefore cannot provide the assessment sought in this question.

8. Even outside of mental health benefits, health plans do not treat all categories of health benefits equally. For example, outpatient physical therapy, emergency care, specialty care, speech therapy, occupational care, chiropractic care, and preventive care often have different limitations than other categories of items or services. Prescription drugs may also have different categories of co-payments based on the kind of financial arrangements a plan can arrange with pharmaceutical companies. Do you consider differences in approach among these categories to be discrimination against the particular patients who may use these services?

Response:

In a manner of speaking, any difference in copayments or deductibles is discrimination (defining discrimination in its broadest term and not implying illegality or unfairness). For example, if you have a $10 copay for primary care office visits and a $15 copay for specialist office visits, and you need more specialist office visits than the average subscriber, I suppose that is a differential of treatment. Nonetheless, specialists often charge the health insurer more than primary care, and thus there is some basis for larger cost sharing. On prescription drugs, the primary driver in different copayments for drugs is whether they are generic or brand. Generic being on average 1/5th the cost of brand, there are a number of very good reasons why generic copays are lower than brand. All this is about realistic cost sharing and behavior change. Within the area of behavioral health, there may be similar differentials of copays depending on the circumstances, provided they do not treat patients/subscribers more adversely for behavioral health than for physical health. THAT is the discrimination that we are here discussing.

9. Medical and surgical services have different reimbursement rates. For example, services required for hip replacement might include surgical fees, MRI fees, hospitalization, and rehabilitation, each of which may be reimbursed at a different level. A broken leg might

require emergency room services and physical therapy in addition to physician fees, and again, each of these services might have still different reimbursement mechanisms.

If this legislation is enacted, health plans would be required to have the same cost sharing requirement for mental health services as some benchmark for medical and surgical benefits. What is your understanding under H.R. 1424, if a health plan has one deductible and coinsurance amount for physician office visits, another one for physical therapy and a third one for occupational therapy, and a fourth one for preventive services? Which one would apply for treatment of schizophrenia or treatment of sibling rivalry condition?

Response:

I believe I have answered this in response to Question 8; as to my understanding under the bill in question, I'd refer you to your legal counsel. As is the case with the application of any law, there is likely to be some line drawing.

10. Group health plan sometimes provide a tiered formulary to address drugs. Under such an approach there are different cost-sharing requirements because the plan was able to get certain discounts or because of different cost effectiveness. Would such a plan violate the parity rules of H.R. 1424 if the net effect of the plan made certain psychotherapy drugs to have a higher cost-share? If so, would the determination be made on a drug-by-drug basis?

Response:

I am not aware that H.R. 1424 addresses the issue of drug formularies. Blue Cross & Blue Shield of Rhode Island administers our drug formulary the same way regardless of whether the drugs are for physical or behavioral health issues. And of course, the cost of a drug to the insurer and the issue of generic vs. brand are primary considerations.

11. Under your understanding of H.R. 1424, could plans differentiate reimbursement based on qualifications? For example, a psychiatrist may have a different reimbursement rate than a psychologist. Could this in any way violate a parity requirement? Let's assume a group health plan creates outpatient categories based on whether or not the visit was to someone with a medical degree -- not on whether it was mental illness related or not. Under H.R. 1424 could such an approach be viewed as discriminatory to psychologists and, thus, to mental health benefits? That is to say, could lawyers argue that there is a disparate impact test?

Response:

It is my understanding that H.R. 1424 does not address the issue of reimbursement to providers. It is also my understanding that the primary purpose of H.R. 1424 is to address discrimination related to behavioral health coverage relative to patients/subscribers—not providers. I am not prepared to present my opinion on the advisability of payment parity relative to fees paid to behavioral providers vs. "similarly situated" physical health providers.

12. Under H.R. 1424, treatment limitations include "limits on the duration or scope of treatment under the plan or coverage." Do you believe this means decisions to limit the duration or scope of treatment for therapeutic reasons must be held up to a parity test? If so, how would this work? If not, why are these included in the definition of treatment limitations subject to the parity requirements?

