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MENTAL HEALTH AND SUBSTANCE ABUSE PARITY

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

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MENTAL HEALTH AND SUBSTANCE ABUSE PARITY

TUESDAY, MARCH 27, 2007

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to notice, at 10:07 a.m., in Room 1100, Longworth House Office Building, Hon. Fortney Pete Stark (Chairman of the Subcommittee), presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
March 20, 2007
HL–7

CONTACT: (202) 225–3943

Health Subcommittee Chairman Stark Announces a Hearing on Mental Health and Substance Abuse Parity

House Ways and Means Health Subcommittee Chairman Pete Stark (D–CA) announced today that the Subcommittee on Health will hold a hearing on mental health and substance abuse parity. **The hearing will take place at 10:00 a.m. on Tuesday, March 27, 2007, in Room 1100, Longworth House Office Building.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

Mental illness affects 24 percent of the adult population, with over 5 percent suffering from serious mental illness. In 2002, President Bush identified unfair treatment limitations placed on mental health benefits as a major barrier to mental health care and urged Congress to enact legislation that would provide full parity in the health insurance coverage of mental and physical illnesses.

According to the National Institutes of Health, mental illness and substance abuse are biological diseases, and yet both private and public health insurers make it more difficult for patients to get treatment for these diseases. Health plans have imposed lower annual or lifetime dollar limits, covered fewer hospital days or outpatient office visits, or increased cost sharing by raising deductibles or copayments for patients with mental illness.

In 1996, a compromise measure, the Mental Health Parity Act (MHPA) (P.L. 104–204), was enacted which provided partial parity for the private health insurance marketplace. It prohibited separate annual and lifetime dollar limits for mental health care, but did not stop group plans from imposing restrictive treatment limits or cost sharing. In addition, the MHPA was specifically not applicable to substance abuse treatment. As a consequence, mental health and substance abuse treatment are still not on parity with physical health care. A recent study of costs associated with adding mental health and substance abuse services to the Federal Employees Health Benefits Plan concluded that implementation of benefits led to a negligible cost increase.

Medicare also fails to provide mental health parity. Medicare's mental health benefit is fashioned on the treatment provided in 1965, but treatments have changed dramatically in the last 42 years. Inpatient coverage at psychiatric hospitals is limited to 190 days over the beneficiary's lifetime. In addition, beneficiaries are charged a discriminatory 50 percent copayment for outpatient psychotherapy services, compared to 20 percent for physical health services. New mental health and substance abuse treatment paradigms, such as evidence-based collaborative care models, are also long overdue for inclusion in Medicare.

"It is long past time to address the inequities in mental health coverage in private plans and Medicare," commented Chairman Rep. Pete Stark (D–CA), Chairman of the Ways and Means Health Subcommittee. **"This hearing will lay the groundwork for future action on this important issue."**

FOCUS OF THE HEARING:

The hearing will focus on legislation and options to provide mental health and substance abuse treatment parity in private health insurance and in Medicare.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, *http://waysandmeans.house.gov*, select "*110th Congress*" from the menu entitled, "*Committee Hearings*" (*http://waysandmeans.house.gov/Hearings.asp?congress=18*). Select the hearing for which you would like to submit, and click on the link entitled, "*Click here to provide a submission for the record*." Once you have followed the online instructions, completing all informational forms and clicking "submit" on the final page, an email will be sent to the address which you supply confirming your interest in providing a submission for the record. You ***MUST REPLY*** to the email and ***ATTACH*** your submission as a Word or WordPerfect document, in compliance with the formatting requirements listed below, by close of business **Tuesday, April 10, 2007**. **Finally**, please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225–1721.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any supplementary materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission or supplementary item not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All submissions and supplementary materials must be provided in Word or WordPerfect format and MUST NOT exceed a total of 10 pages, including attachments. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. All submissions must include a list of all clients, persons, and/or organizations on whose behalf the witness appears. A supplemental sheet must accompany each submission listing the name, company, address, and telephone and fax numbers of each witness.

Note: All Committee advisories and news releases are available on the World Wide Web at *http://waysandmeans.house.gov*.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Chairman STARK. If our guests would like to find seats, and we could begin our hearing. We are going to examine an important change to two important parts of our health care system, the issue of mental health parity in the private health insurance market and mental health parity in government programs.

There have been tremendous changes in diagnosis and treatment of mental illness and substance abuse, but the laws governing the

treatment have not moved as quickly, and we typically have insurers, government and private, imposing lower treatment or higher dollar barriers, higher copayments, limitation of hospital periods. This discrimination does not apply any longer to the Federal Employees Health Benefit Plan, but Medicare continues to have it.

One in four adults will suffer from some form of mental illness, and 5 percent with severe, and one in five seniors will experience mental disorders that are not part of the normal aging process. Those of us over 65 have one of the highest suicide rates, account for 20 percent of the suicide deaths in the United States, while only 13 percent of the population.

I want to thank my colleagues: Mr. Ramstad, who is a Member of our Subcommittee; Mr. Kennedy from Rhode Island, who will testify along with Mr. Ramstad today. These two have been fighting for full parity and for mental health and substance abuse treatment, and they are to be congratulated. They have taken this issue on the road, as we say, hosting field hearings around the country, and today we are going to hear more about what they have learned. They have 256 original cosponsors. That is more than the 218 we need to pass a bill. It is the Paul Wellstone Mental Health and Addiction Equity Act. It is H.R. 1424, and we will hear more about that from our witnesses.

Our first two panels will discuss the need for mental health parity for those with private health insurance, and with strong support in the House and Senate, I am hopeful that we will see this bill move ahead. The third panel will focus on the need for mental health parity in Medicare, and its mental health benefit is fashioned on treatment provided in 1965, and inpatient coverage in psychiatric hospitals. It is limited to 190 days over a beneficiary's lifetime. In addition, there is a 50 percent coinsurance for outpatient psychotherapy as compared to only a 20 percent coinsurance for physical health services, obviously a discriminatory barrier.

Because of these limitations, Medicare spending in mental health is skewed toward the costly hospital services. In 2001, 56 percent of mental health spending in Medicare went to inpatient care, which was over twice the national average of 24 percent. Conversely, the percentage of Medicare spending for cost-effective outpatient care is far below the national trend.

I have introduced legislation since 1995 that provides mental health and substance parity in Medicare for inpatient/outpatient services. It would also redesign the outpatient benefit to make it easier for beneficiaries to get mental health services from cost-efficient options in the community.

Again, I want to thank Mr. Ramstad and Mr. Kennedy for helping me introduce H.R. 1663 this year. President Bush in April of 2002 identified unfair treatment limitations in mental health as a major barrier to mental health care. He launched the New Freedom Commission on Mental Health to identify how mental health care could be improved. One of our panelists today who served on that Commission will discuss their suggestions. President Bush also urged Congress to enact legislation that would provide full parity in the mental health insurance coverage of mental and phys-

ical illnesses. I agree. It is time to end this discrimination against mental health in both commercial insurance and in Medicare.

[The information follows: PENDING]

Chairman STARK. I want to thank our panelists this morning, and we will ask Mr. Ramstad, who is a Member of the Committee, to proceed.

Mr. CAMP. I'm sorry?

Chairman STARK. Protocol and good sense would require that Mr. Camp have some opening remarks.

Mr. CAMP. Thank you, Mr. Chairman. I also want to welcome our colleagues Mr. Ramstad and Mr. Kennedy to the Committee. We all recognize the importance of health benefits for individuals suffering from mental conditions, and by managing the treatment of an individual suffering from mental illnesses, health insurers can provide medical care that can lead to better health and lower costs in the future. Given the dramatic increases in health care costs in recent years, many employers are already dropping or limiting health care coverage. This in turn makes it more difficult for their employees to obtain any health insurance, including mental health benefits.

The question this Subcommittee needs to ask is whether or not access to mental health benefits and, more broadly, health care insurance will be unintentionally reduced because of the added cost to employers. I hope that we will get a chance today to discuss another mental health parity bill which is being developed in the Senate by Senators Kennedy and Enzi. Both bills include a requirement for employers and health plans to cover treatment for mental illnesses on the same terms and conditions as all other illnesses. The Senate, however, adopts a different approach to defining covered diseases and mandates about the networks and providers that must be covered. This approach may significantly reduce the potential cost that could be imposed upon employers.

It is my hope that Congress can move forward with the goal of enacting a bill that expands access to appropriate mental health services while not reducing any worker's access to health care benefits. I look forward to working with my colleagues and with Chairman Stark on this issue.

Thank you, Mr. Chairman. I yield back the balance of my time.

Chairman STARK. Thank you, Mr. Camp.

[The information follows: PENDING]

Chairman STARK. Jim, would you like to proceed to enlighten us?

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

Mr. RAMSTAD. Thank you, Mr. Chairman, Ranking Member Camp and all other friends and colleagues of the Subcommittee. Thank you for holding this important hearing today.

As you know, ensuring access to mental health and addiction treatment is more than just a public policy issue to me. It is a life-or-death issue, like it is for 26 million Americans suffering the ravages of chemical addiction and 54 million Americans suffering from mental illness, something I have been working on since 1996, and I certainly appreciate the hearing we are having here today.

On July 31, 1981, I woke up in a jail cell in Sioux Falls, South Dakota, under arrest for a variety of offenses stemming from my last alcoholic blackout. I am alive and sober today only because of the access that I had to treatment along with the grace of God and the fellowship of other recovering people for the past 25½ years.

I am living proof that treatment works, and recovery is possible, but too many people don't have the access to treatment that I had. It is a national disgrace that 270,000 Americans were denied addiction treatment last year, American people suffering from this disease who had admitted their powerlessness over chemicals, their life had become unmanageable, and the treatment doors were slammed in their faces.

It is estimated that 8 million people in health plans are unable to access treatment for chemical dependency despite being in plans that purportedly cover treatment for this disease. Last year alone, 150,000 of our fellow Americans died as a direct result of chemical addiction, and 30,000 Americans committed suicide from untreated depression, and I believe it is a national crisis that untreated addiction and mental illness costs our economy, and there are various studies that corroborate this, over $550 billion last year. Of course, we all know of the cost that can't be measured in financial terms, the human suffering, broken families, shattered dreams, ruined careers, destroyed lives.

It is time to end the discrimination against people suffering the ravages of mental illness and chemical addiction. I believe it is time to pass the Paul Wellstone Mental Health and Addiction Equity Act. This important legislation would simply prohibit health insurance companies from imposing discriminatory barriers to mental health or addiction treatment through limited treatment stays, higher copayments, deductibles or cost-sharing requirements; that is, discriminatory barriers that don't exist for other diseases.

We should all be alarmed by the dwindling access to treatment for chemically dependent people and people with mental illness. Over half the beds that were available 10 years ago are gone. Even more alarming, 60 percent of the adolescent treatment beds have disappeared in the last decade.

Expanding access to treatment is not only the right thing to do, it is also the cost-effective thing to do, and I just want to address the cost factor that was already raised here today. We have all the empirical data in the world, and I would be glad to make these actuarial studies available to every single Member. We have all the scientific data to show that equity for mental health and addiction treatment will save billions of dollars a year while not raising premiums. The worst-case scenario, premiums would be raised, according to all of these studies, less than 1 percent. In the legislation, if it is raised 1 percent, the parity does not apply.

Let me give you three studies: Medica, extensive study, found the cost for mental health parity 26 cents per member per month; the actuarial firm Millman and Robertson, parity will increase premiums less than 78 cents per month, far less than 1 percent; the most recent study done by the New England Journal of Medicine, costs do not increase, and they studied not only the Federal employees benefit plan, but parity in a number of States. Costs, again,

from the respected New England Journal of Medicine, costs do not increase with parity, but save dollars.

Let me also site an encouraging development. The health plans and the insurance companies are starting to come around. I credit my colleague and partner in this effort, Patrick Kennedy. He has been the leader in arranging these field hearings. He has been to each and every one. I have been to eight or nine. He has been to 13 or 14. The CEO of Blue Cross/Blue Shield of New England testified as to the cost-effectiveness of parity. United Behavioral Health in New England testified as to the cost-effectiveness of parity. Health Partners of Minnesota, same thing; Medica, same thing. Kaiser Permanente also supports this legislation, testifying there is no increases in costs associated with parity.

Let me conclude, Mr. Chairman, by saying as strongly as I can, it is time to end the discrimination against people who need treatment for mental illness and addiction. It is time to prohibit health insurers from placing discriminatory restrictions on treatment. It is time to provide the American people with greater access to treatment. It is time to pass this legislation because we must address America's number one public health crisis, which is clearly untreated mental illness and untreated chemical addiction. The American people, Mr. Chairman, cannot afford to wait any longer. Thank you again for calling this hearing. I would be more than happy to answer your questions.

Chairman STARK. Thank you very much.

[The prepared statement of Mr. Ramstad follows:]

Prepared Statement of The Honorable Jim Ramstad, a Representative in Congress from the State of Minnesota

Chairman Stark, Ranking Member Camp, thank you for holding this important hearing.

As you both know, ensuring access to mental health and addiction treatment is more than just a public policy issue for me. On July 31, 1981, I woke up in a jail cell in Sioux Falls, S.D. under arrest as the result of my last alcoholic blackout.

I'm alive and sober today only because of the grace of God, the access I had to treatment and the fellowship of recovering people for 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. 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 pass the "Paul Wellstone Mental Health and Addiction Equity Act." This important legislation would prohibit health insurance companies from imposing discriminatory barriers to mental health or addiction treatment through limited treatment stays and higher copayments, deductibles or cost-sharing requirements—discriminatory barriers that don't exist for other diseases.

I am absolutely alarmed by the dwindling access to treatment for chemically dependent people.

Over half of the treatment beds that were available 10 years ago are gone. Even more alarming, 60% of the adolescent treatment beds are gone. We must reverse this trend.

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 1 percent.

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.

Chairman STARK. Mr. Kennedy, would you like to proceed?

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

Mr. KENNEDY. Yes. Thank you, Mr. Chairman and Ranking Member Camp. I think you have just witnessed why——

Chairman STARK. I put things like that on my icebox door, but I am not sure that——

Mr. KENNEDY. Well, that is a frown for why we don't have parity right now, and it will be a smiling face when you pass parity. It is a PET scan, which is an X-ray of the brain. It shows that we have a physical illness in mental illness, thereby debunking what is really the popular stigma of mental illness, and that is that it is a moral issue; that when people have a mental illness, that it is their fault; that it is a moral failing that it is their fault that they have an addiction, that they succumb to alcoholism; that is a personal failure of theirs.

We now know that it is a genetic and physiological problem, combined with environmental factors, that leads someone to have these problems. As such, just like someone who has diabetes, or just like someone who has asthma, or just like someone who has cardiovascular disease, we need to treat the combination of someone's physiological environmental factors. But unfortunately in this country, we treat mental illness and addictions differently than we do other chronic illnesses that are no different from mental illnesses.

I just want to begin by saying, I think you have just heard why Jim Ramstad is the heir to Paul Wellstone from Minnesota. He has been the champion before I came to Congress, and, as he has just articulated, remains the most articulate champion for those with addiction and alcoholism in this country, and is somebody that I credit personally with my own recovery in day to day and also as an inspiration to me in this legislative battle to bring parity in this country for millions of Americans, 26 million Americans who are discriminated against on a daily basis simply because they have an illness of the brain. That is what we are after, Mr. Chairman, this notion that just because the organ in the body that we are talking about exists between the shoulders as opposed to anywhere else in the body, it is discriminated against.

We have heard hearings all over the country about how this discrimination takes place, but nothing is as compelling as the personal stories. You will hear some of them today, Mr. Chairman, one of them from Anna Westin, Kitty Westin and Anna Westin, who is

her daughter, who was denied treatment and lost her life as a result of it. She was denied treatment and as a result lost her life.

Now why is it that she was denied treatment? She was denied treatment because her brain illness was not regarded as fully reimbursable. This X-ray, insurance companies will reimburse for Parkinson's disease for the motor cortex, the basal ganglia and the sensory cortex and thalamus 100 percent. It will reimburse it 100 percent. But if you move just a half a centimeter away, insurance companies will not reimburse 100 percent for the limbic cortex. In fact, it will only reimburse 50 percent, maybe 40 percent for the hypothalamus, which is no different in physical characteristics for its physical impact on a disease like the disease of eating disorder that affected Anna or the frontal cortex or hippocampus.

This is no way to justify denying coverage. The basic issue today, Mr. Chairman, is an issue of fairness, and that is why we are here today is to say that it is unfair for people with mental illness to be denied treatment. They pay for their health insurance like everybody else, and yet they are denied their health insurance coverage when they get sick. But that is not fair, Mr. Chairman. So, many Americans are covered when it comes to their health insurance when they pay their premiums, but if it comes to mental illness, they are denied their health insurance when it comes to their treatment.

This I don't think is very American. No one is asked when they are born what their genetics are, what their anatomy, what their physiology is, just like they are not asked what their skin color is and what their gender is. This is just as much a civil rights issue as those two were, and that is why we need to make this the civil rights issue of our time and pass mental health parity.

[The prepared statement of Mr. Kennedy follows:]

Prepared Statement of The Honorable Patrick J. Kennedy, a Representative in Congress from the State of Rhode Island

Chairman Stark, Ranking Member Camp, 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. Kitty Westin, who you will hear from, paid her health insurance premiums just like everyone else. But when her daughter Anna got sick and needed her insurance coverage, she didn't get it. That is just not fair. And it cost Anna her life.

There is no way to justify denying Anna Westin, 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—a dozen so far, with more to come.

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% 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 health care services by as much as 37%. These are costs of our insurance discrimination.

In our field hearings, we've heard from enlightened business leaders and insurance executives, like Jim Purcell, the CEO of Blue Cross/Blue Shield of Rhode Island. This is what Mr. Purcell said about limits on access to mental health and addiction treatment: "I believe that's bad medicine, it's bad law, and it's bad insurance."

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% 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 nondepressed 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 who, like Kitty Westin, 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.

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

In 2001, we brought equity to mental health and addiction care in the Federal Employees Health Benefits Program (FEHB), 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 Kitty Westin, or 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?

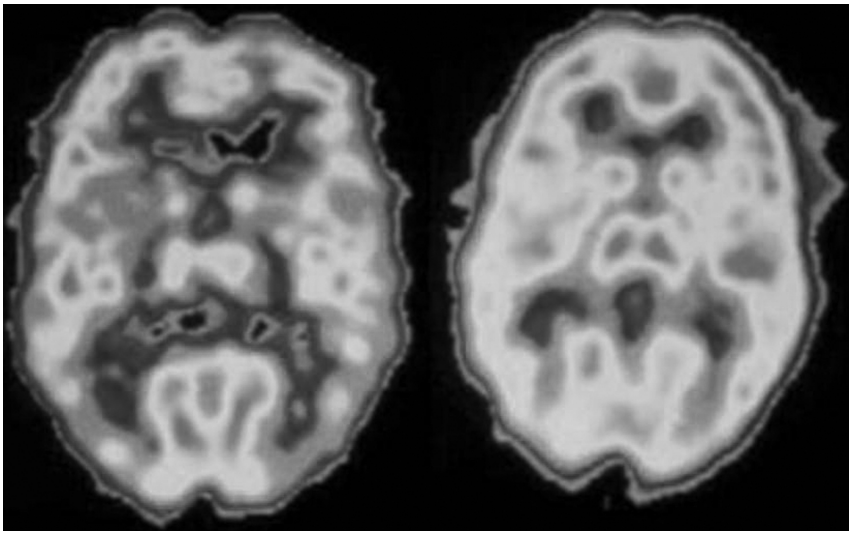
People might say that there is a component of personal responsibility here, especially with addiction. That's true. I'm working hard every day at my recovery, and it's reasonable to ask of me. But it's also true that we don't deny insurance coverage to people genetically predisposed to high cholesterol 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. This 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 a Member of this Subcommittee, 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 mental health 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.



PET scans of schizophrenic (l.) and healthy (r.) brains.

Chairman STARK. Thank you. I share in the applause for both of you. I am only disappointed that the two of you and some of your colleagues have had to share so much of your own painful personal experiences to get the attention of our colleagues. This is something that, as, Jim, you have indicated, we should have done 10 years ago. So I hope that all the efforts that you have put into it, the efforts that our friend Paul Wellstone put into this when he first came to the Congress, that we will recognize that and what over 250 of our colleagues have recognized and move this ahead.

I am sure that there will be some minor objections here or there. I hope we can compromise with them. I am going to let Patrick deal with his fair father to get that compromise taken care of, but I am sure that this is a time when we can move ahead and achieve what is necessary. So, I want to thank both of you for sharing your experiences.

Mr. KENNEDY. Yeah. Mr. Chairman, if I could, one of the most compelling witnesses, we had talked about this as a cost in another way, and that was the lost life that they had. They said—Amy Smith was her name. She said, I would have been able to pursue my dreams for my life like driving a car, holding down a real job, maybe even getting married, volunteering in the community, those kinds of things in my life, if I had just been able to get treatment earlier in my life. I mean, we have to calculate these costs, too. You know, we talk about things so much in financial terms, and the financial terms are, I think, pretty clear-cut.

I would caution the Members to think, too, about the productivity issues if they are looking at cost, because no business person does not take in and evaluate the productivity of their business in terms of calculating the bottom line, and depressed workers and two-thirds of those with chemical and substance abuse disorders are on the job working in this country. Their productivity rates, they are losing over 3 hours to 4 hours a week in productive time, whether they are not at work because they are late for work, or whether they are at work and they are not paying attention at work. Those costs are all calculated in these examples that Representative Ramstad is ready to submit in testimony.

I would caution the Members to pay attention to those, because taking these costs in a vacuum does not fully evaluate the real cost to businesses. It also is worth noting, Mr. Chairman, when it looks at the health care costs, 80 percent of the intake in a trauma care is due to drugs and alcohol in our emergency rooms. Eighty percent of gunshot wounds, car accidents, traumas, knifings, all of those kind of cases in our trauma care are all drug- and alcohol-related, but they never get marked up as drugs and alcohol because they are never reimbursable for drugs and alcohol. So, they don't get marked up for drugs and alcohol. They get marked up as accidents for sutures, and so they never get written up as such.

So, we don't get an accurate reading in this country for the true toll of what cases come into our emergency rooms. If we accurately reimbursed for what the number of cases were that came into our emergency rooms as a result of drugs and alcohol, you would see those cases properly reflected in the numbers.

Mr. RAMSTAD. Mr. Chairman, just for the record, since your testimony was written, your statement was written rather, we have

added cosponsors. There are now officially 261 cosponsors. Three more on my side came aboard last night, I am happy to report.

Let me just talk very briefly in response to the two big myths that we are up against, and they are both myths eminently disprovable by empirical data. First is the cost of parity, and we have again all the empirical studies, whether it is the Millman and Robertson, the Medica study, the New England Journal of Medicine, the Rutgers study, the Minnesota study, the California study, I mean, I could off the top of my head name——

Chairman STARK. Federal employees study.

Mr. RAMSTAD. Exactly. Insurance companies, insurance plans are starting to realize that and see the same data we do. That is why I cited five insurance plans that are now citing parity legislation as being a cost saver. The second myth is that this is a mandate. This is not a mandate. We are not saying to any insurance plan that you must cover mental illness or you must cover chemical addiction. We are just saying if you do include such coverage in your policy then you can't discriminate. You have to treat it like you do physical diseases, that is you can't impose higher copayments than you do for an appendicitis attack or asthma or whatever higher deductibles or limited treatment stays. I think that is why we are getting the support of, as we saw at our field hearings from around the country, from a number of CEOs who testified. One CEO testified in Palo Alto, California, who now applies parity in his policy for all of his employees, and he put it very succinctly when he said, if it is good enough for Members of Congress, i.e., our Federal employees benefit plan, it is good enough for my employees, and I think that sums it up.

Chairman STARK. If the gentleman would yield at that point. Mr. Kennedy had suggested in his testimony that you would make the transcripts from those field hearings available, and without objection, I would like to add those to the record of our hearing today. Thanks.

[The information follows: PENDING]

Chairman STARK. Mr. Camp?

Mr. CAMP. Well, thank you, and thank you both for your testimony. I know it isn't easy to always portray these issues in a personal way, as you both have so effectively done. I certainly look forward to working with you as we move through the process on this. I think you have touched on a very important point, Mr. Ramstad, that there is no requirement that health plans include mental health and substance abuse benefits, and so we need to be very careful about how we craft that. So, we encourage people and plans to include these benefits so that we structure this in a way, and frankly, many of the people who go into emergency rooms don't have any insurance at all. So, it is not a question of how it is coded, it is a question of how we ensure more health coverage in general for more Americans, particularly working Americans.