Response:

This question seeks a legal analysis and opinion that is not appropriate for me to offer and is beyond the scope of the testimony that I presented. It would be inappropriate for me to speculate as to the motives of the authors of this legislation. To the extent there is ambiguity, it is a legislative issue of whether and to what extent to resolve such ambiguity.

14. (Goldman) H.R. 1424 appears to apply the parity requirement to out of network services. My understanding is that FEHBP does not do so. Can you confirm this and what type of effect this might have with respect to the analyses you performed on costs to the FEHBP system?

Response:

It appears this question is directed to Dr. Howard Goldman, one of the other witnesses that testified. I performed no cost analysis involving the FEHBP system. That being said, I testified (at page 56 of the transcript) that I strongly favor applying the parity requirement to in-network services only. I would not support a requirement that coverage must be provided for out-of-network mental health services where that plan does not also provide coverage for out-of-network medical/surgical services. Similarly, I would not support a requirement that out-of-network coverage must carry the same copayment or deductible that the in-network services carry.

15. Under Rhode Island law tobacco and caffeine are excluded from the definition of "substance" for the purposes of mental health parity. "Mental illness" shall not include: (a) mental retardation, (b) learning disorders, (c) motor skills disorders, (d) communication disorders, and (e) mental disorders classified as "V" codes with respect to parity. How do these exceptions compare to H.R. 1424 and would you support such exemptions?

Response:

Again, I am not the person to give legal advice on what H.R. 1424 does or does not provide. I do understand there is some dispute over the "V" codes and whether they are or are not included. Regardless, Blue Cross & Blue Shield of Rhode Island has worked collaboratively with the state legislature, the provider community, business and employer groups, and patient advocates since the Rhode Island statute was first drafted. This language was the result of that collaborative process and has worked well in Rhode Island. The referenced section here is preceded by the part of the statute which defines "Mental illness" as those mental disorders and substance abuse disorders listed in the most updated volume of the DSM or the ICD.

16. Rhode Island law states that:

"Upon request of the reimbursing health insurers, all providers of treatment of mental illness shall furnish medical records or other necessary data which substantiates that initial or continued treatment is at all times medically necessary and appropriate. When the provider cannot so establish the medical necessity and/or appropriateness of the treatment modality being provided, neither the health insurer nor the patient shall be obligated to reimburse for that period or type of care which was not so established. The exception to the preceding can only be made if the patient has been informed of the above and has agreed in writing to continue to receive treatment at his or her own expense.

The health insurers, when making the above determination of medically necessary and appropriate treatment, must do so in a manner consistent with that used to make the determination for the treatment of other diseases or injuries covered under the health insurance policy or agreement."

Would you support such a provision in Federal law?

Response:

Blue Cross & Blue Shield of Rhode Island has implemented this provision for medical/surgical services as well as for mental health services. Inclusion of this provision in federal statute will not change our current business practice.

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U.S. House of Representatives
Committee on Energy and Commerce
Washington, DC 20515–6115

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October 9, 2007

Ms. Edwina Rogers, Esq.
Vice President, Health Policy
The ERISA Industry Committee (ERIC)
1400 L Street NW, Suite 350
Washington, DC 20005

Dear Ms. Rogers:

Thank you for appearing before the Subcommittee on Health on Friday, June 15, 2007, at the hearing entitled "H.R. 1424, the Paul Wellstone Mental Health and Addiction Equity Act of 2007." We appreciate the time and effort you gave as a witness before the Subcommittee on Health.

Under the Rules of the Committee on Energy and Commerce, the hearing record remains open to permit Members to submit additional questions to the witnesses. Attached are questions directed to you from the Honorable Nathan Deal, Ranking Member to the Subcommittee on Health. In preparing your answers to these questions, please address your response to the Member who has submitted the questions and include the text of the Member's questions along with your responses.

Because the Committee is expected to consider this legislation in full Committee markup next week, we are asking that you please respond to these questions as soon as possible but by no later than the close of business **Friday, October 12, 2007**. When your written responses are available, the Committee will arrange to have your responses returned by messenger to the Committee on Energy and Commerce, Attention: Sharon Davis, Chief Clerk, 2125 Rayburn House Office Building, Washington, DC 20515.

We also ask if you would please both fax your response to (202) 225-2125, as well as e-mail the electronic version of your written response to Sharon Davis at sharon.davis@mail.house.gov. We would request that the response be in a single Word formatted document. The electronic version will be used to facilitate its inclusion in the hearing record.

Thank you for your prompt attention to this request. If you need additional information or have other questions, please contact Sharon Davis at (202) 225-2927.

Sincerely,

JOHN D. DINGELL
CHAIRMAN

Attachment

cc: The Honorable Joe Barton, Ranking Member
Committee on Energy and Commerce

The Honorable Frank Pallone, Jr., Chairman
Subcommittee on Health

The Honorable Nathan Deal, Ranking Member
Subcommittee on Health

Subcommittee on Health
Hearing on H.R. 1424, the Paul Wellstone Mental Health and Addiction Equity Act
June 15, 2007

Additional Questions from the Honorable Nathan Deal (R-GA) to
Edwina Rogers, Esq., Vice President of Health Policy
The ERISA Industry Committee (ERIC)

1. Is there any precedent in current federal statutes that says, in effect, that if you provide ANY given service, such as mental health services that you must cover ALL conditions listed in a manual prepared by one group of health care professionals? For example, is there a similar federal law that says that if an insurer or employer provides coverage for some pharmaceuticals or medical procedures that you must now cover ALL pharmaceuticals or medical procedures listed in a manual prepared by a trade association of pharmacists or medical care providers?

   I am aware of no such statute pertaining to the provision of health services that establishes such a precedent. Mandating services modeled after those provided by a certain group is problematic for a number of reasons. It would give a substantial competitive advantage to the company that already provides services mandated, and would therefore be anti-competitive.

   Furthermore, adherence to the scope of one particular plan that happens to have high enrollment denies beneficiaries their choice in plans. An employee, for instance, might prefer a plan option that provides a more limited scope of mental health benefits, but a reduced beneficiary financial requirement.

2. Many states that have looked at this issue of parity provisions have chosen to limit any parity requirements to "biologically-based" or "serious" mental illness as they define them. Such states do not require coverage for all the disorders in the Diagnostic and Statistical Manual of Mental Disorders or DSM IV. There are categories of DSM IV referred to as conditions for clinical focus. These include such items as: sibling relational problem; occupational problem; academic problem; and religious or spiritual problem. The manual provides an example of V. 62.3 "Academic Problem" as "a pattern of failing grades or significant underachievement in a person with adequate intellectual capacity in the absence of a Learning or Communication Disorder or any other mental disorder that would account for this problem." Is it your reading of H.R. 1424 that it could require coverage for these conditions?

   According to Section 3, Subsection d of the proposed legislation, the Public Health Services Act would be amended to mandate the allotment of benefits to cover "any mental health condition or substance-related disorder included in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders" (DSM IV).

   It is my understanding that if a condition is categorized as a mental health condition or substance-related disorder in that manual, group health plans could be challenged, under H.R. 1424, to provide benefits for the diagnosis and treatment of those conditions equivalent to those provided for medical or surgical conditions. If the conditions listed above are included in the DSM IV, they could be subject to inclusion under HR 1424.

3. DSM IV category 315.1 is called Mathematics disorder. One of the diagnostic criteria is that mathematical ability is substantially below that expected for the person's age and intelligence. Another criterion is that it significantly interferes with academic achievement. Is it your reading that employers must have insurance to cover diagnosis and treatment for Mathematics disorder as long as Federal plans cover this and such employer is providing any mental health benefit?

   It is my understanding that under H.R. 1424, if a condition is listed as a "mental health disorder" in DSM IV, covered "under the benefit plan option offered under chapter 89 of title 5, United States Code, with the highest average enrollment..." it can be challenged to receive financial and coverage parity with physical health conditions.