So, I look forward to working with both of you, and I appreciate your testimony very much, and all of work that you have done on this issue, and the numerous field hearings you have had all over the country. Thank you, Mr. Chairman.

Mr. KENNEDY. If I could, the really important thing about this as well is stigma, and passing this legislation will do a great deal

to ending the stigma against mental illness. This is a physical illness, and yet millions of Americans who already have health insurance don't even avail themselves of it because they feel so ashamed because this society has placed this stereotype on people who seek mental help that they are—somehow something is wrong with them.

So, passing it has much more of a salutary effect as just even treating them. It will make an enormous impact on the society's approach overall to health care. So, I can't underscore the importance of this, just in its PR value if anything else. So, I just do not underscore the importance of this for that value in itself. So I appreciate your——

Mr. RAMSTAD. Mr. Camp, if I may, you make a very, very important point. This legislation we are about today, this parity bill only addresses those people in health plans, addresses the 26—well, of the 26 million people suffering from addiction, it is estimated that roughly 16 million have insurance, but it only addresses those in plans.

We have also got to address, as Mr. Stark does in his legislation, the Medicare population, given the incredible increases in depression among seniors and the corresponding increase in alcoholism among seniors, untreated alcoholism. So, that is the second part of addressing the overall problem of treating mental illness and chemical dependency in America.

The third part is the Medicaid population. The Medicaid population; the fourth, veterans and our troops, and we have seen two tragically recent terms in Minnesota and elsewhere around the Nation suicides from PTSD, and we are addressing that as well in legislation that Mr. Emanuel or—or you, I believe, have introduced legislation on point. Certainly Mr. Moran has as well.

Then we are not dealing with addiction problems in our prisons and jails. You know, the sheriff of L.A. County testified at our hearing in Los Angeles. He testified that as the one in charge, in charge with the responsibility of supervision for the L.A. County jails, he is the overseer for the largest mental health institution in the world, largest mental health system in the world. That is how he equated being in charge of the jails there. Columbia University study, all the studies on prison populations, jail populations show that 82 percent of the inmates in jails and prisons are there directly or indirectly because of addiction. So, we are not dealing with that as well. So, your point is well taken, Mr. Camp, that we need to deal with this comprehensively.

Mr. THOMPSON. Thank you, Mr. Chairman, and thank you both for holding this hearing. Jim and Patrick, thank you very much for your interest and your passion on this very, very important issue. I am proud to be a coauthor of your legislation. I want to help you in any way to make sure that this becomes a reality. I just think more needs to be pointed out, and, Jim, you talked a lot about it in regard to the cost of not dealing with this both in opportunity costs. You know, our jails are filled with folks who should be getting medical help, not taking up cell time. The community costs are just outrageous about this.

Patrick, I had an opportunity to cohost an event for you in my district, and welcomed—more than happy to do that as often and

in as many places as I can if we can help get the word out on this very important issue. As far as the reconciling the differences that the Chairman spoke about between you and your dad, I just want to put a pitch in for your bill that recognizes the important State programs such as my State, California, and if there is a bill that is passed that provides some sort of State preemption, that is going to be very, very damaging. So, I think your bill is the bill, and thank you again for just the personal effort that you have put into this.

Mr. KENNEDY. Thank you. Thank you.

Chairman STARK. Are there other Members—Mr. Emanuel?

Mr. EMANUEL. Thank you, Mr. Chairman. I also thank Congressman Camp for having this hearing and our two colleagues who are testifying on this legislation.

As a cosponsor, I will just say when I ran for Congress in 2002, I wrote an op-ed for the Chicago Sun Times on mental health parity, wrote a number of op-eds on different subjects. I was always shocked at how many people came up at both the El stops in Chicago, the grocery stores, the front stoops where I was campaigning and responded directly to this one. I wrote on health care coverage for children; wrote on tax fairness; Great Lakes and Lake Michigan restoration, but it was the mental health parity that doesn't have—and I think the cosponsorship of this legislation show there is no Democrats and Republicans on this issue. There are people, families affected.

I would urge one thing as we look at this. When we talk about mental health parity on health care, we did certain things in the 1990s, Federal employees, the Executive Order by President Clinton at that time requiring companies, insurance companies that participated in the Federal employees system to offer this benefit and make sure that people have the coverage and no discrimination at that level.

But I will say, as everybody knows, we may treat an individual who has mental health issues, but there is no doubt if we get them the insurance coverage, we are curing an illness that affects the entire family with that individual. It is right to focus on that individual. It is right to focus on the issue of productivity, but nobody can say that when a member is affected by any issue, depression, et cetera, that it does not affect the entire family and also places of employment.

So, I thank our two colleagues for their courage in speaking up, and it takes a lot to do what you are doing, and hopefully with this change we will be allowed finally to get this legislation on the floor and through both Chambers. I want to thank you for your leadership, your coverage and most importantly after the years your steadfast determination to see this to this point that it is. Thank you very much.

Chairman STARK. Mr. Kind?

Mr. KIND. Thank you, Mr. Chairman. I want to thank you and Mr. Camp for holding this very important hearing, but I especially want to commend our two colleagues for linking arms on this vitally important issue and for traveling the country, as you have now for a very long time, reaching out, educating a whole lot of people, and elevating this issue to the level it needs to be at in

order for us to take this up finally in this session of Congress. Hopefully we are going to be able to move it through.

I know there has been some initial resistance within some in the business community, but when you take a look at some of the lost opportunity costs associated with mental health, from turnover rate, to absenteeism, to lost productivity, there is another important reason why we need to do this to enhance overall productivity in the workforce.

But one issue—and Ron is exactly right. There is not a family in America that is not affected one way or the other by this issue whether they know it or not. But one of the concerns that I had, and maybe it was the many years I was serving on the Education Committee, was we just need to get better at early identification on mental health issues with our children. I am wondering if you could just take a moment and speak to that and the importance of this legislation in order to get that early identification there, which obviously means quicker and more effective treatment then and hopefully not the associated societal costs that may come from not detecting this early on.

Mr. KENNEDY. Thank you. The real key here is the fight by the insurance companies that they want to wait until it becomes a severe illness before they cover it. Then the irony is that when it becomes a severe illness, then obviously it becomes intractable and more chronic and more costly to treat. So, they have a problem with covering the DSM 4, which is what we are covered by as Federal Employees Health Benefit Plan, because they say it is too broad and would allow too much leeway for a therapist to, you know, allow aggressive treatment.

The irony is you want aggressive treatment, and I don't know a single person who voluntarily just wants to go and get mental health treatment for the sake of just getting mental health treatment to waste their time. That is the last thing I know of anybody who just likes to go around and overutilize the mental health system for the sake of overutilizing the mental health system. Last time I checked, that is not a problem of people, you know, wanting to be known for overutilizing the mental health system. That is the last problem we have, with stigma being what it is.

The key here is you want—you want to actually go out there and proactively bring people in and treat them. You are absolutely right, you want to go out there and screen them preemptively. In fact, when we—we passed the autism bill this year about trying to preactively screen children. We can avoid over 50 percent of the most costly disabling aspects of autism in this country with prescreening of children, babies from 0 to 2. Problem with mental health is that the babies have—part of their cognitive is covered by physical, and part of it is covered by mental health. The irony is part of it is 100 percent reimbursement for the physical part of the brain, and 40 percent reimbursement for the mental health part of the brain. You go figure it out.

We have had these incredible testimonies where parents are having to try to get their health network to get preauthorization for therapy for their autistic child. It makes no sense.

So, the point of mental health parity is to treat the whole person and to treat them together and not have two separate, you know,

authorization systems. You are right, and to get in there early and treat them and identify them, you know, early, and with education—we have a 35 percent dropout rate in my State in all my major cities. A lot of that is because kids are—you know, drugs, alcohol, they come from broken homes. A lot of them—you know what the factors are. If a child comes from a home with a depressed parent, with a parent who is on drugs or alcohol, a parent who has been incarcerated, you know those children are at high risk. You ought to be able to get in there and cover them and get them the mental health services early on, and that should be a matter of public policy. It will save us a lot of money.

Mr. KIND. It just seems intuitive. The better we get at early identification, the more effective the treatment is going to be, and the better we are going to be able to avoid major problems down the road and save a tremendous amount in the process. So, thank you both again for what you have been doing.

Thank you, Mr. Chairman.

Chairman STARK. Thank you.

I want to thank both of you for being here. Jim, I know you will rejoin us here. Patrick, you are welcome to—I am sorry. Did you want to inquire, Mrs. Tubbs Jones?

Ms. TUBBS JONES. I do, Mr. Chairman. Thank you very much. I apologize. I have been in and out.

But to my colleagues, Mr. Ramstad and Mr. Kennedy, thank you so much. I stepped out, and I was talking to a friend on the phone, and this friend of mine from Cleveland had a daughter, manic-depressive, who was just in terrible condition. Finally one day I just went over to her house, put her in a police car, took her to the hospital and got her treatment, and I am just so proud to say that now this woman is a physician. She has graduated from medical school. She is married, is having a baby in September. So I am so excited about the kind of work that can happen for families when they are given what they need, and I just thank both of you for your leadership on this issue.

Throughout my career I have been involved in all kinds of situations where mental health support is so important. So, I am 100 percent with you on parity, and I join you. Tell me what I can do to be helpful. I am there for you.

Thank you, Mr. Chairman, for the opportunity.

Mr. KENNEDY. Well, you hit the nail on the head. Most of our mental health dollars go to the Department of Corrections. That is our biggest mental health system right now. Frankly, we are spending oodles of money through special ed, through special education, through our justice system, through our workers comp system. You wouldn't believe the testimony we have heard from people coming in sick complaining of undiagnosed back pain or irritable bowel syndrome. It has nothing to do with that. We waste so many billions of dollars on tests for undiagnosed pain that is really psychological and depression. The people just want—though they don't know it, they have severe depression, and accentuates other things in their bodies. You know, as a society we ought to get with the program and just realize you are treating the whole person, and that is why it is so vital to pass this legislation.

Ms. TUBBS JONES. Thank you.

Chairman STARK. Mr. Becerra?

Mr. BECERRA. Thank you, Mr. Chairman, and to our two colleagues and witnesses, thank you very much not for the testimony today, but for your championship of this issue for so many years.

Most folks don't realize it, but in the city of Los Angeles we have a city within a city. On any given day there is some 80 to 85,000 homeless people in the city of Los Angeles, most of whom could use some not just health care, but mental health care. We could probably address a great deal of the homeless issue if we were to provide a number of these folks with some basic mental health services. So as you go about your task, we are going to be able to address so many ancillary issues in addressing this parity issue for mental health within the health care system. So, thank you for championing this cause for so many years. Thanks for being here today. But we appreciate what you are doing and have done for a long time. So, I have no questions other than to say I very much appreciate what you are doing today.

Yield back, Mr. Chairman.

Chairman STARK. Again, I want to thank the panel.

Mr. KENNEDY. Mr. Chairman, one last thing. In Los Angeles, it has been great to work with Grace Napolitano, who has been championing this issue with Latinas. Latinas have the highest suicide rate of any group in the country. As Jim said, suicide rate is twice the rate of homicide in this country. Over 34,000 people kill themselves a year, and 90 percent of those are people with a diagnosable mental disorder, meaning you could prevent those suicides with treatment. That is a public health epidemic that we could address in this country.

Mr. BECERRA. Patrick, when you add to the fact that within the teenage population, Latinas, female Latinos, are the most likely to commit suicide, with the fact the Latino community is the least likely to be insured, you have a chemistry that is going to explode. So, we thank you very much.

Mr. KENNEDY. Thank you.

Chairman STARK. Thank you both. Please join us.

I would like to now welcome a panel that consists of Dr. David Shern, president and CEO of Mental Health America from Alexandria, Virginia; Dr. Michael Quirk, who is the director of Behavioral Health Service, Group Health Cooperative from Seattle, Washington; Ms. Kathryne Westin, who is a member of the Eating Disorders Coalition for Research, Policy and Action, who is here.

In a moment, I would like to recognize Mr. Ramstad.

Mr. RAMSTAD. Thank you, Chairman Stark, again. I am pleased to have the privilege of introducing my very good friend and colleague in this effort, Kitty Westin of Minnesota. Kitty Westin is one of the most dedicated mental health advocates in our Nation, certainly one of the most dedicated advocates of any kind I have ever worked with.

I have had the pleasure and privilege of working closely with Kitty Westin to end discrimination against people with eating disorders and other forms of mental illness and addiction. As the mother of a precious child, her daughter Anna who died from anorexia on February 17, 2000, no one, no one understands better the

need for a comprehensive and balanced approach to mental health care than Kitty Westin.

Today Kitty is honoring the legacy of her daughter Anna through the Anna Westin Foundation, which she started. Kitty is president of the Anna Westin Foundation and also president of the Eating Disorders Coalition.

Kitty, thank you so much for coming on short notice and for being here to testify here today.

Chairman STARK. Thank you, Mr. Ramstad.

Welcome to the witnesses. We will start with Dr. Shern, and, Doctor, please inform us in any way you are comfortable. Your entire written testimony will appear in the record without objection, and we will look forward to your summation.

Doctor, can you do two things: Turn the microphone on and pull it as close as you can.

Mr. SHERN. How is that?

Chairman STARK. That is much better.

STATEMENT OF DAVID L. SHERN, PH.D., PRESIDENT AND CEO, MENTAL HEALTH AMERICA, ALEXANDRIA, VIRGINIA

Mr. SHERN. Well, it is a great honor to be here and to participate in these historic hearings. It is great to be testifying to you, Representative Stark, given, you know, your tradition of leadership on that.

Mr. Camp, your remarks have also indicated the severity of the issue and your support for good, sensible approaches.

It is also a great honor to be testifying with Jim Ramstad and following Patrick Kennedy. As so many of you have noted, they have shown extraordinary personal courage in terms of their own experiences and the importance for them in their life of having access to equitable and effective care. In fact, they have done such a good job of summarizing not only their personal experience, but most of the relevant facts in this matter that they have essentially delivered my entire testimony, and I very much appreciate that.

What I would like to do then is to offer sort of some summary remarks and perhaps pull together some themes that might be helpful in terms of the way we think about—think about this problem.

First a word about our organization. We are Mental Health America. Until November 16, we were known as the National Mental Health Association, and we decided to change the name of our organization on November 16 to underline the important integration of health and mental health issues. We firmly believe that when we reflect back on this time—and I think it is so clearly indicated by so many of the comments this morning from the Committee as well as from Representatives Kennedy and Ramstad—when we reflect on this time, we will say that finally during this era, we realized, as Representative Kennedy said so clearly, that there is no meaningful separation between our mind and our body, our brain and our body, our mental and our physical health; that, in fact, they are one and the same.

You know, when Surgeon General David Satcher was asked by Vice President Gore at the time to begin a Surgeon General's report on mental health, he was quite skeptical about whether or not

the science base was really there and ready for a Surgeon General's report on mental health. When he concluded the work, not only was he no longer skeptical, but he was astounded at the strength of our science base.

We now know clearly that mental health conditions are real illnesses, they are reliably diagnosable, and they are effectively treatable. It is critical, as was noted earlier by the Committee, that we move access up, we identify persons earlier and get them to receive effective treatment.

These are the most disabling illnesses. In 2001, the World Health Organization estimated that 36 percent of all disability related to illness in the United States, Western Europe and Canada is directly attributable to mental health and substance abuse conditions, 36 percent. That far outstrips every other medical condition in terms of their severity.

We have to do a better job. It is shameful that we continue to discriminate and frustrate access to these conditions. The cost data have been very adequately summarized by Mr. Ramstad and Kennedy. There is no longer a cost concern. The FEHB study, which was published in the New England Journal and that was mentioned earlier, clearly, clearly demonstrates that with a full spectrum of conditions embodied in the DSM 4 being eligible for care, there is no net increase in costs. Zero net increase in cost. This is the only study this has actually used a comparison group, and it is a very important distinction which allows for us to take a look at what is normally happening in terms of health care coverage. The cost arguments are off the table.

Additionally, we have come to fully understand the importance of comorbidity, so people with cardiac disease or diabetes that have untreated, undiagnosed mental illnesses do much worse, have much higher mortality rates and greater expenditures.

As everybody noted this morning, when we talk about cost, it is very important to think of it comprehensively in terms of cost to family, cost to the criminal justice system, excess mortality and morbidity for persons who have general health conditions who don't receive appropriate care.

Ladies and gentlemen, the science is clear. The cost data are clear. The equity considerations are clear. There is no ambiguity. It is nonsense for us to not have equal access to behavioral health care for persons in this country. Thank you very much.

Chairman STARK. Thank you.

[The prepared statement of Mr. Shern follows:]

Prepared Statement of David L. Shern, Ph.D.,
President and CEO, Mental Health America, Alexandria, Virginia

Mr. Chairman and Members of the Subcommittee:

Mental Health America (MHA) is the country's oldest and largest nonprofit organization addressing all aspects of mental health and mental illness. In partnership with our network of 320 State and local Mental Health Association affiliates nationwide, MHA works to improve policies, understanding, and services for individuals with or at risk of mental illness and substance use disorders. The organization was established in 1909 by a young businessman who struggled with a mental illness and created a national citizens' group to promote mental health and improve conditions for those living with mental illness. Last November we changed our name from the National Mental Health Association to Mental Health America in order to communicate how fundamental mental health is to overall health and well-being.

Mr. Chairman, we appreciate your longstanding commitment to advancing the cause of mental health equity and to modernizing mental health coverage under Medicare, and are very pleased to have the opportunity to testify today. From the vantage point of this organization's long history, it is almost tragic that passage of legislation outlawing inequitable mental health coverage should remain unfinished business at the door of the 110th Congress. We welcome your holding an early hearing on this issue, and applaud the legislation you are considering today.

Whatever the prism—whether from the perspective of science, medicine, ethics, or economics—there is simply no foundation for erecting or maintaining artificial barriers to needed mental health care, whether under the Medicare program or employer-provided coverage, especially when those barriers are higher than those governing access to care for any other illness. Indeed, it has long been our position that the Federal Government should ensure, as a matter of law, that public and private health plans afford people access to needed behavioral health care on the same basis, and subject to the same terms and conditions, as care and treatment for any other illness, without regard to diagnosis, severity or cause.

Mental health is essential to leading a healthy life and to the development and realization of every person's full potential. Yet mental illness and substance use disorders are leading causes of disability and premature mortality. Research has shown that depression is "now the fourth-leading cause of the global disease burden and the leading cause of disability worldwide."[1] The CDC reports that "mental disorders are the second leading source of disease burden in established market economies."[2] A recent paper citing World Health Organization data report that there are "450 million people who suffer at a certain point of a neurological, psychiatric or behaviour related disease, and about 25% of all the inhabitants in the world get a psychiatric or behavioural disorder at a certain moment in their life."[3]

According to the landmark 1999 Surgeon General report on mental health, "Mental disorders are treatable . . . there is generally not just one but a *range* of treatments of proven efficacy." Also, this report stresses the importance of combining both pharmacologic and psychosocial therapies for best outcome.[4] Treatment modalities for mental and substance use disorders are effective at producing full or partial remission of symptoms. In individuals with depression, research has shown that approximately 80% can recover with appropriate diagnosis, treatment and monitoring.[5] Yet all too often people with diagnosable mental disorders do not seek treatment. "Concerns about the cost of care—concerns made worse by the disparity in insurance coverage for mental disorders in contrast to other illnesses—are among the foremost reasons why people do not seek needed mental health care,"[6] the Surgeon General observed.

Health insurance plans have long imposed barriers that limit access to needed behavioral health care with far-reaching and often tragic results. No comparable barriers limit access to needed care for ANY other illness. That such discriminatory practices have continued—more than a decade after enactment of the Americans with Disabilities Act, some 40 years after the adoption of the first modern civil rights' laws, and nearly a century since this organization's establishment as a movement based on principles of social justice—attests to the deep-rootedness of the stigma surrounding behavioral health disorders. But that such ongoing arbitrary discrimination should be countenanced by Federal law is shameful.

The need to establish benefits-parity must be understood not simply in terms of equity and social justice, but in human terms. So let me put a human face on it and tell you briefly about **Ruth, a woman with a more than 20-year history of battling major depression, so severe that she once attempted to end her life. Mental health care, covered by her husband's employer, a Fortune 500 company, has helped keep the illness in check. But she reported to us that she recently learned she had reached her health plan's LIFETIME outpatient mental health care limit of 90 visits—a limit of which she was unaware. She chillingly reported, "I'm afraid I will have to discontinue at**

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[1] "Depression a Leading Contributor to Global Burden of Disease." H. Worley. Population Reference Bureau. June 2006. As Retrieved on *http://www.prb.org/Template.cfm?Section=PRB&template=/ContentManagement/ContentDisplay.cfm&ContentID=13891*.

[2] Mental Health. Guide to Community Preventive Services Website. Centers for Disease Control and Prevention. www.thecommunityguide.org/mental/. Last updated: 06/14/2005.

[3] "Global Mental Health." Kastrup, M.C., and B.R. Ramos, Danish Medical Bulletin. Vol. 54, No. 1, Feb. 2007, pp. 42–3.

[4] "Mental Health: A Report of the Surgeon General," 1999.

[5] "National Institute of Mental Health, *Depression: A Treatable Illness*," NIH Publication No. 03–5299. 04. http://menanddepression.nimh.nih.gov/infopage.asp?id=15. Rockville, MD; National Institute of Mental Health: 2004.

[6] "Surgeon General," p. 23.

least the therapy which will leave me floundering in depression with suicidal tendencies." Is it conceivable that a health insurer would impose a lifetime-coverage bar on people with any other illness, let alone one that is life-threatening? In considering that question, it is important to note that some 30,000 Americans take their lives every year to what the President's New Freedom Commission on Mental Health characterized as a largely preventable public health problem.[7]

The widespread practice of providing unequal coverage for behavioral health and other medical care not only limits access to needed care, but subjects many Americans to the risk of major financial losses from out-of-pocket costs. At the most profound level, these practices reinforce the poisonous stigma underlying disparate treatment of "others." That disparate coverage of behavioral health should be both routine and lawful is not only morally offensive, but—in our view—fosters a climate that tolerates other forms of discrimination and tends to weaken the fabric of equal-opportunity laws.

Congress took a first step toward ending discriminatory insurance practices when it enacted the Mental Health Parity Act of 1996. The Act established the principle that there should be no disparity in health insurance between mental health and general medical benefits. By its terms, however, the Act provided only that employer health plans that cover more than 50 employees and that offer mental health benefits may not impose disparate *annual or lifetime dollar limits* on mental health care.

The 1996 Act represented an important milestone, but has not produced fundamental changes. People with or at risk of behavioral-health disorders still face widespread, arbitrary discrimination in insurance plans. As the General Accounting Office (GAO) reported in reviewing the Act's implementation, the vast majority of employers it surveyed complied with the 1996 law, but substituted new restrictions and limitations on mental health benefits, thereby evading the spirit of the law.[8] As GAO documented, employers routinely limited mental health benefits more severely than medical and surgical coverage, most often by restricting the number of covered outpatient visits and hospital days, and by imposing far higher cost-sharing requirements.[9]

Although subsequent efforts to enact a comprehensive Federal parity law have been unsuccessful, the Federal Government further advanced the principle of parity by requiring participating insurers under the Federal Employee Health Benefits program (FEHB), which covers Federal employees (including Members of Congress), retirees and dependents, to equalize behavioral-health and other health benefits for all conditions in the DSM IV as of January 2001.[10]

Most States have adopted laws requiring parity between mental health and general health benefits in group health insurance. But those State laws vary widely in scope, and, under Federal law, do not govern the health plans of the many employers who elect to self-insure.[11]

The Cost of Parity

Those who oppose parity legislation often assert that it will add to the cost of health care. But the assumptions and models on which parity-opponents have relied have actually been overtaken by major changes in insurance practice as well as changes in clinical practice, and subsequent studies have obliterated the foundations for the assertion. Nevertheless, the myth that parity will increase costs retains a life of its own.

As early as the 1950's, insurers worried that intensive long-term psychotherapy would drive up premiums, and began excluding or setting limits on mental health benefits.[12] The RAND Health Insurance Experiment undertaken in the 1970's was particularly influential in this regard. That study, which randomly assigned families to insurance plans with varying deductible and co-insurance levels, provided a basis for inferring utilization rates based on different health insurance design. The study found that demand for mental health services would rise more than two times that

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[7] "Interim Report to the President," New Freedom Commission on Mental Health, p. 14, 2002.

[8] "Mental Health Parity Act: Despite New Federal Standards, Mental Health Benefits Remain Limited," United States General Accounting Office, p. 21, May 2000.

[9] Id. at pp. 13–14.

[10] Federal Employee Health Benefits Program Carrier Letter, April 11, 2000.

[11] The Employer Retirement Income Security Act of 1974 (ERISA) allows employers to offer uniform national health benefits by preempting States from regulating employer-sponsored benefit plans. Thus, while States can regulate health insurers, they are unable to regulate employee benefit plans established by employers. Federal parity legislation explicitly amends ERISA to ensure that self-insured employer health plans are subject to Federal parity requirements. (*See* H.R. 1402, 109th Congress.)

[12] Barry, C.L., R.G. Frank, and T.G. McGuire. "The Costs of Mental Health Parity: Still an Impediment?" *Health Affairs*. Vol. 25, No. 3, pp. 623–634.

for general medical care with better health benefits.[13] Thus, the research showed that mental health services are more price elastic, and that if patients pay less, in the form of copays and deductibles, they will use more services, and vice-versa. The RAND estimates were based on unmanaged fee-for-service indemnity arrangements. But insurance practices have changed markedly, with fee-for-service indemnity coverage having largely disappeared and with the advent of managed care techniques. In addition to the development of cost-control mechanisms other than benefit design, changes in clinical practice—to include the development of new, more effective psychotropic medications and short-term psychotherapy—have also contributed to lowering the cost of mental health care.[14] In this environment, studies have repeatedly shown that the implementation of parity, which has consistently been accompanied by the use of managed care, has not resulted in significant increase in cost.[15]

The largest study of parity to date analyzed 4 years of data in evaluating the experience with mental health and substance use parity under the Federal Employees Health Benefits program (FEHB). The evaluation, commissioned by the Department of Health and Human Services, was undertaken by Dr. Howard Goldman of University of Maryland School of Medicine as the Principal Investigator, who led a team that included Northrup Grumman Information Technology, RAND, Weststat, and Harvard Medical School's Department of Health Care Policy. The extensive evaluation study analyzed benefits data for ALL FEHB plans, and studied claims data on access, utilization, and cost for a subset of FEHB plans that covered 3.2 million beneficiaries, and compared this data for nine FEHB plans (for the 2-year period prior to parity and the 2-year period under parity) with matched data from nine non-FEHB plans. The FEHB plans were selected for in-depth study on the basis of characteristics on which they were likely to differ—geographic location; breadth of parity under State law, differences in plan types and structure, and size of the enrollee population. The study found that all FEHB plans complied with the parity policy; most plans enhanced their mental health and substance use benefits (84% changed the amount, scope or duration of MH benefits and 75% changed cost-sharing requirements); and that there was no evidence of changes in general medical care benefits resulting from the parity policy. Further, the evaluation showed that parity was implemented with some increase in utilization of mental health care but the increase in utilization was consistent with "secular trends" (i.e. consistent with the increase experienced in the matched non-FEHB plans). Of particular significance, while the cost of mental health care did increase, that increase was in line with the experience in matched plans that did NOT provide parity. The study concluded, therefore, that *parity did not result in cost increases*. In most plans, however, beneficiary out-of-pocket costs declined. In terms of a "bottom line," this exhaustive study showed that the parity policy was implemented as intended with little or no significant impact on access, spending, or quality, while in most instances providing users of mental health and substance use care with improved financial protection.[16] It is certainly a very powerful study, and should provide strong assurance that employers can equalize medical and mental health benefits without increasing costs.

It is unfortunate that cost has assumed such a high profile in the debate over parity. Indeed the focus on parity's purported costs has overshadowed the more compelling reality that the real costs lie in NOT treating behavioral health disorders. The business community itself has come to recognize that those costs include excess turnover, lost productivity, absenteeism, and disability.[17] And leaders in the business community have not only voluntarily provided mental health parity as part of their employee health coverage, but have endorsed the enactment of Federal parity legislation.[18] But it should also be appreciated that as private insurance has limited mental health coverage through such practices as durational limits and higher cost-sharing burdens, it has shifted risk AND cost to the public sector, with that burden borne at all levels of government, and with resultant additional pressure on pro-

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[13] W.G. Manning, et. al. "Effects of Mental Health Insurance: Evidence from the Health Insurance Experiment." Pub. No. RAND R–3015–NIMH/HCFA. Santa Monica, CA; 1989.

[14] Estimating the Costs of Parity for Mental Health, Robert Wood Johnson Foundation Workshop, May 2001.

[15] See, "The Costs of Mental Health Parity: Still an Impediment?", Barry, C.L.; Frank, R.G.; and McGuire, T.G.; Health Affairs, 25, no. 3 (2006), 623–634.

[16] "Behavioral Health Insurance Parity for Federal Employees," New Eng Jnl of Medicine, 354, no. 13, (March 30, 2006); 1378–1386.

[17] "An Employer's Guide to Behavioral Health Services," National Business Group on Health, November 2005.

[18] See Hackett, J.T., CEO of Ocean Energy Inc., testimony before the Subcommittee on Health of the Energy and Commerce Committee, House of Representatives, July 23, 2002.

grams and systems ranging from Medicaid to prisons, jails and juvenile justice systems.

The discrimination in health insurance against people with or at risk of behavioral health disorders; the lack of real protection in current law against such discrimination; and the loss of life, health, and productivity attributable to these insurance barriers make it critical that Congress ensure that health plans equalize medical and behavioral health benefit structures. 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).[19] It is wholly appropriate, accordingly, for Congress to condition entitlement to this tax benefit on employers' providing health benefits in a nondiscriminatory manner.

Public Support for Parity

A vast majority of Americans (89%) oppose insurance discrimination against people with mental health needs, according to a survey Mental Health America conducted late last year. Among its findings, the survey data showed that nearly all Americans (96%) think health insurance should include coverage of mental health care (with only 2 percent responding that health insurance should not cover it, and a large majority (74%) responding that insurance plans should cover substance use treatments at the same levels as treatments for general health issues. Significantly, the public's views on mental health and addiction equity is bipartisan—83% of Republicans and 92% of Democrats support equitable health insurance.

Mr. Chairman, Mental Health America has seen clear evidence of those views in its work to help organize and mount the public forums initiated by the *Campaign to Insure Mental Health and Addiction Equity*, a national clarion call on the need for parity that Representatives Jim Ramstad and Patrick Kennedy launched early this year. In town meetings across the country, the Equity Campaign has powerfully documented the profound effects that discriminatory insurance practices have had on individuals and on the Nation, ranging from job loss and reduced productivity, to increased general health care costs and costs to public systems, to loss of life. That compelling testimony can be found on our equity website, *www.equitycampaign.net*.

Since initiating their Campaign, Representatives Kennedy and Ramstad have introduced the Paul Wellstone Mental Health and Addiction Equity Act of 2007. *That legislation, H.R. 1424, reflects the longstanding views of Mental Health America, and we enthusiastically support House passage.*

Medicare

Today, millions of older Americans and people with disabilities face mental illness, often without the services and supports they need. Some 20 percent of older Americans experience mental disorders, such as anxiety disorders, mood disorders (including depression and bipolar disorder), and schizophrenia.[20] However, two-thirds of older adults living in the community who need psychiatric services do not receive them.[21]

Furthermore, individuals receiving Medicare because of a disability also frequently experience mental illness. Some estimates indicate that over 50 percent of beneficiaries whose Medicare eligibility is based on disability have some kind of mental disorder[22] and according to a survey by the Kaiser Family Foundation, over two-thirds say they often feel depressed.[23] Moreover, psychiatric disorders, such as schizophrenia, bipolar disorder, and depression, were the second most commonly reported conditions among beneficiaries with disabilities.[24]

The President's New Freedom Commission on Mental Health stated in its final report that "[t]he number of older adults with mental illnesses is expected to double to 15 million in the next 30 years . . . [and] [m]ental illnesses have a significant impact on the health and functioning of older people and are associated with increased health care use and higher costs."[25] The Commission recommended that

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[19] *See* 26 U.S.C.A. sec. 162(a)(1).

[20] Administration on Aging, U.S. Department of Health and Human Services, *Older Adults and Mental Health: Issues and Opportunities*, 2001, p. 9.

[21] Medicare Rights Center, *Medicare Facts and Faces*, October 2001.

[22] The Henry J. Kaiser Family Foundation, *The Faces of Medicare: Medicare and the Under-65 Disabled*, July 1999; National Health Policy Forum, George Washington University, *Medicare's Mental Health Benefits*, February 2007, p. 6.

[23] The Henry J. Kaiser Family Foundation, *Understanding the Health Care Needs and Experiences of People with Disabilities: Findings from a 2003 Survey*, December 2003, p. 4.

[24] Ibid.

[25] New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America. Final Report*, p. 59.

"[a]ny effort to strengthen or improve the Medicare and Medicaid programs should offer beneficiaries options to effectively use the most up-to-date [mental health] treatments and services." [26]

Access to treatment through the Medicare program has long been restricted by outdated and discriminatory policies. One of the primary barriers to mental health care for Medicare beneficiaries is the 50 percent co-insurance rate imposed on outpatient mental health treatment, instead of the usual 20 percent co-insurance charged for other outpatient services.

Mr. Chairman, we commend you for your leadership in introducing legislation in the past to repeal the higher co-insurance rate for outpatient mental health services as well as addressing other limits on mental health coverage in Medicare.

Limits on outpatient care in Medicare have resulted in much higher utilization of expensive inpatient care among Medicare beneficiaries than other populations. According to an analysis by the Substance Abuse and Mental Health Services Administration (SAMHSA), "Medicare beneficiaries are much more likely than Medicaid beneficiaries to receive inpatient mental health and substance abuse care, if they receive any mental health or substance abuse services at all" and "Medicare beneficiaries are less likely than Medicaid beneficiaries to receive mental health and substance abuse treatment in ambulatory outpatient facilities." Moreover, when Medicare beneficiaries do receive inpatient care, the care is more intensive, presumably because these individuals have not been able to access adequate outpatient care. According to SAMHSA, "Medicare annual costs per claimant for inpatient mental health and substance use services are higher than costs for Medicaid." [27]

Medicare also imposes a 190 lifetime cap on inpatient days in free-standing psychiatric hospitals. For other illnesses and injuries, the inpatient hospital coverage limit is 150 days, but that limit applies to each period of illness, and the clock is reset each time a person is out of the hospital for over 60 consecutive days. The mental health limit is calculated on a cumulative basis over each individual's lifetime. This lifetime limit is most likely to affect beneficiaries with serious mental illnesses who often have multiple hospitalizations. Limiting coverage of specialty psychiatric facilities undoubtedly creates significant barriers to care in communities where the general hospitals lack psychiatric capacity.

Improved access to outpatient services would reduce the need for costly inpatient psychiatric care by Medicare beneficiaries. Many individuals with more severe mental disorders require intensive outpatient care, but Medicare does not currently cover many of these types of services, including psychiatric rehabilitation, intensive case management, assertive community treatment, and residential detoxification services. Access to these intensive outpatient services would help fill gaps in the continuum of mental health care covered by Medicare.

Again, Mr. Chairman, we applaud your leadership in addressing these shortcomings in mental health care under Medicare as well.

Chairman STARK. Dr. Quirk, would you like to enlighten us?

STATEMENT OF MICHAEL QUIRK, PH.D., DIRECTOR, BEHAVIORAL HEALTH SERVICE, GROUP HEALTH COOPERATIVE, SEATTLE, WASHINGTON

Mr. QUIRK. Chairman Stark, Mr. Camp, thank you very much for the invitation to participate today. I am Mike Quirk from Group Health Cooperative. I am the director of Behavioral Health Service from Seattle, Washington. I would like to share with you some of Group Health's views on parity. First of all, Group Health is a health care system that has 560,000 residents from the State of Washington and northern Idaho that receive medical care from us. Seventy percent of that care occurs in our owner-operated facilities.

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[26] Id., p. 26.

[27] Letter to Representative Pete Stark from Substance Abuse and Mental Health Services Administrator, Charles G. Curie, U.S Department of Health and Human Services, including a report comparing utilization rates and payments for mental health and substance abuse treatment services provided through Medicare, Medicaid, and private insurance, May 22, 2002.

Within Behavioral Health we see 30,000 new patients every year, which equates to a total of 200,000 patient contacts.

Let me just comment a little bit about the nature of Behavioral Health. These conditions are highly prevalent. Twenty-five percent of us in any given year will have a psychiatric disorder or a chemical dependency problem. Fifty percent of us will have such a condition over the course of our lives. Most of us choose to get this care from primary care providers, nutritionists, family doctors, general and internal medicine physicians. Accordingly, we have a collaborative approach in that regard. Those patients that come to see us are the most ill. They are also the ones who prefer privacy and talk therapy.

The care is effective to the extent that it is evidence-based, which means that it is related to interventions that make a difference in people's lives; and the care is successful, meaning that you can get in.

Let me talk a little about Group Health's view in relationship to parity. Group Health is the only health system in the State of Washington that has supported parity in our State legislature. We are very much aware of the concerns in regards to mandates, relative to flexibility, and also in regards to cost.

In relationship to flexibility, our recommendation to you is to craft Federal parity so it is organized around medical management principles. We believe that will increase the flexibility for patients. By medical management, I mean two things. I am talking about medical necessity, making sure you are providing services to people with conditions that can profit from them. I am also talking about appropriate care, which means provide as much as is necessary to help people return to their previous levels of functioning. No less, no more.

In support of our views, the New England Journal of Medicine published an article last year that reviewed the experience with Federal employees and parity, and essentially they demonstrated that, with use of medical management principles, good insurance was assured, and quite affordably as well. So, what would medical management look like at Group Health?

Basically for patients with mild conditions they would come in to Behavioral Heath Service and we would provide counseling services. So, services are basically in support of helping people with their coping skills to deal with life adjustment.

For people with major psychiatric disorders that are uncomplicated, most of those people are seen in primary care for medicine, in relationship to which we have a consultative and a collaborative role. In other words, our psychiatrists help them with selection of medicines and the dosing and the duration. Our psychotherapists help when supplementary counseling is necessary.

For patients who have major complicated severe illness, they are seen for a prolonged course in Behavioral Heath by a psychiatrist and our nurses. Our goal is to work with them so that they are stabilized and they have good lives.

So, essentially what does parity mean to those of us at Group Health? It means a great deal.

As Americans, we all want a good run at life. If you have a psychiatric disorder or if you have a chemical dependency problem,

you have obstacles in your way. With parity, many of those obstacles are taken away. With medical management principles, there is a greater likelihood of an even playing field with higher assurance of access, availability, good results, and affordability.

So, I am from the other Washington. I don't know all the details in regards to the various points of view relative to the different types of legislation, but I think the things that were uniform in relationship to what I have heard consistently today is to support parity for the future.

So, as I conclude, I just want to particularly thank Congressmen Ramstad and Kennedy for their courage and their leadership in regards to this important legislation, and Congressman Stark as well.

I also want to acknowledge Congressmen Baird and McDermott for their professional and political support of this important legislation not only here but in the State of Washington as well. Thank you.

[The prepared statement of Mr. Quirk follows:]

Prepared Statement of Michael Quirk, Ph.D., Director, Behavioral Health Service, Group Health Cooperative, Seattle, Washington

Good morning, Chairman Stark and Members of the House Ways and Means Subcommittee on Health. I am Mike Quirk, clinical psychologist, and director of the Behavioral Health Service at Group Health Cooperative, Puget Sound, which is based in Seattle, Washington.

Thank you for inviting me to be here this morning, as you think through how to best address mental health and substance abuse parity through Federal legislation. Despite the difficult decisions ahead, we are here today to discuss how—not whether—to pass a bill on this important issue. And I thank you for your leadership in getting us to this point.

I would like to take a few minutes to tell you about Group Health Cooperative's history and experience on the issue of mental health parity, why we support equity of mental health and medical care, and what we see as the essential elements of a successful parity bill. We see a critical role for the Federal Government on this issue, and believe that national mental health parity policy will work best if it allows carriers the flexibility to design coverage and services that will benefit both individual patients and whole populations of people with similar problems, such as depression, anxiety, schizophrenia, bipolar disorder, and ADHD.

First, let me introduce you to Group Health Cooperative: Group Health is a nonprofit health care system that provides both coverage and care. We cover more than 560,000 residents of Washington State and northern Idaho, about 70% of whom receive care in Group Health owned-and-operated medical facilities.

Group Health's Behavioral Health Services provides care to patients with mental and chemical dependency disorders, including adults, adolescents, and children. We see 30,000 new patients every year, with a total of 200,000 patient contacts per year. We believe that the best way to better health is via high-quality evidence-based care. And in our integrated behavioral health and medical delivery systems, we believe that access to care is the first and one of the most important roads leading to quality.

Mental health concerns are highly prevalent, affecting about one-quarter of all adults in the U.S., with variable but often very high impact on health and productivity. But such disorders are also generally treatable, as long as patients have access to mental health care coverage, and to a behavioral health provider.

At Group Health, access to appropriate, necessary care is priority one. We bring together our behavioral health service with our medical team to take care of the whole patient. For example, patients with depression benefit from closely integrated mental health and primary care services.

In 2005, Group Health was the first coverage provider in Washington State to support legislation—which subsequently passed—on mental health parity in the large group market. Washington State now has one of the most progressive mental health parity laws in the country. And Group Health was the only health plan to support coverage in the individual market, which just passed our State legislature.

Washingtonians are benefiting from the State's mental health parity law. But with your leadership, we can and should go one step further. Federal parity legislation would extend this protection nationwide, protect those covered by self-funded employers, and further improve equity of Washingtonians' access to needed mental health and substance abuse services.

Parity benefits all sides of the health care system: it allows for flexibility in planning care, has a modest impact on cost, and reduces the likelihood that coming to or staying in necessary services is obstructed because of financial barriers to care.

But in order to achieve its greatest possible positive impact, Federal mental health parity legislation must balance the requirement of parity with the flexibility to clarify the basis for care and the nature of services to fit the individual patient and for populations of patients with similar problems. This requires the following things:

First, Federal legislation should allow carriers like Group Health the flexibility to make reasonable determinations of medical necessity in order to determine who will benefit from care.

Second, Federal legislation should ensure that the clinical care will be appropriate and effective, and that patients have access to services which will reduce symptoms and return them to a reasonable level of functioning as quickly as possible.

These points get to the heart of making mental health parity work. Research on parity for Federal employees has shown that parity of coverage of mental health and chemical dependency services, when combined with effective care management, can lead to greater fairness and insurance protections without significant adverse consequences for health care costs.[1]

And these points support the goal that I and my colleagues at Group Health hold personally and professionally dear: To care for the greatest number of patients possible who will benefit from these services, in the most effective and efficient way.

In policy terms, this means combining transparency around medical necessity criteria with quality improvement programs and adequate appeals processes, because patients should be apprised of how we make clinical decisions so that they can understand them and if needed challenge them. It means providing care and coverage for the right set of treatable conditions, and allowing providers to work with patients to find the right treatment plan. Finally, it means finding the right balance between ensuring access and making sure that resources are maximized to provide care to as many as possible of patients in need.

In human terms at Group Health, this means working with patients with mild mental disorders to tailor and tune new coping mechanisms to adapt to challenging life events. It means integrating the mental health and primary medical care of patients with major but uncomplicated mental disorders, helping them to stay active and to interpret their experiences in a constructive way, while taking any needed medications as long as is appropriate. And it means providing the most challenged patients with ongoing case management assistance from a nurse or team of providers who can help them glue together their personal lives, work lives, and medical care to keep the ball rolling.

Because really, every single one of us just needs to keep the ball rolling. All any of us want is a good run at a healthy life, but people with mental illness have set off running on a path confounded by obstacles. Parity allows us to remove many of the financial obstacles. At the same time, the flexibility to ensure that care is necessary and appropriate helps us steward this limited resource so that behavioral health services will continue to be affordable for all.

Finally, Federal legislation should protect the progress that has been made in States like Washington, and should not inhibit States from finding new or innovative ways to bring mental health and substance abuse services to people who need access. Over the last 2 years, we have made significant improvements in access to mental health care for people in Washington State. I hope that Federal parity legislation will help us bring care to even more.

I thank you for your attention, and for considering my recommendations, from the perspective of one who has provided mental health services for over 20 years. I hope you will think of Group Health as an ally and advisor as you move forward with legislation. And now I welcome your questions.

Chairman STARK. Thank you.

[1] Goldman, HH, Frank, RG, Burnam, MA, et. al. Behavioral Health Insurance Parity for Federal Employees. *N Engl J Med* 2006; 354:1378–86.

Thank you. I am now most pleased to have Ms. Westin testify. She has also, as our first panel, had serious tragedies in her own life, which she has turned into a crusade, if I may.

We are happy to have you here to let us join with you in your efforts. Why don't you proceed?

STATEMENT OF KATHRYNE L. WESTIN, M.A., L.P., EATING DISORDERS COALITION FOR RESEARCH, POLICY AND ACTION

Ms. WESTIN. Thank you, Mr. Chairman and Members of the Committee. It is really an honor to be here today, but it also feels like a huge responsibility because I realize that I am a voice for the millions of Americans who are suffering from mental illness and who are being denied care by their insurance companies. I just realized this morning that I am also a voice for the 30,000 Americans that committed suicide last year. So, I take this very seriously.

I understand this better than most, because when my daughter needed care, she was denied treatment by our insurance company. My family's experience illustrates the suffering and the almost unspeakable consequences when insurance companies are allowed to discriminate against people with mental health issues. This discrimination is killing people and we have to stop it as soon as we can.

But before I talk about parity, I really want to just spend a minute talking about Anna. Anna was an amazing young woman. She was spirited, gifted, talented. She was the most kind and generous person I think I have ever known. She had a future full of promise and possibilities until she was diagnosed with a serious illness.

She was diagnosed with an illness that has the highest mortality rate of any psychiatric disorder, with a death rate of up to 20 percent. She was diagnosed with anorexia, an eating disorder. Anna died on February 17, 2000. She was diagnosed first when she was 16. It was scary for us but we had good insurance and access to care. She was treated in an outpatient setting, and I thought she had fully recovered. At that time I didn't know that treatment very often is a very slow process and oftentimes takes years. I was totally blindsided when she relapsed and our insurance company became an obstacle to her recovery.

She relapsed in 1999 and we knew that she was really in a battle for her life, she was so sick. But, again, we were so confident that she would have access to the care she needed.

We took her to a hospital. We had the very best insurance money could buy. We had a Cadillac insurance plan. We really believed and trusted that our insurance company would be part of the team that was fighting to save Anna's life. I still have trouble believing that insurance companies are allowed to pick and choose what diseases they will cover.

We brought her to the hospital. She was diagnosed with anorexia. The doctors recommended immediate inpatient care because she was in critical condition and they told her she would die. Imagine our horror when they told us to take her home until insurance authorized that treatment.

It is almost unbelievable. According to our insurance company, almost all of Anna's care was, quote, not medically necessary. I couldn't believe that a medical director of the insurance company was authorized to make decisions about Anna's treatment without ever examining Anna. Those decisions proved to be fatal.

I still have trouble understanding how someone so sick could be treated so casually just because of their diagnosis. I have no doubt that if I had brought Anna into the hospital that day with the same symptoms caused by some, quote, physical abnormality, she would have been admitted without question. She would have gotten the best care available and she would have stayed there until she was fully recovered.

Now, I don't blame the insurance company for Anna's death, anorexia killed her, but I do hold them partially responsible. They repeatedly denied the coverage that her doctors were recommending. Her treatment team warned us that without intensive specialized care, Anna would die.

Imagine an insurance company denying chemotherapy to a cancer patient. It is almost unthinkable. The insurance company's statements to Anna saying that her care was not medically necessary only reinforced her own denial about her illness, which is a common thing for mental illness and eating disorders and, sadly and most tragically, their denials caused Anna to believe, because we were paying for her care, that she was a burden to our family and that we would be better off if she were dead.

The last words she wrote in her journal were "My life is worthless right now. Saying goodbye to such an unfriendly place can't be as hard as believing in it. Essentially my spirit has fled already."