4. The DSM IV manual also states criteria to describe mild, moderate, and severe disorders. Mild disorders or example are defined as "[f]ew if any symptoms in excess of those required to make the diagnosis are present, and symptoms result in no more than minor impairment in social or occupational functioning."

   Under H.R. 1424 how would and insurer or employer be able to ensure they are not paying for inappropriate treatment. Would specific evidence be required from the health professional to describe a mild version of any of the following conditions in DSM IV:

   Parent-Child Relational Problem V61.20
   Sibling Relational Problem V61.8
   Child or Adolescent Antisocial Behavior V71.02
   Borderline Intellectual Functioning V62.89
   Age-related Cognitive Decline 780.9
   Bereavement V62.82
   Academic Problem V62.3
   Occupational Problem V62.2
   Identify Problem 313.82
   Religious or Spiritual Problem V62.89
   Acculturation Problem V62.4
   Phase of Life Problem V62.89

   In my reading of H.R. 1424, in its current form, it does not provide adequate safeguards for plan sponsors or providers to ensure appropriate treatment is provided for mental health conditions that meet the medical necessity requirements under the legislation.

   An amendment offered by Mr. Hulshof during the Ways and Means Committee Subcommittee on Health markup of the bill could have provided a group health plan the "ability to negotiate separate... service delivery systems for different benefits and allow plans to manage the provision of mental health benefits" was defeated. (Ways and Means Committee Subcommittee on Health Subcommittee Report on HR 1424, 9.21.2007).

5. Could you support language that says that the diagnosis of a disorder and its treatment must be well established and supported by substantial scientific evidence?

Any legislation mandating minimum scope of coverage of mental health and substance related disorders should not rely on as a broad a compilation of disorders as is contained in DSM IV. Furthermore, plan administrators should have the capacity to verify a condition warranting coverage is of a clinically serious nature, and is treated and diagnosed by appropriate methods, well established and supported by substantial scientific evidence.

6. Provision 313.81 in DSM IV called "oppositional defiant disorder"? The diagnostic criteria require four among the following:

- often loses temper
- often argues with adults
- often actively defies or refuses to comply with adults request or rules
- often deliberately annoys people
- often blames others for his or her mistakes or behavior
- is often touchy or easily annoyed by others
- is often angry and resentful
- is often spiteful or vindictive

Under your reading of H.R. 1424, if there is a disagreement with the group health plan over an individual case, does the beneficiary or provider have the burden to show a clinically significant impairment?

If the condition cited is listed in DSM IV, it would be my reading of the legislation, in its current form, that the burden to prove the condition is not of a clinically significant nature could be construed as being unfairly placed on the health plan, or its sponsors. The way HR 1424 is written, the presumption a condition listed in DSM IV is a legitimate clinical impairment could be read to exist in favor of the beneficiary.

This would create an environment in which beneficiaries afflicted with marginal impairments could seek reimbursement for treatment for disorders based on symptoms that do not necessarily conclude definitively they suffer from a DSM IV condition, because their symptoms may overlap with one.

7. In a letter to carriers dated April 11, 2001, OPM emphasizes that managed care behavioral health care organizations (MBHO) can implement mental health benefits. Where plans do not choose to use such organizations, OPM recommends approaches such as gatekeeper referrals to network providers, authorized treatment plans, and pre-certification of inpatient services. OPM states that plans may limit parity benefits when

patients do not substantially follow their treatment plans. Is this consistent with your understanding of how FEHBO operates. Are these provisions set out in H.R. 1424?

8. Even outside of mental health benefits, health plans do not treat all categories of health benefits equally. For example, outpatient physical therapy, emergency care, specialty care, speech therapy, occupational care, chiropractic care, and preventive care often have different limitations than other categories of items or services. Prescription drugs may also have different categories of co-payments based on the kind of financial arrangements a plan can arrange with pharmaceutical companies. Do you consider differences in approach among these categories to be discrimination against the particular patients who may use these services?