Try to imagine what it would be like to watch your child struggle with a disease that ravages the body and the mind. I lived with Anna's hopelessness and despair, and I watched her slip away from me. It was heartbreaking watching her fight when there were roadblocks being erected along the way, all along the way. I knew that much of those roadblocks were driven by ignorance and money.

I am confident that if this comprehensive mental health parity bill had been in place, Anna's chances of survival would be much greater and she probably would be alive today.

Sadly, it is too late for Anna, but it is not too late for the millions of Americans who struggle with mental illness. The story you just heard isn't unique. I hear stories like this every single day. I hear people. They call me, they are crying and begging for help after their insurance company has denied care for their child. They spend their savings, their retirement, their college accounts. They borrow from everybody they know. They have no place else to turn. This breaks my heart and it is outrageous that we are still fighting this battle.

After Anna died, I vowed to do everything I could to fight eating disorders, and I started the Anna Westin Foundation and I also started the Eating Disorders Coalition. We are a Washington-based organization that is working to increase the awareness and educate policymakers to the devastating effects of eating disorders. We worked really closely with Congressman Jim Ramstad and Congressman Patrick Kennedy and we applaud your efforts—your entire efforts—to pass the mental health parity. It is just such a

strong piece of legislation and I urge everybody here to support this lifesaving legislation.

Every day we wait, another Anna dies unnecessarily. We need this parity bill that includes eating disorders, substance abuse, and all mental illnesses. This bill will improve the lives of Americans with mental illness and it won't preempt State laws, another really important point that has been brought up several times today.

This bill will give people much-needed hope, and to quote Congressman Ramstad, "This is a life-and-death issue for millions of Americans." I couldn't agree with you more.

Please support parity legislation and pass this bill. It will save lives and it will prevent the suffering that Anna faced and that her family has faced.

Thank you.

[The prepared statement of Ms. Westin follows:]

Prepared Statement of Kathryne L. Westin, M.A., L.P.,
Eating Disorders Coalition for Research, Policy and Action

It is an honor to be here today to talk with you about the need for mental health parity legislation. It is also a huge responsibility because I am speaking for the millions of Americans who are affected by mental illness and who have been denied treatment by their insurance companies. I am the voice for people who are vulnerable and suffering and who are desperate for your help. I probably understand this better than most because my daughter Anna, who suffered from an eating disorder, was denied care when she needed it to save her life. I am here as a mother who paid the ultimate price for our country's unwillingness to pass parity legislation. My family's experience illustrates the suffering and unspeakable consequences when insurance companies are allowed to discriminate against people with mental illness. This discrimination is killing people and needs to stop now. Congressmen Ramstad and Kennedy's parity bill, with comprehensive language that includes diagnoses like eating disorders is a key step in saving lives.

Before I talk about parity I want to tell you about my daughter Anna. Anna was a spirited, vibrant, gifted young woman. She grew up in a small town in MN with a family who cherished her. She had a smile that could melt your heart and she was one of the kindest and most generous people I have ever known. She had dreams, goals and a future full of promise and possibility until she was diagnosed with a deadly illness. Anna was diagnosed with a mental illness that affects over 10 million American women and 1 million American men, a disease that has the highest mortality rate of ANY psychiatric illness with a death rate of up to 20 percent. Anna suffered from an eating disorder; anorexia. She died on February 17, 2000; she was just 21 years old.

Anna was first diagnosed with anorexia when she was 16 years old. I admit that my husband and I actually breathed a sigh of relief when she was finally diagnosed because once we knew what illness she had we could get on with the treatment and healing. We had good insurance and I was confident that she would get the care she needed. I really did believe the worst was over; I could not have imagined what was in our future.

Anna was treated in an outpatient setting when she was first diagnosed and she seemed to fully recover. We were optimistic that she was back on track and that life would return to "normal." At the time nobody told me that recovery would most likely be gradual and could take years. We were totally blindsided when she relapsed and our insurance became the obstacle to her recovery.

When Anna relapsed in June of 1999 we knew that she was in for the fight of her life; she was extremely ill. Her symptoms included heart abnormalities, low blood pressure, kidney failure and dizziness but we were confident that she would have access to the best care available. After all, our family had the best insurance money could buy and we trusted that they would join us and be part of the "team" fighting to save her. We understood that by purchasing the "Cadillac" of insurance plans our family would be covered for both minor and major health problems. We never dreamed that insurance would be allowed to decide what illnesses are covered. I cannot even begin to describe our reaction when we learned that our insurance company had denied Anna the care her doctors told us was necessary. We had brought her to a hospital that specialized in treating eating disorders. She met cri-

teria for a diagnosis of anorexia and her doctors were recommending immediate inpatient care because she was in critical condition. Imagine our shock when we were told to take her home until the insurance company authorized her care. At first I thought it was a misunderstanding but I soon realized that it was not a mistake. According to our insurance company Anna's care was "not medically necessary." Suddenly we were forced to somehow "prove" that Anna was sick enough to get the care her doctors recommended. I could hardly believe that the medical director of the insurance company was given the authority to make decisions about her care without even examining her; decisions that would prove fatal. To this day I have trouble understanding how someone so sick could be treated so casually by insurance only because she happened to be diagnosed with a mental disorder.

I have no doubt that if I had brought Anna to the hospital that day with similar symptoms caused by a "physical" illness she would have been admitted without question and she would have gotten the best care available until she was fully recovered. Instead, Anna fought her eating disorder and at a time when we should have been totally focused on helping Anna we were forced to put energy into fighting with our insurance company.

I don't blame our insurance company for Anna's death, anorexia killed her but I do hold them partially responsible. Our insurance company repeatedly denied coverage for Anna's treatment even though her treatment team (which included medical doctors, a psychiatrist, a psychologist, a dietician, and several other professionals) warned that intensive, specialized care was vital to save her life. Imagine an insurance company denying the necessary chemotherapy for a cancer patient. The insurance company's portrayal that treatment was not medically necessary encouraged Anna's own denial about the seriousness of her illness; a common trait of eating disorders. One of the most heartbreaking results of the denial was Anna's belief that, because we were paying for her care, she was a burden to our family and we would be better off if she were dead. The last words she wrote in her journal were: "My life is worthless right now. Saying goodbye to such an unfriendly place can't be as hard as believing in it. And, essentially my spirit has fled already."

Try to imagine what it would be like to watch your child struggle with a disease that ravages the body and the mind. To be a witness to the suffering, helplessness, and excruciating pain. I lived with Anna's hopelessness and despair and I watched her gradually slip away from me. I was heartbroken watching her fight for her life confronted with roadblocks all along the way that were constructed by people who made excuses like "there is no effective treatment for eating disorders so we don't pay for care." I knew that money and ignorance were the driving force behind the denials. I am confident that if this comprehensive mental health parity law had been in place Anna's chances of survival would have been greater. She would not have felt like a burden, she would not have been stuck in the revolving door of treatment that only seemed to strengthen her illness and she would have felt supported.

Sadly, it is too late for Anna but it is not too late for the millions of Americans who suffer from eating disorders and other mental illnesses. The story you just heard is not unique; I talk to people every day who have similar experiences. I listen as parents cry and beg for help for their daughters and sons after insurance refuses to pay for care. I hear stories from families who have spent all of their savings, retirement, and college accounts and who have borrowed from family and friends and have nowhere else to turn. I know families who have taken out second and third mortgages on their homes to help cover the cost of care to save their child. It breaks my heart and makes me furious that we still have not passed parity and done all we can to insure that people get the care they need. It is an outrage that people who have purchased insurance and trust that they will be protected in the event of illness are still being denied care based on diagnosis. This IS discrimination!

After Anna died I vowed to find a way to transform my grief and rage into something positive. Within days of Anna's death our family founded the Anna Westin Foundation and within months I joined the Eating Disorders Coalition for Research, Policy and Action; a Washington D.C.-based advocacy organization that has been working to increase awareness, educate policymakers, and promote understanding about the disabling and life-threatening effects of eating disorders. We have worked closely with Congressman Jim Ramstad and Congressman Pat Kennedy and we are extremely grateful to them for their tireless efforts to pass mental health parity. We urge you to join them in support of this lifesaving legislation. Every day we wait another Anna dies unnecessarily of an eating disorder. We need a parity bill that includes eating disorders, substance abuse and other mental illnesses. This bill will improve the lives of people with mental illnesses throughout the country without preempting State laws that are already in place.

This is an exciting time; when I told my friends and colleagues that I was speaking to you today it gave them much needed **HOPE**. **HOPE** that the system can and will change, **HOPE** that their daughters and sons will finally have access to care and **HOPE** that their voices will be heard. In 2001, immediately following the Help Panel's approval of Mental Health Parity I spoke to my dear friend, the late Senator Paul Wellstone, and he told me how excited he was that parity was moving forward because it would finally end discrimination against people with mental illness. More recently, Congressman Jim Ramstad said: "It's time to finish what we started in 1994 with our good friend and colleague, the late Senator Paul Wellstone, and end discrimination against people with addiction. This is a life-or-death issue for millions of Americans." I agree with Congressman Ramstad; ***this is a life-or-death issue for millions of Americans***. I urge you to pass the "Paul Wellstone Mental Health and Addiction Equity Act" this session. I guarantee, it WILL save lives. Thank you

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Appendix

Why We Need Mental Health Parity Now: A Matter of Life or Death

Millions of Americans suffer from eating disorders, known as anorexia nervosa, bulimia nervosa, binge eating disorder, and eating disorders not otherwise specified. Eating disorders are illnesses with a biological basis modified and influenced by emotional and cultural factors. The stigma associated with eating disorders has long kept individuals suffering in silence, inhibited funding for crucial research and created barriers to treatment. Without proper insurance coverage for treatment someone with a serious eating disorder is at risk for premature death.

High prevalence rate. An estimated 8 million Americans suffer from eating disorders. Eating disorders cut across race, color, gender and socioeconomic categories. No one is immune.

On the rise and affecting children. The incidence of eating disorders has doubled since the 1960s and is increasing in younger age groups, in children as young as seven. Chronic dieting is a primary risk factor and girls at five years old are already concerned about their weight and diet. Eating disorders are not simply a passing phase but serious mental illnesses that need proper treatment and attention.

Impact on health. Eating disorders are commonly associated with substantial psychological problems, including depression, substance abuse, and all too frequently with suicide. They also can lead to major medical complications, including cardiac arrhythmia, cognitive impairment, osteoporosis, infertility, and most seriously, death.

High death rate. Anorexia nervosa has the highest mortality rate of all psychiatric disorders. A young woman with anorexia is 12 times more likely to die than other women her age without anorexia.

Treatment can work. Research shows that eating disorders can be successfully overcome with adequate and appropriate treatment. Such treatments are typically extensive and long-term.

Health insurance companies contribute to high death rate. Insurance companies routinely limit the number of days they will reimburse, which force doctors to discharge patients with eating disorders too early. Although patients with eating disorders often require more than 6 weeks of inpatient therapy for proper recovery, insurance companies typically offer an average of 10–15 days a year. Patients are suffering relapses and are placed in life-threatening situations as a consequence of such managed care coverage limits.

Congress can save lives by passing mental health parity this session. Time has run out. Our daughters, sisters, brothers, mothers, and friends are dying from eating disorder-related causes. Congress cannot afford to wait another day to pass legislation that provides people with eating disorders better access to care.

REQUEST: Pass the Paul Wellstone Mental Health and Addiction Equity Act of 2007.

Facts About Eating Disorders

How Common Are Eating Disorders?

Results from the first nationally representative study of eating disorders in the United States were published in the *Biological Psychiatry*, February 2007. The National Comorbidity Survey Replication (NCS–R) is a nationally representative survey of the U.S. population that was administered face-to-face to a sample of 9,282 English-speaking adults ages 18 and older between February 2001 and December 2003.

A highlight of the results:

- Lifetime prevalence of individual eating disorders is 0.6–4.5%.
- Lifetime prevalence of anorexia nervosa is .9% in women, .3% in men.
- Lifetime prevalence of bulimia nervosa is 1.5% in women, .5% in men.
- Lifetime prevalence of binge eating disorder is 3.5% in women, 2.0% in men.
- Eating disorders impair the sufferer's home, work, personal, and social life.
- Binge eating is more common than anorexia or bulimia and is commonly associated with severe obesity.
- Eating disorders display substantial comorbidity with other mental health disorders.
- While eating disorders often coexist with other mental health disorders, they often go undiagnosed and untreated. A low number of sufferers obtain treatment for the eating disorder.

Other Facts About Eating Disorders

- Doubled since 1960s.
- Increasing in younger age groups, as young as 7 years.
- Occurring increasingly in diverse ethnic and sociocultural groups.
- 40–60% of high school girls diet.
- 13% of high school girls purge.
- 30–40% of junior high girls worry about weight.
- 40% of 9-year-old girls have dieted.
- 5-year-old girls are concerned about diet.

Source: Journal of the American Academy of Child and Adolescent Psychiatry.

Revolving Door

Research shows that discharging patients prematurely (i.e., reached 90% of expected body weight) doubles the likelihood of relapse. According to data from the Renfrew Center, patients in this residential facility had an average length of stay of 50 days prior to the proliferation of managed care contracts. Today, the average length of stay has dropped to 15 days. A consequence to the shorter periods of treatment is that more people are relapsing. Prior to managed care, the return rate was under 10%. Today, it is 33%. This revolving door is a long-term cost on society. The person may end up on disability, unable to work, or otherwise able to contribute. Perpetuating the cycle of illness affects not only the patient and her family, but over time, the same insurance company—or companies—that restricted her treatment in the first place.

Mortality

Anorexia nervosa has the highest mortality rate of any psychiatric disorder, as high as 20%. Risk of death among individuals with anorexia is 12 times greater than their same age peers without anorexia. Death can occur after severe bingeing in bulimia nervosa as well. Health consequences such as osteoporosis (brittle bones), gastrointestinal complications and dental problems are significant health and financial burdens throughout life.

Treatment Can Work

With early detection and intervention.

Treatment must be as complex as the illness including attention to the following:

- Nutritional
- Medical
- Psychiatric
- Psychotherapy with patient, family

Rates of Recovery

- ⅓ recover after initial episode
- ⅓ fluctuate with recovery and relapse
- ⅓ suffer chronic deterioration

If patients do not receive adequate treatment then multiple re-hospitalizations are common.

Health Consequences of Eating Disorders

Anorexia Nervosa

- Heart Muscle Shrinkage
- Slow and Irregular Heart Beats
- Heart Failure
- Amenorrhea
- Kidney Stones and Kidney Failure
- Lanugo (Development of Excessive Fine Body Hair on Face, Arms and Legs)
- Muscle Atrophy
- Delayed Gastric Emptying, Bowel Irritation
- Constipation
- Osteoporosis

Bulimia Nervosa

- Electrolyte imbalance, heart arrhythmia, heart failure
- Teeth erosion and cavities
- Irritation and tears in the throat, esophagus and stomach
- Laxative dependence
- Emetic Toxicity
- Death

Chairman STARK. Thank you very much, Ms. Westin. I appreciate your efforts and your taking the time to share with us both your personal tragedy and your efforts to help us and help the entire community improve the situation so that we won't have more Annas in the world.

Doctor Shern, you described the Act of 96 as a first step. Was there an effort to evade the spirit of that law and do we still need some corrections in the 96 parity law that provide full coverage?

Mr. SHERN. The 96 parity law was monumental in terms of its importance and the bravery that was represented by Senators Domenici, Wellstone and others, Alan Simpson and others, in getting that passed.

However, it didn't get us as far as we needed to go. As you may be aware, Mr. Chairman, the GAO took a look at it, systematically evaluated the impacts of the 96 legislation, and determined that it didn't go far enough, and in fact, that other management techniques were used to essentially frustrate many of the most important intentions of that bill.

That is why it is so important that we continue to push, and pass the parity bill in the House and its companion bill in the Senate.

Chairman STARK. Thank you.

Dr. Quirk, you are a staff model plan?

Mr. QUIRK. Staff model and network, yes.

Chairman STARK. Can you give me some sense—you provide both group plans and individual plans; is that correct?

Mr. QUIRK. That is correct.

Chairman STARK. Under Washington law they have to have parity in——

Mr. QUIRK. So, in 2005, parity was passed for the large-group commercial market, and as of last week there is parity passed in relationship to small group.

Chairman STARK. Now, did you always have parity as a matter of practice in your plan, or did you change and have parity once the law was passed?

Mr. QUIRK. Once the law was passed.

Chairman STARK. Then you have seen, probably, the individual markets too soon to tell, but what could you tell us about any differences in costs to your plan after the 2005 law came in?

Mr. QUIRK. 2005 law is a staggered implementation, so 2006 was equity in cost share; 2008 will be equity in stock loss; and 2010 will be equity in relationship to days and visits.

So, the cost changes with the cost share in 2006 were small. Essentially what it means is that you would pay the same cost share on the medical side as you would on the chemical dependency—or, excuse me, on the mental health side. So, of course, there is a little more cost involved in that, but not a great deal; and there has been a little uptick in the way of utilization to—in terms of people coming in.

Chairman STARK. When you say you have a copayment for all of your visits, both acute care and mental illness?

Mr. QUIRK. Yes.

Chairman STARK. Is it small, or can you tell us the difference prior to the——

Mr. QUIRK. So, prior to the cost-share equity, the cost share was like $20. On the average it would go to $10 with equity.

In relationship to inpatient it was 80 percent covered, and it went to like $300 payment per day.

Chairman STARK. So now what do you anticipate your costs will do in the outyears as you complete the parity program?

Mr. QUIRK. I believe it will be consistent with what we heard earlier today from Congressmen Ramstad and Kennedy, and that is consistent with what the actuarial folks have been telling us. That is for any of our plans that have historically had relatively good—although not parity benefits—and had a managed medical management practice in place, the transition to full parity will not be terribly expensive. It will probably be 1 percent or less. I am anticipating that for us as well.

Chairman STARK. Thank you. Mr. Camp.

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

Dr. Quirk, just following up on Mr. Stark's questioning, you referenced the medical management approach in your plan. Do you believe that coverage for mental health and substance abuse should be based on a treatment plan? If so, should health plans be given the flexibility to use medical management approaches to make sure the plan is established by the provider and followed by the patient?

Mr. QUIRK. I believe so. I have been in Group Health for 23 years. I have been the director for 18 years.

I had the early experience of not having these management principles in place and essentially had access problems and had financial problems. So, with the medical management system in place these days, the majority of the patients get seen within 2 weeks' period of time. We have standards in terms of availability both in network and in staff model. We do patient satisfaction studies and upward of 80 percent of the people who come and receive care from us are very satisfied. They would let us know otherwise if medical management principles were somehow contrary to their wishes. We have few complaints.

When you look at quality of care indicators like the HEDIS post-hospitalization followup measure, Group Health ranks within the top 10 percent of health plans that participate through NCQA in the country, some 250.

So, yes, I think that having an orderly, thoughtful process works in the patient's interests, and we hear very little to the contrary from the patients.

Mr. CAMP. Thank you.

The House bill—I don't know if you are familiar with the legislation before the Congress—requires the employer's plan to cover the same range of mental illnesses as covered by the Federal Employee Benefit Plan, which uses what is known as the diagnostic and statistical mental disorders known as DSM–IV. The Senate bill, in contrast, does not have that same requirement.

There are some conditions in that list as you look at it that really don't seem biologically based or appropriate for medical treatment, frankly, such as sibling relational problems and nightmare disorder, jet lag, other lists.

Do you have the definition in your plan of DSM–IV in Washington State and if so, could you comment on the impact mandatory coverage of some of those types of conditions might have on the health plan, the cost of insurance and the employer's ability to continue that coverage?

Mr. QUIRK. Sir, in my mind the DSM question is basically a practical one in regards to who needs care that can get care and is satisfied with what they received and who, if anyone, is going to be excluded in the process.

So, at the level of the conditions that you spoke of, Mr. Camp, relative to life transition-type problems that aren't psychiatric disorders, when we have people call us on the phone and ask us to receive care in regards to those conditions, what we ordinarily do is make social services available at their own expense in the community. Most people are happy with that.

There is a small number that feel insistent that they have a psychiatric disorder. For those we bring them in and we do one session and we provide consultation to them.

Now, there are certain conditions that are more severe and chronic that are in the DSM that typically do not include people coming and asking for services from us.

Mental retardation is in the DSM, learning language disabilities is in the DSM, anti-social personality disorders is in the DSM, and by and large those people don't have conditions that are treatable from a health care point of view. They do not come to us.

So, the DSM issue to me is more a theoretical issue than it is an issue of major complication. Does that get to your question?

Mr. CAMP. Well, it does, and it sounds as though some of the medical management techniques that you referred to in your testimony you use as prospective patients come to you, and that those help determine that.

What is the standard for covered conditions in your plan?

Mr. QUIRK. We provide services to people who have psychiatric disorders from the medical necessity point of view that are treatable, people who by and large have had destabilizing experiences in relationship to which either counseling or medicine can make a difference in terms of returning them to their previous level of function.

Mr. CAMP. So, you allow the plan—at least your plan defines those disorders. The State has not defined those disorders for you,

which is in contrast to the legislation we are considering today where the Federal Government would define the various covered——

Mr. QUIRK. Yes.

Mr. CAMP. Thank you very much. Thank you all for your testimony. I certainly appreciate it.

Thank you, Mr. Chairman. I see my time has expired.

Chairman STARK. Dr. McDermott.

Mr. MCDERMOTT. Thank you, Mr. Chairman, for having this hearing and for giving me an opportunity to participate.

I want to talk with Dr. Quirk a little bit further about the Group Health model, because I think it says something about why you need a universal system that manages people's problems in the most efficient way. Group Health was started by the people, basically, and they basically still run it.

Now, on mental health care, can someone refer themself to your unit without passing through a general practitioner?

Mr. QUIRK. That is correct.

Mr. MCDERMOTT. They can come directly to you?

Mr. QUIRK. Absolutely. It is a self-referral system. It always has been. I trust it always will be.

Mr. MCDERMOTT. Then what percentage of your referrals are self-referrals, people feel they have a mental health need, rather than those sent over by internists or by general practitioners in the rest of the system? How does it split out?

Mr. QUIRK. We see about 7 percent of the enrolled population in a given year. Because we have this long history of being a self-referral system and an integrated system with the medical group, often formal referrals do not occur. So, if there were inquiries of patients in regards to whether your doctor encouraged you to come, my guess—and it is simply that—would be that half of the folks just self-initiate and probably half are encouraged by their personal physicians coming for care.

Mr. MCDERMOTT. One of the fears, always, of insurance companies and others in this whole area is, well, it would be a lot of people coming and wasting your time and wasting your ability. How many of those self-referrals do you find the system ultimately says there is nothing wrong with you, you can go away, or you should go away, or whatever? How often do you find people who are going in because they want to talk to somebody about things that perhaps could be handled in some other way?

Mr. QUIRK. It is rare that that occurs. As I was explaining to Congressman Camp, when we have the initial contact through our entering group, which includes a cadre of mass prepared people who take the calls on the phone, there is a brief interview that occurs there. In the context of that discussion, if it appears to be a life transition problem rather than a psychiatric problem, we make the social services available in the community. If it appears to be ambiguous, we bring those folks in. By and large they are very happy with one visit, and life goes on. So, the myth that mental health is basically a place where people come in to develop friendships or get social support is simply that. That is not our experience.

Most people come in, they have real issues in their lives, real conditions. They want to remedy them as quickly as possible and get back into their lives.

Mr. MCDERMOTT. You said—I think I caught 30,000 visits a year out of your 500,000 patients?

Mr. QUIRK. We see 30,000 new patients each year in relationship to which there are 200,000 patient contacts.

Mr. MCDERMOTT. How many actual inpatient beds do you have to maintain, or do you refer them out to another setting?

Mr. QUIRK. We purchase all of the psychiatric inpatient services from the community. We do have an inpatient chemical dependency program that is in Bellevue. We also purchase those services from the community as well.

Mr. MCDERMOTT. The purchasing is from the university hospital or from community hospitals or psychiatric facility?

Mr. QUIRK. All of the above.

Mr. MCDERMOTT. All of the above.

Mr. QUIRK. Yes.

Mr. MCDERMOTT. How many beds do you purchase a year? If you have a bed, do you have five beds filled continuously during the year or three beds?