Each category of health benefits needs to be addressed on its own merits. An emergency procedure, for instance, that is needed to save a beneficiary's life must be, and is, addressed differently than a physical therapy regimen for golf-related back pain. To enforce parity between the coverage of these two medical procedures would compel plans, and their sponsors, to cater to the lowest common denominator, and not cover emergency procedures as comprehensively as they might want to.

Plans have limited resources to cover conditions, and if they were forced to reimburse emergency procedures in the same fashion as elective surgeries, the cost burden on seriously ill or injured beneficiaries would surely increase.

A similar circumstance would occur with mental health parity; if an employer was mandated to provide reimbursement for expensive mental therapy sessions for a case of mild depression to the same degree they reimburse an emergency room visit, the plan would be drained, in a lopsided manner, of limited resources.

9. Medical and surgical services have different reimbursement rates. For example, services required for hip replacement might include surgical fees, MRI fees, hospitalization, and rehabilitation, each of which may be reimbursed at a different level. A broken leg might require emergency room services and physical therapy in addition to physician fees, and again, each of these services might have still different reimbursement mechanisms.

If this legislation is enacted, health plans would be required to have the same cost sharing requirement for mental health services as some benchmark for medical and surgical benefits. What is your understanding under H.R. 1424, if a health plan has one deductible and coinsurance amount for physician office visits, another one for physical therapy and a third one for occupational therapy, and a fourth one for preventive services? Which one would apply for treatment of schizophrenia or treatment of sibling rivalry condition?

In my reading of HR 1424, as amended by Mr. Pallone in the Committee on Energy and Commerce, Subcommittee on Health markup, the mental health or substance related disorder treatment would be reimbursed in a comparable manner to a physical health related disorder in the same "Category of items and services for

application of treatment limits and beneficiary financial requirements." These are listed in Section 3, subsection (a), paragraph 1, subparagraph (C).

However, these delineations, as the question correctly points out, do not adequately categorize and define the full range of services that could potentially be rendered in treatment of physical or mental health disorders. HR 1424, uses "predominance"(Subparagraph (E)) as the benchmark in defining how "restrictive" treatment limits and beneficiary financial requirements can be, meaning the reimbursement for the procedure most frequently performed would be the standard by which a procedure of mental health in the same category would be treated. This is a deeply flawed, ambiguous, and inconsistent benchmark.

10. Group health plan sometimes provide a tiered formulary to address drugs. Under such an approach there are different cost-sharing requirements because the plan was able to get certain discounts or because of different cost effectiveness. Would such a plan violate the parity rules of H.R. 1424 if the net effect of the plan made certain psychotherapy drugs to have a higher cost-share? If so, would the determination be made on a drug-by-drug basis?

    Yes, an unintended consequence of this bill might affect such cost-sharing arrangements. As for how the determination is made, that is not specified, by my understanding, in the legislation, and we would have to await regulatory guidance on that matter.

11. Under your understanding of H.R. 1424, could plans differentiate reimbursement based on qualifications? For example, a psychiatrist may have a different reimbursement rate than a psychologist. Could this in any way violate a parity requirement? Let's assume a group health plan creates outpatient categories based on whether or not the visit was to someone with a medical degree -- not on whether it was mental illness related or not. Under H.R. 1424 could such an approach be viewed as discriminatory to psychologists and, thus, to mental health benefits? That is to say, could lawyers argue that there is a disparate impact test?

    By my reading of HR 1424, the nexus between the concept of "predominance" and the five "categories of items and services" leaves little room for reimbursement discretion based on quality or qualifications of providers. Therefore it is conceivable that a plan that reimburses a chiropractor differently from a psychoanalyst could be exposed to discrimination liability.

12. Under H.R. 1424, treatment limitations include "limits on the duration or scope of treatment under the plan or coverage." Do you believe this means decisions to limit the duration or scope of treatment for therapeutic reasons must be held up to a parity test? If so, how would this work? If not, why are these included in the definition of treatment limitations subject to the parity requirements?

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The treatment limitation provisions in HR 1424 are a source of major ambiguity and inconsistency. The hypothetical situation described would be difficult to answer without knowing more about the situation.