Mr. QUIRK. As you are well aware, Group Health is spread out geographically across a landscape that is not sort of consistent in terms of the volume of people. As a result, we buy services from everywhere, from Spokane to Bellingham to Riverton to Seattle, Bellevue, et cetera, and we have good contractual understandings with those local hospitals, so that in our regular back-and-forth with them through the hospital liaison nurses, we have regular and consistent availability of services.

We have a concentration of services offered through the overlay facility in the Bellevue area, as you are well aware, part of our heaviest population area. But we don't essentially purchase beds in terms of holding them over the course of time.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

Ms. WESTIN. Mr. Chairman, could I say something?

Chairman STARK. Certainly.

Ms. WESTIN. In followup with that, one of the issues of the availability of services and having that readily available, the importance of that is very often somebody coming in with a mental health disorder—certainly eating disorders—is that you have this little window of opportunity that that person's defenses are down, their denial is down, and they are ready to go into the hospital or they are ready to get the help they need. If there is a delay in that—even by a few hours, certainly a couple of days, while insurance is taking a look at and authorizing that care—you can actually miss that window, and that person may then refuse to go in.

That is exactly what happened with our daughter when they told us to take her home. I flatly refused because I knew if I missed that window that day, I probably would not get her back the next day. So, we have to have those beds available. We have to have that access to care.

The other piece that I really would like to comment on, as we have been talking about, there is the cost of care and the cost of care up front to behavioral health and to, you know, the American

public, which has proven to be minimal from all the studies. The cost of not treating these illnesses is huge, and not only in lost lives, because we certainly understand that, but the long-term physical health effects of especially eating disorders, which include serious physical consequences, osteoporosis, infertility, electrolyte imbalance, cardiac, those kinds of things.

So, if we look at the overall cost of care, we really see why it is so important to treat these illnesses very quickly, very aggressively, and as soon as we can do it, because overall the cost will be much, much less. Thank you.

Chairman STARK. Thank you.

Mr. Ramstad.

Mr. RAMSTAD. Thank you, Mr. Chairman.

Dr. Quirk, I just want to thank you for your support for the parity legislation before us. I omitted your health plan—I will never do it again—from the list of health plans I enumerated who are supporting this legislation. I am sorry. That is because I missed the Vancouver field hearing, one of the few that I missed. But thank you for being one of the enlightened health plans, willing to speak out in favor of fair and equitable coverage for medical care.

I want to follow up on the line of questioning from Mr. Camp and point out that our bill does not prohibit medical management. It just says you have to do it, the management, the same way as for medical or surgical.

I was wondering if you could just enumerate the requirements a patient would have to meet in order to be deemed as medically necessary to receive inpatient substance abuse treatment under an average Group Health policy.

Mr. QUIRK. Sir, in the State of Washington we have a statutory requirement in regards to making certain amounts of moneys available every 2 years for chemical dependency services.

We have a system within Group Health that is both a primary care and a behavioral health system. So, as much as possible—and we have a long ways to go, I believe—we attempt to pick up in regards to people's chemical dependency patterns within the primary care approach. If indeed they are severe, referred for chemical dependency specialty, and to the extent that they result in significant impact in regards to overall health, their ability to function in life, we send them for inpatient detox. That is why we put together this chemical dependency inpatient program in our Bellevue campus. So, it is basically for people who have very severe conditions.

Mr. RAMSTAD. I thank you again for being here today and for testifying at the field hearing and for your enlightened approach to this incredible public health problem, which I deem America's number one epidemic, and appreciate enlightened plans like yours, as I said before.

Kitty, I want to ask you a question. Again, you have been there. Thank you for being there since Day One when you worked with Senator Wellstone, before I was even involved. I want to thank you again for your work with the Anna Westin Foundation and the Eating Disorders Coalition. You have helped countless people suffering from the deadly disease of eating disorders.

Let me ask you this. In treating as many people as you have, in your experience how would you compare the efficacy of treatment

for eating disorders with that of chronic conditions like asthma, hypertension or diabetes? The studies all show that the relapse rates are about equivalent.

Is that corroborated by your own personal experience at the Anna Westin Foundation?

Ms. WESTIN. Yes, that is correct. To answer your question, treatment does work. I think that is really important for people to understand and to know. The sooner somebody gets in for treatment and the more aggressive that treatment is, the more effective it will be.

What we do know is that a person that comes in for treatment and leaves prematurely will have a much higher chance of relapse. The continually revolving door I was speaking about, where someone is admitted and then discharged, is not the right body weight, and then readmitted, it serves to only strengthen the illness, which I think is pretty typical of a lot of illnesses.

When somebody is allowed to stay in the hospital a long enough time to restore themselves to ideal body weight, get their brain functioning again, be able to utilize the therapies and other approaches to care, they have a very, very good chance of total full recovery.

So we really advocate for long-enough lengths of stay. Those percentage, those number of days, have dropped significantly in the last few years. I think originally, for a long time, the lengths of stay were a month or longer, and now they are down to just a matter of days.

Or, in Anna's case, that first time she was given 3 days in the hospital.

Mr. RAMSTAD. The average treatment stay, I know, for people who are chemically dependent, now in plans it is 7 days. Ask any chemical dependency professional, ask any doctor or other professional, and they will tell you that no one can get on the road to recovery, nobody can receive effective treatment—right, Dr. Shern—in 7 days. That is what we are allowing to happen in this discrimination toward people with mental illness, eating disorders, and other forms of mental illness as well as chemical addiction.

Thank you again to all three of you. Thank you, Mr. Chairman.

Chairman STARK. I want to thank the panel for their assistance and their testimony. Appreciate your taking the time to do it. We will recess for about a minute while we excuse this panel and give the next panel a chance to join us.

[Recess.]

Chairman STARK. If our guests will take their seats, we will resume. Our third panel consists of three experts in the field of mental health substance abuse. Dr. Eric Goplerud—did I pronounce that correctly, Doctor—is the director of Ensuring Solutions to Alcohol Problems at George Washington University. Dr. Manderscheid, who is the director of Mental Health and Substance Use Programs at the Constella Group in Baltimore. Both of you two have been with SAMHSA previously, your experience there. Dr. Henry Harbin of Baltimore, Maryland. Dr. Harbin is in private practice; is that correct? More or less.

Welcome to the Subcommittee, gentlemen, and as you know we try to divide our panel into two bills, or two areas, the first dealing

with the private insurance market, and with this panel we would like to look at the question of parity in the Medicare system.

I would presume to some extent it might fall into the Medicaid system, but we just don't have jurisdiction over that, which is why we don't offer mention here.

Would you like to proceed, Dr. Goplerud, in any manner you are comfortable to enlighten us. Remember to turn on your mike and get as close to it as you can.

STATEMENT OF ERIC GOPLERUD, PH.D., DIRECTOR, ENSURING SOLUTIONS TO ALCOHOL PROBLEMS, GEORGE WASHINGTON UNIVERSITY

Mr. GOPLERUD. Chairman Stark, Congressman Camp, distinguished Subcommittee Members, my name is Eric Goplerud and I am a professor of mental health and substance use policy at George Washington University Medical Center.

Previously I served as associate administrator for policy and planning at the Substance Abuse Mental Health Services Administration.

Thank you for the opportunity to participate in this important discussion of Medicare parity. The proposed Medicare Mental Health Modernization Act, H.R. 1663, would resolve crucial problems caused by the existing Medicare benefit, especially the much higher copayment requirements for outpatient treatment of mental and substance use conditions and the absence of coverage for cost-effective residential and intensive outpatient treatments.

In my remarks today I will highlight four points:

Parity in Medicare is the right thing to do.

Parity will fix discontinuity problems caused by the current benefit.

Parity will lead to healthier seniors.

The benefits of parity outweigh the slight increase in initial costs.

In addition, I will address parity for treatment of alcohol and other drug-use disorders.

In 1965 when Medicare was established, its benefit closely mirrored the typical commercial health insurance product at the time. Most mental health insurance restricted mental health benefits because diagnoses were viewed as subjective, treatments were questionable, and outcomes difficult to measure.

Medicare followed conventional wisdom. The result, 42 years later, Medicare still requires 50 percent copayments for outpatient treatment of mental and substance use conditions, but only 20 percent for other illnesses. Medicare limits lifetime inpatient days for psychiatric hospitals, but has has no limits for other illnesses. An inequitable benefit may have been right more than 40 years ago, but advances in diagnosis and treatment of mental health illness and addiction and studies in cost and benefits of parity require us to reevaluate old assumptions.

In 1999 I led a team in HHS that negotiated with the Office of Personnel Management for full and comprehensive parity for 9 million beneficiaries in the Federal Employees Health Benefits Plan program. We now have 6 years' experience with FEHBP parity and a high-quality evaluation of the program.

Equitable coverage improves access without substantially increasing costs.

Forty-two States now mandate coverage for treatment of mental and substance use conditions. Most are more equitable than the Medicare benefit. Dr. Shern's organization, Mental Health America, released a poll in November 2006 that found 19 out of 20 Americans support coverage of parity, and this support is bipartisan.

A 2004 poll found that 76 percent of probable voters are more likely to vote for candidates supporting parity for substance abuse treatment.

In a moment, Dr. Manderscheid will discuss his research on how Medicare benefits contribute to the overutilization of emergency and inpatient services and create barriers to integrated care.

I want to point to indicators as problems with continuity of care that Dr. Manderscheid will not address. Quality measures reported by the health plans to the National Committee for Quality Assurance, NCQA, showed this problem. People with mental illnesses and substance use disorders that are so severe that they require inpatient treatment need to be immediately linked to outpatient treatment when discharged.

For commercially insured patients, 56 percent of seriously ill patients discharged from the hospital get into outpatient care within 7 days.

For Medicare patients, only 39 percent are seen within 7 days. Medicare financial barriers probably account for this almost 20 percent quality gap.

From every authoritative source, a consistent message is heard supporting integrated care. In my written testimony, I listed 33 authoritative research-based clinical practice standards from professional medical societies in the United States, independent quality assurance organizations, and guidelines from the Veterans Administration and Department of Defense that direct clinicians to provide integrated health and behavioral health care for older Americans. The clinical practice guidelines for all of the big disabling conditions affecting seniors and disabled Medicare beneficiaries—heart disease, diabetes, cancer, cardiovascular disease, COPD, chronic pain, stroke, depression, Alzheimer's—all call for clinicians to screen for depression, anxiety, and alcohol use and to actively manage these occurring conditions.

The impact of parity is clear. Access improves, while service costs barely increase.

In 2002 MedPac recommended eliminating the outpatient copayment disparities for Medicare and estimated that this would increase costs by $500 million a year. This increase of 2 cents for every $10 in premium is justified, according to MedPac, by improved access to treatment and simplify applied cost sharing.

Before I conclude, I would like to briefly discuss the integration of alcohol and drug use treatment under parity. Alcohol use disorders are predominant substance abuse conditions affecting Americans no matter what age or income level.

The chart in my written testimony shows that alcohol use disorders share all the characteristics of other chronic illnesses, except one. Health insurance coverage is not equitable.

G.W. recently analyzed the 11 State legislature-mandated studies of substance use parity. The studies reached a unanimous conclusion. The cost to employers is negligible. Substance use treatment parity increases costs annually by 0.2 percent per year.

In conclusion, I would like to thank the Committee for the opportunity to address this important issue and look forward to answering questions. Thank you.

[The prepared statement of Dr. Goplerud follows:]

Prepared Statement of Eric Goplerud, Ph.D., Director, Ensuring Solutions to Alcohol Problems, George Washington University

Chairman Stark, Congressman Camp, distinguished Subcommittee Members, I am Eric Goplerud, research professor in mental health and substance use policy in the Department of Health Policy at George Washington University Medical Center (GWU). I am pleased to be here this morning to discuss the research evidence supporting parity between the treatment of mental and substance use conditions treatment of other illnesses.

For the last 5 years, I have directed a research program at GWU, Ensuring Solutions to Alcohol Problems, whose mission is to improve access to effective, affordable treatment for people with alcohol use disorders. We assist employers, government officials, health plans, and health care professionals to use effective, science-based strategies to change policies and practices that inhibit access to alcohol treatment. Previously, I served as associate administrator for Policy and Planning at the Substance Abuse and Mental Health Services Administration (SAMHSA), and directed quality improvement, finance and performance metrics programs at SAMHSA.

Thank you for the opportunity to participate in this important discussion of Medicare parity. The proposed Medicare parity legislation would resolve crucial problems caused by the existing Medicare benefit design, especially the much higher copayment requirements for outpatient treatment of mental and substance use conditions. H.R. 1424, the subject of the first panel's discussion this morning, would resolve critical problems in commercial insurance coverage of mental and addictive disorders. In particular, H.R. 1424 would extend coverage to all of the mental disorders defined by the professional standard, the American Psychiatric Associations Diagnostic and Statistical Manual (DSM); health plans will have to make their criteria for determining medical necessity available to beneficiaries and providers; it requires out-of-network options if necessary treatment is not available in network; and it does not preempt State laws that have stronger benefits.

In my remarks today, I would like to highlight several key points:

- Parity is the right thing to do.
- Now is time to eliminate disparities in Medicare coverage.
- Parity will fix problems in service use and provider payment.
- Parity will lead to better healthier seniors.
- The benefits of parity outweigh the slight increase in initial cost.

In addition, I would like to address specific issues related to parity coverage for persons with alcohol and other drug use disorders.

Parity is the Right Thing To Do

In 1965, when Medicare was established, its benefit closely mirrored the typical commercial health insurance product at the time. In 1965, most health insurance offered very limited coverage for treatment of mental and substance use conditions. Most singled out mental health for more restricted benefits because of concerns that diagnosis was subjective and imprecise, treatments were of questionable effectiveness and outcomes difficult to measure. There was a concern (perhaps justifiable) that equitable coverage would lead to overuse and uncontrolled costs. Given this environment, Medicare followed conventional wisdom.

The result: Medicare requires 50 percent copayments for outpatient treatment of mental and substance use conditions, but only 20 percent for outpatient treatment of other illnesses. Medicare limits lifetime inpatient days in psychiatric hospitals, but has no limits for inpatient treatment of other illnesses.

Although an inequitable benefit design may have been the right decision more than 40 years ago, advances in the diagnosis and treatment of mental illness and addiction require us to reevaluate those old assumptions. The biochemical, genetic and neurological bases of many mental illnesses and addictions are far better understood now. Diagnosis is more precise and predictive. Psychological treatments are

more specific and effective. Medications and psychotherapy now help millions of people to live fulfilling lives in with families, jobs and friends.

In 1999, I led the team in HHS that negotiated with the Office of Personnel Management for full and comprehensive parity for 9 million beneficiaries in the Federal Employees Health Benefit Program. We now have 6 years' experience with FEHBP parity and a high-quality evaluation of the program demonstrates that equitable coverage of mental and substance use treatment improves access to care without significantly increasing costs.

There are now 42 States that mandate mental health and substance abuse coverage requirements for group health insurance products. Most are substantially more equitable than the present Medicare benefit. Employers, State Medicaid programs, and Medicare through Medicare Advantage have used managed care techniques that have dramatically changed mental health and substance use treatment patterns, dropping hospital lengths of stays, increasing use of intensive outpatient and psychosocial rehabilitation services, and increasing access to outpatient treatment from mental health and substance use treatment specialists. The availability of powerful, safer, and more easily managed psychotropic medications (coupled with physician counseling) has rapidly expanded the role of primary care physicians and other health care professionals. These changes make re-examination of the unequal outpatient copayment in Medicare Part B, the limitations on psychiatric inpatient days in Part A, and the extension of coverage for intensive outpatient services the right thing to do.

Now Is the Right Time To Eliminate Disparities in Coverage

In creating the New Freedom Commission in 2002, President Bush stated:

> *"Our country must make a commitment: Americans with mental illness deserve our understanding, and they deserve our excellent care. They deserve a health care system that treats their illness with the same urgency as a physical illness. Health plans should not be allowed to apply unfair treatment limitations or financial requirements on mental health benefits. I'll work with the Senator [Dominici]. I will work with the Speaker. I will work with their House and Senate colleagues to reach an agreement on mental health parity."* (April 29, 2002)

Surgeon General Satcher, in his Report on Mental Health and Mental Illness, found:

> *". . . formidable financial barriers block off needed mental health care from too many people regardless of whether one has health insurance with inadequate mental health benefits, or is one of the 44 million Americans who lack any insurance. We have allowed stigma and a now unwarranted sense of hopelessness about the opportunities for recovery from mental illness to erect these barriers. It is time to take them down."* ("Mental Health: A Report of the Surgeon General," 1999)

Public opinion polls consistently show overwhelming support for health insurance to handle mental illnesses and addictions like other illnesses. A November 2006 poll conducted for Mental Health America found that most Americans support covering mental health treatment, support parity in coverage, and this support is bipartisan:

- Nearly all Americans (96 percent) think health insurance should include coverage of mental health care.
- 89 percent assert that insurance plans should cover mental health treatments at the same level as treatments for general health problems.
- A large majority (74 percent) believe that insurance plans should cover substance abuse treatments at the same levels as treatments for general health issues.
- Public demand for mental health equity is bipartisan: 83 percent of Republicans and 92 percent of Democrats want equitable health insurance.

A Michigan poll conducted in 2000 found that 88 percent of Americans feel that a person's health insurance should pay the cost of treatment for mental illness to the same extent that it pays for the cost of treating other illnesses. A 2004 poll by Peter Hart and Coldwater Associates found that 76 percent of likely voters are more likely to vote for a candidate favoring legislation requiring health insurance to handle addictions the same as other medical conditions. In California, 54 percent of voters in 2004 supported Proposition 63 to impose a tax to cover expanded treatment for mentally ill adults and children.

In 2002, the Medicare Payment Advisory Committee (MedPAC) recommended that the outpatient mental health limitation be eliminated, finding that the modest

increase in program costs likely to result from parity ($500 million in 2002) is justified in light of the improvement in access to treatment and cost-sharing simplifications that would be the result. (MedPAC, 2002, p. 65).

Parity Will Fix Problems in Service Use and Provider Payment

Later, Dr. Manderscheid will discuss his research on how the 50 percent copayment for outpatient mental and substance use treatment disrupts good community care, contributing to over-utilization of emergency and inpatient services, hinders continuity of care when patients are discharged from the hospital, and creates barriers to integrated outpatient care by physicians and other health care providers who are managing the many co-occurring physical and mental illnesses of Medicare beneficiaries. I would like to point to two consequences that Dr. Manderscheid will not address:

- **Continuity of care is undermined by the current Medicare coverage disparity.** Standard quality measures developed by the National Committee for Quality Assurance (NCQA) include measures of the proportion of patients with mental or substance use conditions discharged from a psychiatric hospital who start outpatient treatment within 7 and within 30 days. Medicare lags far behind private insurance.
  - For commercially insured patients, 56 percent get outpatient care within 7 days and 76 percent within 30 days. For Medicare patients, only 39 percent are seen within 7 days and 57 percent within 30 days. Apparently, Medicare benefit restrictions create financial barriers for patients and health care professionals that account for this almost 20 percent quality gap.
  - In Medicare, only 2 patients out of 1,000 beneficiaries are identified as having a substance use problem—even though 3.2 percent of persons 65 years or older drink heavily, and 0.7 percent intentionally misuse prescription drugs. Of those identified, fewer than 1 in 20 receives a minimum of 3 services in the next 45 days. In commercial insurance, three times as many patients receive this level of care.
- **Distortions and inconsistencies in payment will be corrected with Medicare parity.** The DHHS Office of the Inspector General (OIG) recently found that Medicare fiscal intermediaries have adopted inconsistent policies regarding the application of the outpatient limitation. In a study of 57 carriers, nine different policies for the application of the limitation were identified. In over one-half of the service areas, carriers incorrectly subjected evaluation and management services for patients with Alzheimer's disease to the 50 percent copay. Other CMS and OIG studies have found widespread confusion among MH/SA treatment providers and carriers, protracted reimbursement adjudication processes and high rates of claims denials (up to 20 percent of medication management and 50 percent of group therapy claims are denied).

Parity Will Lead to Healthier Seniors

From almost every authoritative source, a consistent message can be seen supporting integrated care. For example, the fundamental finding in the Institute of Medicine's report, "Improving Health Care for Mental and Substance Use Conditions" (2005) is that "Health care for general, mental, and substance use problems and illnesses must be delivered with an understanding of the inherent interactions between the mind/brain and the rest of the body." The committee recommended "removal of barriers to and restrictions on effective and appropriate treatment that may be created by copayments, service exclusions, benefit limits, and other coverage policies" (IOM, 2005, p. 12). In three places the IOM report points to Medicare's 50 percent copayment for outpatient treatment as an example of financial barriers to effective care.

Establishing Medicare parity is consistent with at least 29 authoritative, research-based clinical practice standards from professional medical societies, independent quality improvement organizations and the VA/DoD. These guidelines direct clinicians to provide integrated health and behavioral health care (especially for the chronic, disabling conditions that afflict older adults). Several of these guidelines are listed in the appendix.

Clinical practice standards for heart disease, type II diabetes, chronic pain and stroke all direct clinicians to screen for depression, anxiety and alcohol use, and to actively manage these commonly co-occurring conditions. The Veterans Administration and Department of Defense have created a number of joint evidence-based clinical practice guidelines for common health and behavioral health conditions affecting elderly and disabled veterans. Their guidelines for depression, substance use disorder, post-traumatic stress disorder, and other mental illnesses recommend pri-

mary care screening and ongoing management, with referral to mental and substance use treatment specialists for severe or complicated problems.

In 2005, Medicare initiated the "Welcome to Medicare" preventive physical and screening examination. The preventive assessment explicitly includes screening for depression, alcohol and drug use. The one-time Welcome examination is covered as a regular outpatient visit, subject to the 20 percent copayment. The inclusion of depression and alcohol screening is consistent with the recommendations of the U.S. Preventive Services Task Force (USPSTF). The USPSTF is an independent panel of experts in primary care and prevention that systematically reviews the evidence of effectiveness and develops recommendations for clinical preventive services. It recommends:

- **Screening adults for depression in clinical practices that have systems in place to assure accurate diagnosis, effective treatment, and followup.**
- **Screening and behavioral counseling interventions to reduce alcohol misuse** by adults, including pregnant women, in primary care settings.

Without Medicare parity, primary care clinicians who follow CMS recommendations for the Welcome to Medicare preventive evaluation face the dilemma of finding patients with possible depression or alcohol problems who will not be able to afford the copay to get necessary treatment.

The Benefits of Parity Will Outweigh the Slight Increase in Initial Cost

Studies on the impact of parity have found that access improves while service costs barely increase. For example the evaluation of the Federal Employees Health Benefit Program parity found that costs increased by less than 1 percent (0.94 percent), at the same time that utilization increased by 15 percent. More people used mental health and substance use treatment services because parity makes treatment more affordable. At the same time, health plan costs barely increase as plans and patients have more flexibility in benefit usage, less expensive alternatives to inpatient care are emphasized, and early intervention and preventive care services are promoted. SAMHSA's report on actual State experiences with parity found that "State parity laws have had a small effect on premiums. Cost increases have been lowest in systems with tightly managed care and generous benefits. Most insurers in Maryland, Minnesota, New Hampshire, and Rhode Island reported small increases in total premium due to MH/SA parity laws."

Parity for Treatment of Alcohol and Other Substance Use Disorders

Before I conclude, I would like to briefly discuss the integration of alcohol and drug use treatment under parity.

Alcohol use disorders are the predominant substance use conditions affecting Americans—no matter what age or income level. This chart shows that alcohol use disorders share all of the characteristics of other chronic illnesses, except one—health insurance coverage is not equitable.

Comparisons Among Alcohol-Related Problems, Including Alcoholism, And Other Chronic Diseases

	ALCOHOL-RELATED PROBLEMS	ASTHMA	DIABETES	HIGH BLOOD PRESSURE
Prevalence	13.8 million (includes 8.1 people with alcoholism)	17.6 million	10 million	50 million
Total Economic Costs	$185 billion	$11 billion	$98.1 billion	$40 billion
Health Care Costs *(including medical complications and treatment)*	$26.3 billion	$7.5 billion	$44.1 billion	$29 billion
Other Medical Complications	YES (heart & liver disease, cancer, depression, fetal alcohol syndrome)	NO	YES (heart disease, adult blindness, kidney failure, lower limb amputation)	YES (heart disease, kidney disease, stroke)
CAUSES				
Controllable Risk Factors	YES ‣ limit drinking	YES ‣ limit exposure to allergens	YES ‣ limit food intake ‣ exercise regularly	YES ‣ limit food and fat intake ‣ limit salt intake ‣ exercise regularly
Uncontrollable Risk Factors	YES	YES	YES	YES
Estimated Genetic Influence	50 60%	36 70%	30 55% type I 80% type II	25 50%
TREATMENT				
Cure	NO	NO	NO	NO
Clear Diagnostic Criteria	YES	YES	YES	YES
Research-based Treatment Guidelines and Protocols	YES	YES	YES	YES
Effective Patient and Family Education	YES	YES	YES	YES
Percent of Patients Who Follow Treatment Regimens Faithfully	40 60%	30%	30%	30%
Percent of Patients Who Relapse Within a Year	40 60%	50 70%	30 50%	50 70%
HEALTH INSURANCE				
Equality (Parity) With Other Medical Conditions	NO	YES	YES	YES

Sources: National Institute on Alcohol Abuse and Alcoholism (1994, 2000a, 2000b); Centers for Disease Control and Prevention (1999); National Center for Health Statistics (no date: a, b, c); McLellan et al (2000); American Lung Association (no date); American Heart Association and National Pharmaceutical Council (2000).

The Cost of Substance Use Parity

An extensive George Washington University Medical Center analysis of 11 State studies on SA parity shows that the cost of parity to employers is negligible—*raising annual premiums just 0.2 percent*.[1]

"The cost of parity is comparatively small when compared to overall health expenditures and when spread out over all enrolled members," concluded California's State Legislative Analyst's Office after reviewing health insurance coverage of substance abuse treatment.[2] Mandating parity would not place an undue burden on businesses[3] that offer health insurance to their employees.[4] The analysis shows that:

- Equitable coverage reduces pressure on States budgets (and the tax burden on citizens and employers). Oregon, for example, found the State saves $5.62 in tax-supported health, corrections and welfare costs for every State dollar spent on people who complete treatment.[5]
- Parity increases the number of people who receive treatment, thereby reducing their long-term cost to the State. In addition, more get treatment as outpatients and inpatients, while the length of (more expensive) hospital stays is sharply reduced.
- The benefits of mandatory employment-based insurance parity are substantial. A North Carolina legislative report concludes: "Studies from several States have consistently shown that appropriate treatment of chemical dependency results in a significant reduction in medical claims, absenteeism, and disability; an increase in productivity; and a healthier and safer environment for all employees."[6]
- According to a PricewaterhouseCoopers actuarial analysis, the cost of parity to individual businesses goes down sharply when all or most businesses in a State are required to have equal coverage.[7]

In recent years, many States and the Federal Government have taken steps to require businesses that offer health insurance for their employees to cover alcohol and drug treatment on equal basis with coverage for treatment of other illnesses. Forty-two States require equitable coverage for some or all mental illnesses. Seven States also require equal coverage for treatment of alcohol-related problems.[8] To aid their consideration of substance abuse parity legislation, 11 States conducted studies of the costs and impact of equitable coverage of treatment for alcohol and other drug problems.[9]

The parity reports recognize that States have a significant financial, social and political interest in preventing and treating the disease of alcoholism and other alcohol-related problems.[10] Overall, the parity studies recommended including substance abuse in parity. "A State requirement is the only real option that will accomplish the objective of improved mental or nervous coverage at a reasonable premium

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[1] http://www.ensuringsolutions.org/resources/resources__show.htm?doc__id=339043.

[2] Legislative Analyst's Office, California State Legislature. Unpublished. Review of Health Insurance Coverage of Substance Abuse Treatment, Pursuant to Chapter 305, Statutes of 2000 (SB 1764, Chesbro). Sacramento, CA.

[3] Generally, small businesses of fewer than 25 or 50 employees are exempt from State parity mandates, as are companies that self-insure health benefits.

[4] Goplerud, Eric and Cimons, Marlene. 2002. Workplace Solutions: Treating Alcohol Problems through Employment-Based Health Insurance. Washington, DC: Ensuring Solutions to Alcohol Problems. http://www.ensuringsolutions.org/pages/rerere.html.

[5] Oregon Legislative Administration Committee Services. 2000. Joint Interim Task Force on Mental Health and Chemical Dependency Treatment: Final Report, Salem, OR.

[6] North Carolina Legislative Research Commission. 2000. Mental Health and Chemical Dependency Parity: Report to the 2000 Session of the 1999 General Assembly of North Carolina. Raleigh, NC. Legislative Research Commission.

[7] Bachman, R.E. 2002. An Actuarial Analysis of Comprehensive Mental Health and Substance Abuse Benefits for the State of New York. Atlanta, GA: PricewaterhouseCoopers L.L.P.

[8] Connecticut, Delaware, Maine, Minnesota, Vermont, Virginia, and West Virginia. The remaining States either require some lesser level of coverage, or lack any requirements. See Goplerud, Eric and Cimons, Marlene. 2002. Workplace Solutions: Treating Alcohol Problems through Employment-Based Health Insurance. Washington, DC: Ensuring Solutions to Alcohol Problems. http://www.ensuringsolutions.org/pages/rerere.html.

[9] The studies were performed in Alaska, California, Delaware, Hawaii, Maine, New York, North Carolina, New Jersey, Ohio, Oregon and Vermont.

[10] National Center on Addiction and Substance Abuse at Columbia University (CASA). 2001. Shoveling Up: The Impact of Substance Abuse on State Budgets. New York, NY.

cost," concluded Ronald E. Bachman, Principal, PricewaterhouseCoopers.[11] The experts found it is more cost-efficient and is easy to include with mental health coverage, resulting in increased productivity, saving tax dollars, fewer hospitalizations, shorter inpatient stays and the use of less expensive outpatient services.

"Parity creates a level playing field for all insurers and provides adequate risk-sharing over a large population to minimize any premium increase due to the claims experience of any one group," concluded the New Jersey task force.[12]

Ripple Effect

Minnesota found that almost 80 percent of the costs of substance abuse treatment were offset in the first year following treatment due to decreased use of hospital, emergency room and detoxification services and reduced arrests.[13] California found that criminal activity declined by 66 percent, drug and alcohol use declined by 40 percent, and hospitalizations declined by 33 percent following treatments.[14]

The Ohio Department of Alcohol and Drug Addiction Services found that 1 year after participants completed treatment, "absenteeism was reduced by 61 percent, incomplete work by 37 percent, and mistakes in work by 36 percent," according to Director Lucille Fleming.[15]

A Healthier Approach

The report by the Alaska task force explicitly recognizes the connections between mental illnesses and addictions: "There is a high incidence of substance abuse among the mentally ill, and unless both disorders are treated, positive outcomes for either are unlikely. As the director of the Ohio Department of Alcohol and Drug Addiction Services observed, improving access to treatment effects change measured by "real numbers, real people, [and] real benefits to the employer, to the employee, and to . . . taxpayers."[16]

Conclusion

Before I conclude, I would like to thank the Committee for the opportunity to address this important issue. In considering Medicare parity, these points are key:

- Parity is the right thing to do.
- Now is time to eliminate disparities in Medicare coverage.
- Parity will fix problems in service use and provider payment.
- Parity will lead to better healthier seniors.
- The benefits of parity outweigh the slight increase in initial cost.

I wish to thank the Committee for this opportunity and look forward to answering any questions that you may have.

Chairman STARK. Thank you very much, Dr. Goplerud.

Dr. Manderscheid, he didn't give all your testimony; would you like to continue with what he left you?

STATEMENT OF RONALD W. MANDERSCHEID, PH.D., DIRECTOR OF MENTAL HEALTH AND SUBSTANCE USE PROGRAMS, CONSTELLA GROUP LLC, BALTIMORE, MARYLAND

Mr. MANDERSCHEID. Thank you very much, Mr. Chairman, Mr. Camp, other Members of the Committee. I am honored to be here to testify here today.

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[11] Bachman, R.E. 2001. An Actuarial Analysis of Full Parity for Mental Health and Substance Abuse Benefits in the State of New Jersey. Atlanta, GA: PricewaterhouseCoopers L.L.P.

[12] Bachman, R.E. 2001. An Actuarial Analysis of Full Parity for Mental Health and Substance Abuse Benefits in the State of New Jersey. Atlanta, GA: PricewaterhouseCoopers L.L.P.

[13] North Carolina Legislative Research Commission. 2000. Mental Health and Chemical Dependency Parity: Report to the 2000 Session of the 1999 General Assembly of North Carolina.

[14] Gerstein, D.R., Johnson, R.A., Harwood, H., Fountain, D., Suter, N., and Malloy, K. 1994. Evaluating Recovery Services: The California Drug and Alcohol Treatment Assessment (CALDATA). Sacramento, CA: State of California Department of Drug and Alcohol Problems.

[15] Ohio Department of Alcohol and Drug Addiction Services. 1996. Ohio Cost Effectiveness Study. Columbus, OH: Ohio Department of Alcohol and Drug Addiction Services.

[16] Alaska: Alaska Mental Health Parity Task Force. 1999. Mental Health Parity Task Force Report: Final Report. Anchorage, AK.

The reforms you are proposing are very badly needed. The current system of mental health benefits was designed for the world of 1965.

Today, I would like to make three major points in support of proposed reforms:

My first point is that reducing Medicare copayment for outpatient mental health services from 50 percent to 20 percent so that it is the same as for all other illnesses will increase appropriate outpatient service use, decrease costly inpatient service use, and encourage better use of physician services. In my written testimony I provide statistical evidence of this point. The current situation is such that Medicare recipients are less likely to use mental health services than our Medicaid recipients. They are more likely to use inpatient services to cost more per year. They are less likely to use outpatient services and they are also less likely to use physician services. I would be very glad to work with the Congressional Budget Office to document that the proposed change in the copay from 50 percent to 20 percent will not arrive at a tremendous increase in the cost to the Medicare program.

My second point is that parity is needed both for mental health and substance use services, because elderly people are subject to all of these disorders. Again in my written testimony, I provide evidence of the high rate of depression, anxiety disorders, and alcohol use disorders in the elderly population.

I won't repeat those here.

We should also note that these problems not only cause disability, they also co-occur with other chronic illnesses. For example, elderly Medicare recipients with diabetes are almost 1.6 times as likely as other Medicare recipients to have depression. Untreated depression in the elderly can also lead to suicide, which has been mentioned in previous testimony here today.

What do these statistics mean? Achieving parity for both mental health and substance use care will lead to better treatment for mental health and alcohol problems and also help to contain the cost of treating other chronic diseases.

By other chronic diseases, I cited this statistic on diabetes. We could also talk about chronic heart disease. We could also talk about chronic asthma. There are high correlates there with mental disorders.

My third point is that collaborative care between mental health substance use and primary care, with oversight by qualified care managers, will be a very productive and cost-effective way to deliver mental health and substance use services.

It is well known that public mental health clients die 25 years younger than other citizens primarily because they do not receive appropriate primary care services. Similarly, when one suffers a heart attack, lack of assessment and treatment for depression greatly increases the likelihood of death. Problems of depression are also frequently accompanied by inappropriate alcohol use or dependence.

What do these findings mean? Together they point to the importance of coordinating good primary care with mental health and substance use care. This can best be done through collaborative

care carried out through a care manager. One's very life may depend on whether this is done.

I would like to thank the Chairman and Members of the Committee for the opportunity to testify today. I would also like to thank each of you on behalf of all people who are mentally ill or suffer from addictive disorders for taking on this very important issue.

Thank you very much.

[The prepared statement of Mr. Manderscheid follows:]

Prepared Statement of Ronald W. Manderscheid, Ph.D., Director of Mental Health and Substance Use Programs, Constella Group LLC, Baltimore, Maryland

Mr. Chairman and Members of the Subcommittee, I am Dr. Ron Manderscheid. Currently, I am the director of Mental Health and Substance Use Programs at Constella Group and adjunct professor in the Department of Mental Health at the Bloomberg School of Public Health, Johns Hopkins University. Previously, I was chief of Mental Health Statistics and Informatics at the National Institute of Mental Health and the Substance Abuse and Mental Health Services Administration in the U.S. Department of Health and Human Services, where I also edited the biennial publication, *Mental Health, United States*.

For a period of 10 years while I was at SAMHSA, I also served as the Federal Project Officer for a large study on service use and expenditures for Medicare, Medicaid, and Private Insurance. To my knowledge, this project represents the only long-term research on Medicare mental health and substance use expenditures. Simultaneously, I served as a consultant on the evaluation of the mental health parity provisions of the Federal Employees Health Benefit Program.

I would like to make three major points today, based on my previous research work.

My *first point* is that reducing the Medicare copayment for outpatient mental health services from 50% to 20%—so that it is the same as for all other illnesses—will increase appropriate outpatient service use, decrease costly inpatient service use, and encourage better use of physician services.

Available multiyear data [1] consistently show that the 50 percent Medicare copayment for outpatient mental health care has a specific set of negative consequences in terms of patterns of service use:

1. The percent of all Medicare service recipients who use mental health and substance use services is *smaller* than for Medicaid.
2. For Medicare mental health service recipients:
   - The percent that use inpatient services is generally *larger* than for Medicaid, and annual costs for these services are *higher*. This pattern is consistent across diagnosis, age, race/ethnicity, and gender groups.
   - The percent that use outpatient services is *smaller* than for Medicaid, and annual costs for these services are generally *lower*.
   - The percent that use physician services is *larger* than for Medicaid, but annual costs are *lower*.

What do these patterns mean? Because of the 50% Medicare copayment for outpatient mental health services, fewer Medicare recipients receive mental health and substance use services; those who do are more likely to receive costly inpatient care; and they receive fewer needed physician services.

My professional opinion is that the total cost to Medicare will increase only slightly as a result of the proposed change of the mental health outpatient copayment from 50% to 20%. This will be true because of the tradeoff between inpatient and outpatient care. Inpatient care will decrease; outpatient care will increase. Further, because many Medicare mental health service recipients are dual eligible for Medicaid, a change in Medicare is likely to have a salutary effect on Medicaid costs. I would be glad to work with the Congressional Budget Office to document these assertions.

The current copayment structure was designed for the world of 1965. It incentivizes costly inpatient care. Today, more than 40 years later, we have dra-

[1] "Evolution of Mental Health Care under Medicare," Congressional Staff Presentation, May 2, 2003, electronic file provided.

matic new drug treatments and psychotherapy care that are documented to be effective. These can all be provided in outpatient settings. It is time to change the discriminatory Medicare mental health copayment.

My *second point* is that *parity* is needed for *both* mental health and substance use services because elderly people are at risk for serious mental illnesses *and* alcohol problems. If left untreated, these problems exacerbate other chronic conditions that also are very common in the elderly population. Currently, only a small fraction of Medicare beneficiaries with alcohol and other substance use problems actually receive services under Medicare.[2, 3] The rates of care are low for mental illness and substance use disorders among Medicare recipients compared to national prevalence figures for these disorders.

The elderly population covered through Medicare needs outpatient mental health and substance use services. Elderly people are particularly vulnerable with respect to depression, anxiety, and alcohol use problems, each of which can be treated on an outpatient basis.

The national data on diagnoses are quite informative:[4]

DISORDER	*PERCENT OF POPULATION*	
Major Depression:	2.9%—Last Year	(For ages 60+)
	10.6%—Lifetime	″
Anxiety Disorders:	8.8%—Last Year	″
	17.7%—Lifetime	″
Alcohol Use	0.3%—Last Year	″
(With and Without Dependence)	6.3%—Lifetime	″

For alcohol use,[5] we know also that about 40% of persons aged 65 and older used alcohol in the past month, more than 8% were binge drinkers, and 1.7% were heavy drinkers.

These problems not only cause disability, they also co-occur with other chronic illnesses.

For example, elderly Medicare recipients with diabetes are almost 1.6 times as likely as other Medicare recipients to have depression.[6] Untreated depression in the elderly can also lead to suicide. Depression and anxiety are also frequently associated with the early phases of Alzheimer's disease.

What do all of these statistics mean? Achieving parity for both mental health and substance use care will lead to better treatment of mental health and alcohol problems and also help to contain the costs of treating other chronic diseases.

Offering parity for both mental health and substance use services will also likely lead to lower overall costs for the program. By encouraging that these issues be addressed before they become crises, it is likely that recipients will cost the program less over their lifetimes.

My *third point* is that *collaborative care* between mental health, substance use, and primary care, with oversight by qualified *care managers*, will be a very productive and cost-effective way to deliver mental health and substance use care services.

It is well known that public mental health clients die 25 years younger than other citizens, primarily because they do not receive appropriate primary care.[7] Similarly, when one suffers a heart attack, lack of assessment and treatment for depression greatly increases the likelihood of death. Problems of depression are frequently accompanied by inappropriate alcohol use or dependence. That is why the Institute of Medicine and the National Business Group on Health have both issued strong calls for closer coordination between mental health, substance use, and primary care services.

What do these findings mean? Together, they point to the importance of coordinating good primary care with mental health and substance use care. This can best

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[2] *Mental Health, United States, 2002*, Chapter 13, accessible at: http://mentalhealth.samhsa.gov/publications/allpubs/SMA04-3938/Chapter13.asp.

[3] *Mental Health, United States, 2004*, Chapter 16, accessible at: http://mentalhealth.samhsa.gov/publications/allpubs/sma06-4195/Chapter16.asp.

[4] Lifetime and Annual Prevalence of DSM–IV/WMH–CIDI Disorders by Sex and Cohort, from the National Comorbidity Survey Replication, accessible at: http://www.hcp.med.harvard.edu/ncs.

[5] *Results from the 2005 National Survey on Drug Use and Health: National Findings*, accessible at: http://oas.samhsa.gov/nsduh/2k5nsduh/2k5Results.htm#TOC.

[6] Prevalence and Costs of Major Depression among Elderly Claimants with Diabetes, in *Diabetes Care*, electronic file provided.

[7] Congruencies in Increased Mortality Rates, Years of Potential Life Lost, and Causes of Death Among Public Mental Health Clients in Eight States, in *Preventing Chronic Disease*, accessible at: http://www.cdc.gov/pcd/issues/2006/apr/05__0180.htm.

be done through collaborative care, carried out through a care manager. One's very life may well depend upon it.

I would like to thank the Chairman and the Members of the Subcommittee for the opportunity to testify today on this very important issue.

Chairman STARK. Thank you. Dr. Harbin.

STATEMENT OF HENRY T. HARBIN, M.D., BALTIMORE, MARYLAND

Dr. HARBIN. Thank you very much, Chairman Stark and Ranking Member Camp and other Committee Members for holding this important hearing. I guess I had better explain my background a little bit. I am a psychiatrist for over 30 years. Most of my career, however, has been spent in health care administration; 10 years of that in the public mental health system in Maryland; 3 of those years as director of the State Mental Health Authority, where I had a lot of experience with some of the community-based programs that you are putting into this bill, as well as the financing of them by Medicaid and Medicare.

Most of the last 16 years I have spent with two national private managed mental health care companies, Greenspring Health Services and Magellan Health Services. I was CEO of both of those companies at different points. Magellan, at the time that I was there, was the largest of the national managed behavioral companies, and at one point we were managing the mental health and substance abuse benefits for over 70 million Americans, and that included almost 40 percent of the Fortune 500 companies, as well as both Medicare and Medicaid recipients.

I have also had the privilege to serve on President Bush's new Freedom Commission on Mental Health, and more recently worked with the National Business Group on Health on an important document that they published at the end of 2005 on how large employers could do a better job of purchasing behavioral health care services. I am pleased to see that many of the items in this Medicare bill were all recommendations from the National Business Group as well.

A couple of comments. You have heard a lot about the data on the cost of parity—or the lack of cost, I might say. I think that we have at least four major documents—the Surgeon General's Report, New Freedom Commission's Report, the Institute of Medicine Report that came out in 05, as well as the National Business Group, all of which support the changes in these financing issues that you are addressing in this bill.

I would like to just add Magellan and Greenspring's experience of managing parity benefits. We manage many accounts, large employers or groups of employers that shifted to parity in the midst of our managing their care. Our experience was actually even lower than what you have seen from some of the actuaries. We range from .2 to .8 percent increase of total medical premiums in those accounts.

I would like to talk now a little bit about two areas that I would call unintended consequences of a limit of the specialty mental

health and substance abuse benefit, but are very important and haven't been emphasized as much.

The first of those is we are seeing an increased reliance on the general medical setting in primary care physicians' offices and the sole use of psychiatric medications for the treatment of many common mental health and substance abuse problems.

One of the reasons for this is the benefit constraints that make it difficult financially for patients and their families to go see a specialist, so they are incentivized basically to get their care in a primary care physician's office. Now, many people will get good care there and primary care physicians are an important part of the behavioral health continuum. But most primary care physicians' offices are not equipped to handle the full range of diagnostic and treatment services, and the most common intervention by many primary care doctors is only giving psychiatric medication.

Many studies have shown that about 60 percent of all psychiatric medications are given by primary care doctors, not specialists, and a number of quality problems have been repeatedly documented. I will just read from one of those. The National Co-Morbidity Survey that was published in 05 showed that only 12.7 percent of mental health patients treated in a general medical setting received minimally adequate care compared to over 40 percent of the specialty mental health sector. Most studies have shown a combination of appropriate psycho-social and medications are needed to effectively treat these disorders. But when you block one aspect of that, namely the specialty treatment, you won't get a full balance.

The second point is that the blocking of access to effective behavioral health care continuum is going to make it difficult for our health care system to adequately address chronic medical physical problems, diabetes, and heart disease. We have discovered in the last decade or two that many of these patients, in a range of 30 to 50 percent, have comorbid depression and other mental health problems.

As many insurers—I will stop in a second—have tried to focus on this, it is clear that without effective access to depression treatment of the disorders, it will make it difficult to handle these chronic medical problems.

My final comment, and I will answer this as I run out of time is to re-emphasize what Dr. Manderscheid said. There are programs called collaborative care, which effectively narrate the primary care system and the specialty behavioral system, and I would support adding elements of that if possible in this bill. Thank you.

[The prepared statement of Dr. Harbin follows:]

Prepared Statement of Henry T. Harbin, M.D., Baltimore, Maryland

I would like to thank Chairman Stark and Ranking Member Camp for holding this hearing on the important issue of mental health and substance abuse parity for both private insurance as well as Medicare.

As a psychiatrist for over 30 years, I have been an advocate for full parity for all mental health and substance use disorders for all payers both public and private. Most of my career has been in mental health care administration in both the public and private sector. I spent 10 years in the public health system in Maryland, three of those years as director of the State Mental Health Authority.

I have also been chief executive officer of two national managed behavioral health care organizations: Greenspring Health Services and Magellan Health Services. Both of these companies held responsibility for managing the mental health and

substance abuse benefits for millions of Americans. These individuals were insured by commercial insurers, Medicaid, or Medicare. I was CEO of Magellan from 1998 to 2001, and chairman for almost 2 more years. During that time Magellan was the largest of the managed behavioral health care companies and had approximately 70 million members. Magellan managed the behavioral health benefits for approximately 40 percent of Fortune 500 companies. I had the privilege of serving on the President's New Freedom Commission on Mental Health in 2002 and 2003, and more recently co-chaired a work group for the National Business Group on Health that produced a document in December 2005 entitled "An Employer's Guide to Behavioral Health Services." Currently, I am providing health consulting services. My comments about the Chairman's Medicare Mental Health Modernization Act of 2007 are based on these professional experiences.

There have been at least four major publications over the last decade to summarize the progress that has occurred in the behavioral health field, as well as many of the remaining challenges. Key recommendations to address these challenges would advance the treatment success of individuals with mental health and substance use disorders.

The publications include:

1. The 1999 publication of the Surgeon General's Report on Mental Health;
2. The President's New Freedom Commission Report on Mental Health in 2003;
3. The Institute of Medicine's report on Improving the Quality of Health Care for Mental and Substance Abuse Conditions from November 2005; and
4. The December 2005 National Business Group on Health's guide to behavioral health services mentioned above.

All of these documents recognize the critical importance of adequate financing of behavioral health care services in implementing the recommendations outlined in all of these national reports. Removing or reducing the financial barriers that exist today in private insurance, Medicare, and Medicaid are minimum requirements for the successful achievement of effective, evidence-based behavioral health services and the improvement of the lives of our citizens who are suffering from these illnesses. The most significant barrier to equal access is of course the 50 percent coinsurance requirement for outpatient psychotherapy services under Medicare, whether delivered by a psychiatrist, psychologist or other behavioral health specialist. If a Medicare patient has an office visit with any other medical specialist such as a cardiologist, endocrinologist, or oncologist for a physical illness the coinsurance is 20 percent. The Medicare Mental Health Modernization Act would end this longstanding discrimination against the mentally ill.

Other witnesses can attest to the negligible increase in cost resulting from the implementation of parity in many insurance programs over the last two decades. Numerous studies have shown that the increased cost for full parity ranges from no increase in cost to an increase of around 0.9 percent in total medical premiums. At Magellan we managed a number of accounts that introduced parity benefits, and in our experience, the increase in cost was from a low of 0.2 percent to about 0.8 percent of the premium. Most of the increase was due to an expansion of outpatient services, paired with a decrease in out-of-pocket expenditures for the consumer and a corresponding increase in expenses by the payer. The concern that providing equal benefits for medical and behavioral health care would lead to runaway costs and increases in utilization has not materialized in study after study. All of these studies, however, were based on the ability to provide utilization management of the mental health benefit.

There have been a number of unintended and deleterious consequences that have resulted from the arbitrary limitation of access to specialty behavioral services. I will focus on two of these consequences in my testimony, as I am sure other witnesses and panel members will discuss other important negative consequences.

Increased Reliance on the General Medical Setting for Behavioral Care and Use of Psychiatric Mediations as the Sole Form of Mental Health Treatment

Many patients want their mental health and substance abuse treatment to be given by primary care physicians and this type of utilization has increased significantly over the past decade. But due to benefit limitations and higher out-of-pocket expenses for mental health services, patients who both want and need access to specialty care often have little choice but to receive mental health treatment in primary care settings alone. Most primary care offices are not equipped to provide a full range of behavioral diagnostic and treatment services. The most common intervention by the primary care office for these disorders is the prescription of psychotropic

medications, and increasingly these drugs are being used as the sole form of treatment.

The 2003 New Freedom Commission Report has described the general medical system as the "de-facto mental health system." The Surgeon General's Report of 1999 documented that primary care physicians prescribe over 60 percent of psychotropic drugs. Some studies have shown that over 50 percent of patients with depression who receive any treatment are managed exclusively in primary care settings. This percentage is even higher among older adults covered under Medicare. Primary care physicians are an essential part of the health care system for behavioral disorders, but when this becomes the only option, we are depriving many patients of the most effective and medically appropriate treatment. Many primary care physicians have expressed the need for greater support and collaboration from behavioral health specialists, and enactment of the Medicare Mental Health Modernization Act would make this possible.

Several studies have documented the delivery of suboptimal psychiatric care when located solely in primary care settings. The National Comorbidity Survey Replication Study (NCS–R) found that only 12.7 percent of mental health patients treated in the general medical setting received minimally adequate care compared to 43.8 percent treated in the specialty mental health sector (Wang et al, *Arch of General Psych*, 2005).

Most studies have shown that the majority of mental health and substance use disorders have better outcomes when appropriate drug treatments are combined with psychosocial interventions. Most, but not all, private payers and the Medicare program have benefit structures that make it less expensive for the consumer to access care in the general medical setting with psychotropic drug treatment than to get optimal access to specialty care where a more effective combination of psychosocial and pharmaceutical interventions can be delivered. Many health care leaders as well as legislators and citizens have expressed concerns that psychiatric drugs are being overused in some populations. Concerns have been raised about the frequent use of stimulant drugs such as Ritalin for children with Attention Deficit Disorders, antidepressant usage for depression in children and teenagers, and antipsychotics being used extensively in the elderly. As long as we continue to have a benefit design that restricts access to the most appropriate care, we should not be surprised by these trends.

Limited Ability to Appropriately Address High-Risk, High-Cost Chronic Conditions Such as Diabetes and Congestive Heart Failure

Lack of access to effective behavioral health care for common mental disorders such as depression also contributes to the inadequate intervention by health care professionals for high-risk and high-cost chronic medical (physical) conditions. Many studies have shown that a small percentage of patients with chronic medical conditions insured by Medicare, as well as other payers, account for a majority of the spending. We now know that a significant number of these patients also have behavioral disorders, particularly depression. The estimates range from as high as 30 to 50 percent of patients with diabetes and heart conditions. The medical costs for patients presenting chronic medical conditions along with mental health conditions such as depression are often double those of patients without a comorbid behavioral condition (see New Freedom Commission Report and the National Business Group on Health Report listed above).

Many physicians, managed care companies, disease management companies and payers, including Medicare, are exploring specialized interventions for this high-cost subgroup to address the chronic medical conditions and behavioral health concerns of these patients. Without effective treatment for depression and other common behavioral conditions presenting in 30 to 50 percent of these patients, however, the success of these intervention programs will be severely limited.

Evidence-Based Practices and Collaborative Care

In my final comments, I would like to focus on another key aspect of the Medicare Mental Health Modernization Act of 2007. The legislation recognizes the importance of evidence-based practices and requires the Medicare program not only to equalize benefits between medical and behavioral health care services, but also to cover a range of evidence-based practices for care.

Just as health care payers have been slow to modernize their payments for behavioral health services, they likewise have not allowed for payment of clinical programs that have been scientifically proven to be more effective than the traditional inpatient programs and office-based outpatient programs. As I said at the beginning of my testimony, parity is a minimum requirement—but not a sufficient one—to

bring Medicare payment policies in line with 21st Century treatment for mental health and substance use disorders.

There are several community-based treatment programs listed in the Medicare Mental Health Modernization Act that are both more effective and less expensive than the traditional inpatient care currently funded by Medicare. Oftentimes, these community-based programs do not require the addition of new services under Medicare, but only flexibility in payment so that these more efficient programs can be substituted for the more costly services.

Unfortunately, the current draft of the Chairman's bill fails to recognize one critical evidence-based practice that has already shown great effectiveness, especially for elderly depressed patients: collaborative care. While parity and the access to evidence-based specialty mental health treatments are essential to reducing the barriers to effective treatment for the millions of older adults with common mental disorders, many older adults will continue to visit primary care providers rather than mental health specialists for treatment of common mental disorders such as depression. "Collaborative care programs" facilitate effective collaboration between primary care physicians and mental health specialists, and over 35 studies spanning 20 years of research in the United States and Europe have demonstrated that collaborative care programs are more effective than the care available if collaboration is restricted. Collaborative care has been shown to more than double the effectiveness of traditional care for depression, and at a lower cost than traditional care alone.

In short, collaborative programs improve access to evidence-based mental health treatments and improve coordination of primary care and mental health care for patients with a combination of mental and chronic medical disorders. I will reference the National Business Group on Health's Report to describe the collaborative care model:

"Collaborative Care: A Cost-Effective Primary Care Treatment Modality"

Successful interventions to improve care for depression have a number of common features, commonly referred to as "collaborative care." The collaborative care model focuses on treatment in general medical settings (vs. specialty behavioral health care settings) for most patients. Collaborative care includes and combines several quality improvement strategies, such as screening, case identification, and proactive tracking of clinical (e.g., depression) outcomes, clinical practice guidelines and provider training, support of primary care providers treating depression by a depression care manager (e.g., a nurse, clinical social worker, or other trained staff), and collaboration with a behavioral health specialist (e.g., a psychologist or a psychiatrist).

While the details vary, collaborative care interventions have two key elements. The first is case management by a nurse, social worker, or other trained staff, to facilitate screening, coordinate an initial treatment plan and patient education, arrange followup care, monitor progress, and modify treatment if necessary. Case management can be provided in the clinic and/or by telephone. The second is consultation between the case manager, the primary care provider, and a consulting psychiatrist, in which the psychiatrist advises the primary care treatment team about their caseload of depressed patients. This consultation is intended to maximize the cost-effectiveness of collaborative care, by facilitating a process described as "stepped care," where the treatment algorithm starts with relatively low-intensity interventions such as antidepressant medication prescribed by the primary care provider and telephone case management, with patients who fail to respond being shifted to progressively more intensive approaches including specialty behavioral health care.

More than 10 large trials, in a wide range of settings, have demonstrated the feasibility of improving depression treatment and outcomes, relative to usual care. The documented benefits of collaborative depression care include:

- Higher rates of evidence-based depression treatment (i.e., antidepressant medication and/or psychotherapy)
- Better medication adherence/compliance
- Reduction in depression symptoms, and earlier recovery from depression
- Improved quality of life
- Higher satisfaction with care
- Improved physical functioning
- Increased labor supply

Collaborative care has typically been found to increase direct health care costs slightly, relative to usual care, mainly by increasing the use of evidence-based depression treatment. However, this investment yields substantial improvements in patients' health status and functioning, so that collaborative care is more cost-effec-

tive than usual care for depression and has very favorable cost-effectiveness compared with other accepted medical interventions. For example, the largest trial of collaborative care for depression to date found that the program participants were depression-free for an additional 107 days over 2 years, relative to usual care, without adding significant increases to health care costs.

Many of the elements of collaborative care would be adequately financed if the parity section of this bill is approved. However, to fully implement an evidence-based collaborative care program two additional services would need to be included for reimbursement, as the current Medicare payment structure would not allow for payment. These two elements are: (1) the care management/disease management function, and (2) the psychiatric consultation to care managers and primary care providers. Over 30 studies suggest that these elements are required to make collaborative care effective and to achieve maximum value from the mental health benefits covered under the parity section of this bill. I would hope that the Committee would consider adding these service categories. The addition of these categories would allow older adults to receive more effective treatment for common mental disorders in primary care settings, where many of them prefer to receive care, while also providing access to consultation from experienced mental health specialists and effective mental health specialty services if needed.

This concludes my testimony, and I would like to thank the Subcommittee for inviting me to present these views and suggestions. I would welcome any questions from the Chairman or Members of the Subcommittee.

Chairman STARK. Thank you. I guess I am not sure I want to go here, but it is a looming question. There is an effort in the other body to have mental health parity, but approaching it somewhat differently. My colleague, Mr. Camp, brought it up in a reference to the DSM 4 and the issue—I suspect is that by the Federal Government mandating a broad range of coverage, I think it was referred to as jet lag and nicotine—or not nicotine, but caffeine dependency, things like that, which might be considered frivolous, and the worry I suppose is that if the Federal Government mandates this broad range of problems, there would be increased utilization that we would spend too much money on what might be considered frivolous problems that aren't necessarily classified as mental health.

Could each of you kind of, could you address that? What is the danger that we are going to just turn loose either in allowing providers such as therapists to provide some of the care and bill directly or creating too broad a range? What do we have to worry about in that case? Do you want to just start with Dr. Harbin and we will go down the line.

Dr. HARBIN. I think it is a very important issue. I would like to say, first of all, I think both the Senate and the House private insurance parity bill will be a significant advancement over our current situation. I am aware of the differences. I would like to speak a little bit to the DSM 4 issue, and to your comments, Congressman Camp, to the earlier panel. You have to accept there are a list of disorders in the DSM 4, and they also have a list of "conditions which are typically called v codes." Some of what you brought up were v codes. I don't believe—I am not 100 percent sure about this that the Federal employee program covers v codes, even though I will add in general medicine, most insurers pay for v codes, for medical coverage, for things like hair loss, physicals where there isn't a clear disorder, that is the common practice there.

But I don't believe—but it would need to be double-checked if Federal employees covers v code. So, that has been a historic criticism when everything is thrown in in terms of all disorders. But there are some disorders, frankly, and you heard that from Dr. Quirk, frankly, that receive very little attention in any sort of managed benefit or are unlikely to run up the cost.

So, I think it has been a worry historically. There are employers, and in States when they have passed their parity bills that have basically allowed any DSM 4 disorder, diagnosis in there, and we still see these very minor increases in costs. So, I think it is—I understand the flexibility that employers and some of their managed care company agents would desire in this. I think that is a very valid issue, but I don't think from a cost and access point of view this would be a problem.

Mr. MANDERSCHEID. I think that is an excellent question. There are several major issues here to be put on the table. One is, again, the issue of stigma that has been brought up by many of the witnesses today. I think the problem is exactly the reverse. The problem is getting people to care early enough rather than getting them to care too early about too frivolous a disorder. The incentives in Medicare currently drive people toward higher levels of care rather than toward ambulatory outpatient care.

As a consequence, they would not get into that care if they did not have very serious disorders at the time they were receiving care. A second feature here is the whole issue of practice standards. I think a number of witnesses have raised that question as well. We have new practice standards in these fields. We have new evidence-based practices that we didn't have in 1965.

So, I think very little frivolous care is actually given in any part of the mental health system, including in the primary care system where a lot of mental health services are offered. I think the third feature of this is the fact that our world has changed. When Medicare was created, we needed 190-day lifetime limit because people went for 60-day inpatient stays. That world is long ago gone. We don't need the 190-day lifetime limit anymore. We need to open the doors so people get the care earlier. We get more toward preventive and early interventions with people before they have very serious disorders and they end up as someone with a serious mental illness who is dying 25 years before they should.

Chairman STARK. Dr. Goplerud?

Mr. GOPLERUD. Thank you. I would like to talk a little about alcohol and drug abuse disorders, which often are being put on the side of being frivolous or self-imposed illnesses or disorders. In fact, only in the Medicare program, about one person in 20 who meets the DSM criteria of alcohol dependence or abuse disorder gets any treatment for their condition. The consequence is that we have way, way too few people who could benefit from the care. There has been reference made to the very large number of people who are coming in through the trauma care system of this country who are there because of alcohol or drug use which is impaired judgment or impaired reaction times while driving cars. Many of those people do not meet the DSM diagnosis of an alcohol or drug use disorder but prompt immediate counseling there in the emergency department can cut by 50 percent their likelihood of reinjury, rehos-

pitalization and perhaps more importantly, their injuring somebody else or killing somebody else. So, what we really have as an issue is not enough people who are getting identified, as Dr. Manderscheid says, early enough for the conditions which are imminently treatable and for which there are evidence-based practice standards available.

Chairman STARK. Thank you. I am going to thank the panel. Mr. Camp?

Mr. CAMP. Thank you, Mr. Chairman. Dr. Harbin, I would like to just follow up on that. This would be a change in that at least we are talking about Medicare now. The plans that we have been talking about between the House and Senate typically have not—the House-Senate plan does not define each and every mental illness, but says only—it is a true parity bill. It says only if you cover a mental illness, you must cover them equally with physical illnesses and the House bill lists each plan. I don't know the answer to the decodes, but we will try to get that, but it just seems to me that for the Federal Government to prescribe each and every—in specific detail each and every covered item, there is certainly more tradition for than that in Medicare, but I think there is a concern there.

I wanted to talk about the collaborative care issue. I think Dr. Manderscheid talked about coordinated care, how we transition those folks who have come to a primary care physician to actually get the sort of specialty care they need, and how do you envision a coordinated care plan working?

Dr. HARBIN. Thank you. As I ran out of time in that. It is in my written testimony in a little more detail. The collaborative care model now has almost 37 different randomly assigned control studies internationally supporting its efficacy. It really consists of four elements, improved screening by the primary care physician of mental health and substance abuse problems; secondly, that if the primary care physician initiates treatment for depression or another common mental health problem, the tracking by that patient of a case manager disease manager function, so that there is some outreach, there is some patient education, there is some encouragement of that person or his family to continue with treatment and to follow through if there is a referral to a specialist.

Third, it consists of psychiatric consultation to the primary care physician's office about the psychiatric medications and about the treatment plans. This is often a phone-based consultation. The fourth element is close linkage between the primary care office and the specialty behavioral system. So, those are the four elements. If this bill on Medicare would pass, it would fund adequately part of that. It would not fund the case management function or the psychiatrist consultation function, which I think is key to all of this research elements, all four elements that I listed. Part of this would allow many elderly Americans to stay and get their treatment within the primary care office, not have to move all the way over.

Mr. CAMP. Are not some of those services covered under Medicare advantage plans?

Dr. HARBIN. I am not sure whether they are or not.

Mr. CAMP. Does anyone in the panel know that? Do some of the Medicare advantage plans cover case management and other issues in your—if you don't know, that is fine. It may be out of the scope——

Dr. HARBIN. I am not sure. They may do that. It may not be a required service but I would say this recommendation of collaborative care was part of the recommendations of the New Freedom Commission, it was also part of the recommendation of the National Business Group for fully managed plans in those blocks of business. So, it is often not implemented fully, even where they fully managed care structure.

Mr. CAMP. Are not some of the services that we have talked about, such as case management treatment planning and others, covered under Medicaid?

Mr. MANDERSCHEID. Yes. Some of those services are covered under Medicaid. A point that has not come out here today is the fact that there is overlap in the Medicaid and Medicare populations. Changes to Medicare can have a salutary effect on Medicaid costs, and that idea needs to be put on the table as well with the Congressional Budget Office. Let me say one——

Mr. CAMP. I just want to follow up on that. But salutary effect, my question is, by putting these benefits under Medicare, are we not creating an opportunity for States to shift their costs, their current spending under the Medicare program from Medicaid?

Mr. MANDERSCHEID. I don't believe so. You would need to structure the program so that that would not, in fact, happen. I wanted to say one additional word about collaborative care. A recent study done by the National Business Group on Health looking at the interface between mental health and primary care found that the use of a care manager could be very salutary in coordinating the two pieces of care we need to bring together, and we need to keep that idea on the table here as well.

Mr. CAMP. All right. Thank you very much. I see my time has expired. Thank you, Mr. Chairman.

Chairman STARK. Mrs. Tubbs Jones.

Ms. TUBBS JONES. Mr. Chairman, I am going to yield any questions. I thank you all for your testimony, and it is clear that our entire Committee believes that this is an area that we need to focus in on, and having experts like you to testify and give us some guidance is really helpful. I thank you, Mr. Chairman. Yield back.

Chairman STARK. Mr. Ramstad.

Mr. RAMSTAD. Thank you, Mr. Chairman. I want to thank all three of you distinguished doctors for being here today and for the outstanding work you do in the field. You all contribute a great deal in the area of mental health and chemical addiction. I guess, Dr. Goplerud, I will start with you. I am most familiar with your outstanding work, expanding access to treatment for people with chemical addiction. I know that ensuring solutions to alcohol problems, the organization you head, is truly at the forefront of this debate nationally, and you are certainly—as the other two distinguished doctors are—you are a true expert in the field.

I want to ask you two questions. First, I know you have studied the economic impacts of the issue of untreated addiction. I cited earlier the cost of $550 billion last year, estimated according to the

Brandeis study and the NAMI study, National Association For Mentally Ill, the costs of untreated mental illness and addiction. Could you elaborate on those costs and what form they take and so forth? I am sure you are familiar with those studies and that number.

Mr. GOPLERUD. Sure. Perhaps one of the most remarkable numbers is that about $26 billion a year is spent for the treatment of alcohol-related health care problems. Of that $26 billion, only $1 out of $5 goes for the actual payment of treatment for the alcohol problem itself. The other $4 out of $5 go for the payment for the injuries and illnesses that are associated with untreated alcohol problems.

So, the costs simply of treating the health care consequences is at least $19 billion every year, a tiny fraction of which goes into actual health care. Now, many of us carry around these little items, BlackBerrys, blueberries, Trios, et cetera. If you go out to Research in Motion's Web site, they will tell you that for every dollar you invest in this, you get about $2 back in increased productivity, not counting all the family distress that it happens. For the treatment of alcohol problems, the return on investment is about $2.60 or a better investment than an investment in one of these things. Thank you.

Mr. RAMSTAD. The second question—and thank you for your response, Dr. Goplerud. The second question I had concerns the Medicare program and the focus of the second bill we are discussing here today, albeit a little bit obtusely. But has it been your experience, and actually those doctors who could comment as well whether early screenings and diagnoses of other illnesses result in a cost savings for the Federal Government? I would just cite the mammograms under Medicare, the PSAs required under Medicare. Do such early screenings and early diagnoses of other illnesses result in the cost savings for the Federal Government? Is there anything to substantiate that assertion?

Mr. GOPLERUD. It is very clear that early identification is better than treatment for the catastrophic consequences. One of the peculiar things with the current Medicare benefit is that the required or strongly recommended in the welcome to Medicare preventive screen is screening for alcohol, drug and depression. However, if a physician identifies any of that, you would—the treatment would be subject to the 50 percent copay. In other words, it would be very difficult to actually pay for the care that you are identifying in the free service.

Mr. MANDERSCHEID. I agree with Dr. Goplerud. The 50 percent copay is the major inhibitor to conducting such screening. There are excellent screening tools available at the present time. One of those for adults is the PHQ 9, which is recommended by the Centers for Disease Control.

Mr. RAMSTAD. I should have asked the second half of my question, the first half merely being a preface to my main question, that is whether these savings could be applied to earlier screenings, earlier diagnosis of chemical addiction.

Mr. MANDERSCHEID. I think we have a big hill to climb up to move our treatment system from one that focuses on mainly long-term disaster oriented chronic care to early intervention, preven-

tive interventions and screening, and we have to climb over that hill to get there. Once we get there, and we do these screenings much earlier, mammograms, colonoscopies, screening for depression, then I think you will begin to see cost savings as a result of that. I don't think you would see cost savings in the initial few years because we have the hill to climb over here. Thank you.

Dr. HARBIN. I would like to speak to one aspect of that, which is the need to screen earlier and more effectively for chronic medical problems. As I mentioned earlier, that group with diabetes, the 20 percent or so recipients or people who have that disease are costing more than 60 percent of the dollars in every health insurance program, Medicare and so on. Thirty to 50 percent of that group has a comorbid depression, and that group appears to cost in study after study about double on the medical spending than the person who just has diabetes without depression. So, I think it is imperative to try to screen and treat the depression aspect in order to have the cost savings on the medical side.

Mr. RAMSTAD. Well, thank you again to all three of you distinguished gentlemen for your testimony. Yield back, Mr. Chairman.

Chairman STARK. Mr. Becerra?

Mr. BECERRA. Thank you, Mr. Chairman. Doctors, thank you very much for your testimony today. I am not sure most people recognize that there is an issue of addiction or substance abuse among our Medicare population. Most of us would say Medicare beneficiaries, oh, substance abuse, do not go together. Can any of you tell us—either of you tell us what you know about the prevalence of substance use or abuse among the Medicare population?

Mr. GOPLERUD. Yes. Although the problems associated with drinking or with drug use are much smaller for the Medicare population than they are for say 21-year-olds, there still is a substantial alcohol and drug problem among our elders. According to the National Survey on Drug Use in Health, a Federal survey, about 3.2 percent of persons over 65 drink heavily, and 0.7 percent, just about 1 percent of seniors misuse prescription drugs. Now, you take them together, about 4 percent of seniors have a serious alcohol or drug use problem, yet in the Medicaid program, only two beneficiaries per thousand are identified and receive even one chemical dependency service a year.

Mr. BECERRA. That is .2 percent.

Mr. GOPLERUD. .2 percent, or in other words, about one in 20, who has a serious problem gets even one service for that problem, and I believe that that is directly attributable to the benefit problem.

Mr. BECERRA. Actually, I find it healthy that our discussion here has focused almost exclusively on how we get to a parity level for mental health services. But I know that some folks are out there still have on their mind this issue of abuse of the system of the benefit if you get to the point of offering mental health services at the same level that you offer other health services, physical health services. I wonder if you can comment on the possibility of fraud or abuse that might lead to overutilization of certain services or abuse of use—or use of services in ways that are not meant to be provided, yes, Dr. Harbin.

Dr. HARBIN. I would like to respond to that. One of the reasons I shared my prior experience with these two national managed care health companies, that was our responsibility, we were at risk for the mental health and substance abuse spending for all of these many millions of Americans. So, it was a daily focus about whether people were abusing. I know their services. I know when I first started with Green Spring Health Services in particular, I sort of had the same view, even as a psychiatrist, there was going to be a lot of use of psychoanalysis, the classic stereotype of mental health, Woody Allen is going to spend 20 years on the couch five times a week.

I was positively surprised to see it was very rarely used, some of those employers did have a psychoanalytic benefit and we actually set up a psychoanalytic review program for that. It was very rare that somebody used that, and we found that the outpatient services in particular echo what Dr. Manderscheid said. The problem is not getting people to use them enough and early enough. You have to have some level of management. It does not need to be too intrusive of the benefit, but it is just an old issue. There was a problem of overuse of inpatient services in the 1970s and 1980s when many of these commercial insurers were spending 70 and 80 percent of all of their dollars on the inpatient level of care. That has changed. This is just not an issue at this point, and so——

Mr. BECERRA. Can you give us more specifics about what has changed or what we did to change that so that we could avoid that type of overutilization?

Dr. HARBIN. Well, I think frankly the managed care intervention in the last 20 years both on commercial insurance and Medicaid and some degree Medicare has changed—helped change practice patterns. Also providers and science has pointed to the alternatives to inpatient care, are cost effective. I mentioned my experience in the public sector. The progress was light years ahead of the private system in Medicare, often because they created a whole range of alternative community-based services that were quite cost effective.

So, it is a mixture of science, management interventions and recognitions by providers. I think it would be very difficult to go back to where we were 20 years ago where everybody got put in the hospital. That is appropriate for certain people for a period of time. But it was the first offer often for many people.

Mr. BECERRA. Thank you very much for your testimony. We appreciate your comments. Mr. Chairman, I yield back.

Chairman STARK. Mr. Ramstad, did you have a further inquiry?

Mr. RAMSTAD. I don't have any further questions, Mr. Chairman. But before we adjourn, I would just like to ask unanimous consent to speak out of order for 1 minute.

Chairman STARK. Please.

Mr. RAMSTAD. If you want, I don't have any further questions for this panel.

Chairman STARK. You are recognized.

Mr. RAMSTAD. Oh, thank you, Mr. Chairman. Mr. Chairman, before we close this hearing and again, I want to thank you and Ranking Member Camp for holding this hearing today, I made a promise to a young man who attended, I think, 7 of our 12 field

hearings. We have been everywhere from California to New York and Texas to Minnesota and Rhode Island and everyplace in between. A young man who happens to be in a wheelchair, paraplegic named Steve Winter, if you read any of the field hearing testimony, read the testimony of Steve Winter. I think it pretty much sums up what we are all about in this legislation. Steve Winter is probably a young man about 35 now, and he started showing up at these field hearings, and Patrick and I befriended him and like I said, he came to a number of them at his own expense and was never on the witness list, but we always had him testify after hearing his compelling story.

He testified about how when he was in high school—he is from Arizona, and he was going to high school and Steve Winter woke up one morning with a burning sensation in his back, and he went to the kitchen table as he did every morning to have breakfast with his sister and his mom and his dad, and he said to his mother, I am not feeling right today. Something is burning, and he reached back and he brought his hand forward, and it was full of blood. Just then his mother raised a pistol in his face and said, I am going to take you with me. Your sister is already in heaven. I am going to take you and you and I are going to join your sister in heaven. Well, he said, mom, put the gun down. Mom, put the gun down, and he was able to convince her to put the gun down.

Unfortunately the bullet pierced his spinal cord and he is confined to that wheelchair for life. But he was asked at the hearing, do you have animosity toward your mother who is still alive today, and he said no because my mother didn't shoot me while I was sleeping in bed. Her mental illness shot me. What had happened is she had been treated for psychosis and depression, and the coverage was stopped for 3 months and it was during those 3 months that the demons came back and her mental illness took over and caused that horrible tragedy, and that tragedy, like the tragedy of Anna Westin, shouldn't happen in this land of ours, and there are things we can do to prevent those human tragedies.

I believe this legislation that we have discussed here today at this hearing is one of those things we can do to prevent other people from suffering as Kitty Westin and her family has, Steve Winter and his family has. Thank you, Mr. Chairman. Yield back.

Chairman STARK. Thank you for your remarks, and I want to thank the panel for their contributions. If there is no further inquiry, the hearing is adjourned.

[Whereupon, at 12:28 p.m., the hearing was adjourned.]

[Submissions for the Record follow:]

Statement of American Academy of Child and Adolescent Psychiatry

The American Academy of Child and Adolescent Psychiatry (AACAP) is a medical membership association established by child and adolescent psychiatrists in 1953. Now over 7,600 members strong, the AACAP is the leading national medical association dedicated to treating and improving the quality of life for the estimated 7–12 million American youth under 18 years of age who are affected by emotional, behavioral, developmental and mental disorders. AACAP's members actively research, evaluate, diagnose, and treat psychiatric disorders and pride themselves on giving direction to and responding quickly to new developments in addressing the health care needs of children and their families.

AACAP would like to thank House Ways and Means Health Subcommittee Chairman Pete Stark for holding this hearing. We appreciate his interest in mental

health and substance abuse parity and its impact on our health care system. Thank you for the opportunity to submit a written statement for the record.

Statement on Mental Health Parity

While almost one in five children in the United States suffers from a diagnosable mental disorder, only 20 to 25 percent of these children receive treatment.[1] This is a troubling fact considering treatment of many mental disorders has been deemed highly effective. According to the National Alliance on Mental Illness, between 70% and 90% of people with serious mental illnesses have a significant reduction of symptoms and improved quality of life with a combination of pharmacological and psychosocial treatment.

However, our current health care system fails to provide the most basic mental health services to children in need. In the United States, 10% of children and adolescents suffer from serious emotional and mental disorders that cause significant functional impairment in their day-to-day lives at home, in school, and with peers.[2] Furthermore, 70% of youth involved in State and local juvenile justice systems throughout the country suffer from mental disorders.[3] Children, as a group, tend to be high service users of health care services and are often involved in multiple agencies. This poses a challenge to managed care systems because children require services at various levels of intensity for extended periods of time. Due to the risk-adjustment strategies to protect the financial interests of managed care organizations, there is little incentive to offer parity for services for children with the most serious disorders. As a result, these children are often left underserved and responsibilities for care are shifted to other systems such as special education, child welfare and juvenile justice systems.

A *New England Journal of Medicine* study has shown that mental health and substance abuse treatment can be provided in health care plans at a negligible cost to employers.[4] A more recent study submits that full mental health parity *for children* can be achieved without adversely affecting health care costs.[5] The AACAP strongly supports Federal and State parity legislation that provides patients with access to the full range of appropriate evaluation and treatment services. The AACAP calls for the end of discriminatory insurance policies that limit access and help to perpetuate unnecessary stigma. Contractual limits on psychiatric outpatient visits and inpatient days, higher copayments/deductibles, and annual and lifetime benefit limits create financial burdens and barriers to treatment for patients and their families. Financial obstacles should be the last burden that parents face when attempting to get the proper treatment and care for their ailing children.

Access to Care

Lack of access to specialty mental health services, including child and adolescent psychiatrists, is a major problem when seeking mental health care in this country. As the President's New Freedom Commission on Mental Health has stated, there is a shortage of psychiatrists and other mental health professionals trained to diagnose and treat children and adolescents nationwide. The shortage of these specialists, and all other health care professionals, is particularly severe in rural and urban areas. The AACAP calls for legislation that would provide incentives to individuals interested in education in the field of children's mental health. The AACAP has been active in the promotion of comprehensive community-based systems of care across health, education, child welfare and juvenile justice systems for children and adolescents with mental illness. These programs should include consultation with mental health specialists through telemedicine or bi-monthly office visits, which are needed to ensure appropriate mental health care for children.

Conclusion

Mental health is integral to the health and well-being of *all* children. It is time this is realized. Children coping with emotional and mental disorders must be identified, diagnosed, and treated to avoid the loss of critical developmental years that

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[1] U.S. Department of Health and Human Services. Mental Health: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999.

[2] Id.

[3] Blueprint for Change, National Center for Mental Health and Juvenile Justice, 2006.

[4] Goldman HH, Frank RG, Burnam MA, et al. Behavioral Health Insurance Parity for Federal Employees. *N Engl J Med* 2006; 354:1378–86.

[5] Arzin SA, Haiden HA, et al. Impact of Full Mental Health and Substance Abuse Parity for Children in the Federal Employees Health Benefits Program. *Pediatrics*. 2007; 119(2):452–459.

will never be recaptured. Mental health parity and improved access to care is a must for this Congress to enact.

AACAP appreciates the opportunity to participate in this discussion. The AACAP applauds the Committee for its timely consideration of this important issue. Your continued leadership is pivotal to children and adolescents who suffer from the effects of mental illness. We strongly urge the Committee to support the passage of the Paul Wellstone Mental Health and Equitable Treatment Act of 2007.

Statement of American Association for Geriatric Psychiatry

The American Association for Geriatric Psychiatry (AAGP) commends the Health Subcommittee of the House Committee on Ways and Means holding this hearing on parity for mental health benefits under both private-sector health benefit plans and the Medicare system. AAGP welcomes the opportunity to share its views on this important issue.

AAGP is a professional membership organization dedicated to promoting the mental health and well-being of older Americans and improving the care of those with late-life mental disorders. AAGP's membership consists of about 2,000 geriatric psychiatrists as well as other health professionals who focus on the mental health problems faced by senior citizens.

The Medicare law of 1964 defined outpatient treatment of "mental, psychoneurotic, and personality disorders" as covered services for eligible recipients. While the initial language did not discriminate between psychiatric conditions and classic medical conditions, the implementation of subsequent language and policy resulted in these two classes of illness categories being managed in very different manners. The most important remaining difference is that Medicare requires a beneficiary copayment of 50 percent of outpatient psychiatric services, as opposed to the 20 percent copayment required for medical outpatient services. This discriminatory policy is not supported by current scientific, medical, or social knowledge. As our understanding of behavior and brain function has so greatly expanded over the last 40 years, our Nation's Medicare policy needs to be updated not only to rectify ongoing discrimination to this vulnerable population but also to recognize that untreated mental disorders complicate other medical conditions, leading to unnecessary additional suffering and costs.

Background

At the time of the initial passage of the Medicare statute, the inclusion of coverage for mental health care was seen as quite progressive since many private insurance plans had not yet provided any such coverage. The lack of private coverage then was a result of several factors. First, much of the care at the time was provided in publicly funded State mental hospitals or community clinics which did not bill insurance plans. Second, the dominant model of outpatient psychiatric treatment was psychoanalysis, which was very intensive and expensive and was not seen as "medical treatment." Third, the experience of those plans that did provide coverage (such as the Screen Actors Guild) was that utilization was high and so were the resulting expenditures.

Partly as a result of the latter experience and in order to control costs, Medicare effectively required that beneficiaries pay a coinsurance of 50 percent for outpatient psychiatric services in contrast to the 20 percent coinsurance required for any other covered service. A number of enhancements have been made to the psychiatric benefit over the years, including lifting the original $250 cap on outpatient psychiatric services to reflect inflation and a realistic understanding of the needs of psychiatric patients. However, the copayment for outpatient psychiatric services has not changed, thus perpetuating discriminatory treatment of individuals with mental illness.

Changes in Mental Health Treatment

Much has changed in the area of mental health treatment since the original enactment of Medicare more than 40 years ago:

- The explosion of knowledge about the biologic basis for most mental illness and the development of evidence-based treatments have become the dominant model of outpatient psychiatric treatment rather than psychoanalysis.
- Most psychiatric treatment is provided in community-based office settings rather than in publicly funded inpatient facilities.

- Most private insurance plans now cover outpatient psychiatric treatment, although in many instances there are still discriminatory practices relative to coverage of other medical conditions, a problem that is the focus of Federal legislative efforts for reform.
- Many States now require parity in mental health coverage for plans governed by State insurance statutes. In 1996, the Congress enacted and the President signed the Mental Health Parity Act, which requires parity for annual and lifetime limits on coverage for mental illness. As a result of these parity statutes and regulations, there is now a considerable body of data which show that implementation of mental health parity results in minimal incremental costs. For example, in the Federal Employees Health Benefits Program, it is estimated that parity implementation resulted in a 1.64 percent premium increase for fee-for-service plans and a 0.3 percent increase for health maintenance organizations.
- There is increasing recognition that mental illnesses are just as real and treatable as many other medical conditions.

Reimbursement Issues and the Effect on Patient Care

Patient Access Barriers: The Medicare requirement that beneficiaries pay 50 percent of the charge for outpatient psychiatric services in contrast to the 20 percent copayment required for any other covered service is outdated and not consistent with modern medical-psychiatric treatment and Medicare's intent with regard to medically necessary services. The effective 50 percent copayment exacts an increased out-of-pocket cost for beneficiaries who seek services that they expect will be covered like other health care services they receive. To the extent beneficiaries cannot afford this added cost, it keeps them from getting medically necessary services.[1–4]

It is important to note, as well, that studies have shown that untreated depression greatly increases the severity and costs associated with other medical conditions, such as heart disease and diabetes. Among older adults, comorbidities of this sort are the rule, not the exception, among those who suffer from depression.

Provider Disincentives: Geriatric mental health services are inadequate in many areas. The psychiatric limitation contributes in a major way to this state of affairs. The reality that, in many instances, the 50 percent actually paid by Medicare will amount to payment-in-full imposes a financial burden on health care providers, a circumstance that, in turn, imposes a profound barrier to access to needed care.

These barriers also affect delivery of mental health care in the primary care sector, where most mental health care is actually provided. The psychiatric limitation makes primary care physicians reluctant to spend the time needed to address mental health problems.[5] When psychiatric problems are addressed, services are often coded diagnostically for established medical illnesses (e.g., diabetes) rather than the psychiatric problem, in order to avoid the psychiatric fee reduction. This coding skews Medicare claims data on the utilization of health care services for mental health problems.

Addressing these problems will be crucial over the next 25 years, as the Baby Boomer population reaches Medicare eligibility. By the year 2010, there will be approximately 40 million people in the United States over the age of 65. Over 20 percent of those people will experience mental health problems. A national crisis in geriatric mental health care is emerging and has received recent attention in the medical literature. While many different types of mental and behavioral disorders can occur late in life, they are not an inevitable part of the aging process. However, these Medicare beneficiaries must have access to mental health professionals with expertise in geriatrics.

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[1] Med Care. 2006 Jun; 44(6):506–12. "The impact of parity on major depression treatment quality in the Federal Employees' Health Benefits Program after parity implementation." Busch AB, Huskamp HA, Normand SL, Young AS, Goldman H, Frank RG.

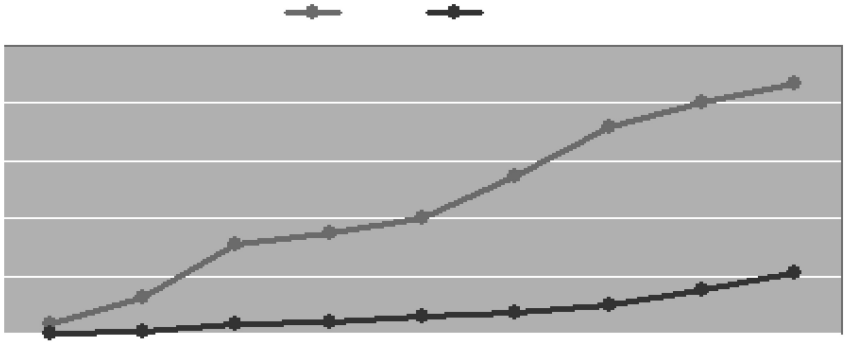
[2] Med Care. 2006 Jun; 44(6):499–505. "The effects of State parity laws on the use of mental health care." Harris KM, Carpenter C, Bao Y.

[3] Med Care. 2006 Jun; 44(6):497–8. "Mental health parity, access, and quality of care." Druss BG.

[4] N Engl J Med. 2006 Mar 30; 354(13):1378–86. Comment in: N Engl J Med. 2006 Mar 30; 354(13):1415–7. "Behavioral health insurance parity for Federal employees." Goldman HH, Frank RG, Burnam MA, Huskamp HA, Ridgely MS, Normand SL, Young AS, Barry CL, Azzone V, Busch AB, Azrin ST, Moran G, Lichtenstein C, Blasinsky M.

[5] Texas A&M University Health Sciences Center. Podium presentation. "One-and-a-Half-Minute Mental Health Care: Inside Primary Care Visits." Ming Tai-Seale, PhD, MPH; Thomas McGuire, PhD; Christopher Colenda, MD, MPH; David Rosen, MD; Mary Ann Cook, PhD.

The chart below, derived from U.S. Census Bureau statistics, demonstrates the sharp increase expected in the older population, and especially those over age 85, whose health care needs are particularly difficult to meet absent geriatric training:



Dual Eligibles: Another complication arises as a result of the use of State Medicaid funding to cover the copayment for financially disadvantaged Medicare recipients (dually eligible). Often the amount paid by Medicaid for these dually eligible recipients is minimal or disallowed altogether. This occurs because the allowed Medicaid rate is often near or below 50% of the Medicare allowed charge. This variation in allowed payment rate results in an effective decrease in revenues for those providing psychiatric care to the dually eligible Medicare/Medicaid population. As socioeconomic status and severity of psychiatric illness are highly correlated, those psychiatric specialists whose expertise is most needed for these more seriously ill patients experience a disproportionate amount of financial burden.

Coding Problems: These problems are further exacerbated and complicated by regionally varying rules regarding how the copayment is applied. Depending on the State, this variation in copayment is applied either to mental health providers, specific "psychiatric" diagnosis, or the type of CPT code utilized. Some Medicare carriers apply the psychiatric limitation based on the ICD–9 diagnosis code utilized. In some illnesses, two differing ICD–9 codes exist, one for "medical" care and another for "psychiatric" care. For example, 310 is the "medical" code for depression while 296.XX is the "psychiatric" code for Major Depression. The ICD–9 code 331 is defined as a neurologic code for dementia while 290.XX is the psychiatric code for senile or presenile dementia. Thus the particular code chosen can determine whether the psychiatric limitation applies for a particular Medicare carrier. Other carriers apply the psychiatric limitation strictly to mental health specialists even when the actual service delivered, CPT code chosen, and ICD–9 diagnosis is essentially identical to that used by a non-psychiatric physician and disregarding the fact that psychiatry itself is a medical specialty. Some carriers require that mental health professions use only psychiatric CPT codes. These practices are discriminatory to both mental health professionals as well as all those who are more seriously ill and require the additional expertise of the specialist.

The Cost of Inadequate Care

Major depression in late life is common, affecting 5–10% of patients in primary care. However, it is rarely the patient's only health problem; it may co-exist with chronic pain (40–60%), cancer (10–20%), neurologic disorders (10–20%), diabetes (10–20%), heart disease (20–40%), and geriatric syndromes (20–40%). Medical illnesses with depression have been shown to have worse outcomes—greater symptom burden, disability, complications, mortality, and cost for all health services. It is a major barrier for effective chronic disease management; a recent diabetes study demonstrated that depression meant poorer adherence to medications, more obesity and smoking, less exercise and healthy eating, and higher blood sugar levels.[6] Total health care costs are 50% higher for patients with depression, even after adjusting for comorbid medical illnesses.[7, 8] And depression is deadly; older adults have the highest rate of suicide in the United States.

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[6] *Annals of Family Medicine*. 2006; 4:46–53. "Effects of Enhanced Depression Treatment on Diabetes Self-Care." Elizabeth H.B. Lin, MD, MPH, et al.

[7] JAMA. 1997 May 28; 277(20). "Depressive symptoms and the cost of health services in HMO patients aged 65 years and older. A 4-year prospective study." Unutzer J.

Depression can be treated with medications or psychotherapy, but only half of depressed older adults are "recognized" and even fewer are treated. Older men, African Americans, and Latinos have particularly low rates of depression treatment. Most older adults prefer treatment by their primary care physicians. However, in this setting, there is an increasing use of antidepressants but treatment is often not effective, due to early treatment dropout, staying on ineffective medications too long, and little access to psychosocial treatments. On the other hand, programs for collaborative care for depression in primary care settings have been shown to be more effective, consistently, than usual care, if the programs include active care management (not case management), support of medication management in primary care, and psychiatric consultation.[9]

Recommendation

AAGP strongly supports this legislation to amend Medicare law to provide for the same support for treatment of mental illness as would be standard for any medical illness. Passage of parity would not only improve the quality of care and life for those suffering with mental illness but would end the existing practice that unfairly penalizes practitioners who choose to serve this population and discourages new practitioners from entering the field.

Statement of American Association for Marriage and Family Therapy

Chairman Stark, Ranking Member Camp, and other Subcommittee Members, on behalf of our 24,000 members, the American Association for Marriage and Family Therapy (AAMFT) appreciates this opportunity to submit comments for the record of the Subcommittee's hearing on mental health and substance abuse parity in Medicare and private health plans. AAMFT is the sole national organization representing the 50,000 licensed Marriage and Family Therapists (MFTs), and the profession of Marriage and Family Therapy is one of the five federally-defined "core mental health professions."

Health insurance is supposed to protect consumers from catastrophic financial expenses when they experience major illnesses. But under current Federal law, neither Medicare nor private health insurance plans are required to provide full parity in mental health or substance abuse benefits in comparison to coverage of physical illnesses. So current law exposes millions of Americans and their families to financial ruin when they incur a major mental health or substance abuse impairment, even though behavioral health treatment is effective and a relatively inexpensive share of total health care spending. And because of the paucity of third-party coverage, there are widespread shortages of mental health practitioners in lower-income areas, especially in rural and inner-city locales.

As a result, each year, millions of Americans do not receive needed behavioral health treatment. This situation is simply unacceptable in a country that has the most wealth and the most advanced health care system in the world. That is why AAMFT strongly endorses the following legislation:

- The Medicare Mental Health Modernization Act, H.R. 1663, by Reps. Stark, Ramstad and Kennedy, which would make a number of improvements to Medicare, including adding coverage of MFTs under Part B.
- The Seniors Mental Health Access Improvement Act, H.R. 820, by Reps. Towns and Pickering, which also would add coverage of MFTs under Part B.
- The Paul Wellstone Equitable Mental Health Treatment Act, H.R. 1424, by Reps. Kennedy, Ramstad and 257 other House Members, which would require private health plans to set all coverage conditions for behavioral health benefits in the same fashion as for physical illnesses.

We would like to focus our comments on how these bills would improve access to MFTs and other behavioral health care providers. Among 1,253 rural U.S. counties with 2,500 to 20,000 people, nearly three-fourths lack a psychiatrist, 58 percent have no clinical social worker, and 50 percent lack a master's or doctoral psychologist. The supply of all these professionals is far lower in the 769 rural "frontier" counties with fewer than 2,500 people. Further, the HHS Health Resources and

[8] Arch Gen Psychiatry. 2003; 60:897–903. "Increased Medical Costs of a Population-Based Sample of Depressed Elderly Patients." Katon WJ, et al.

[9] *Arch Intern Med*. 2006; 166:2314–2321. "Collaborative Care for Depression: A Cumulative Meta-analysis and Review of Longer-term Outcomes." Gilbody, et al.

Services Administration indicates that 90% of psychiatric and mental health nurses with graduate degrees are in metropolitan areas.

There are many counties where only a marriage and family therapist is present to serve the elderly population. A targeted study of licensed professionals in a sampling of States found many counties with no Medicare mental health providers, but with a marriage and family therapist, including Clayton, Iowa; Hamilton, Florida; Hutchinson, Texas; and Brunswick, Virginia, to name only a few.

In addition, our profession is working diligently to increase the supply of MFTs in areas with concentrations of ethnic minorities. As two examples of this, MFTs are eligible for placement in underserved inner-city areas as part of the National Health Service Corps, and ethnic-minority MFT students are now eligible for scholarships under the HHS Substance Abuse and Mental Health Services Administration's Minority Fellowship Program.

MFTs are legally authorized through State licensing laws to treat mental illness. They are required to obtain a master's degree in a mental health discipline and 2 years post-graduate supervised clinical experience, much like existing Medicare-covered mental health providers such as clinical social workers. H.R. 1663 and H.R. 820 would not change Medicare's mental health benefit or modify the MFT scope of practice, but would merely allow Medicare beneficiaries who need medically necessary covered mental health services to obtain those services from a marriage and family therapist. In other words, these bills would increase the pool of qualified providers that Medicare beneficiaries can choose from without change to the services.

In addition, to minimize costs, H.R. 1663 and H.R. 820 would set MFT Part B payment rates at 75% of the corresponding amounts allowed for psychiatrists and psychologists for the same services. This 75% level is the same as applied to clinical social workers, who—as with MFTs—also must have a minimum of a master's degree in order to be Medicare-eligible. Staff of the Congressional Budget Office (CBO) estimate that the cost of covering MFTs under Part B would be approximately $9 million annually.

Legislation for Medicare MFT coverage has twice passed the U.S. Senate, as its original Medicare Modernization Act (S. 1) in 2003 and its original Deficit Reduction Act (S. 1932) in 2005. But this provision was dropped both times in conference with the House, despite the fact that in the previous Congress, 137 House Members cosponsored one or more bills that included Medicare MFT coverage.

AAMFT believes the current limits on Medicare's mental health benefit contribute to the elderly's suicide rate being 50% greater than for the under-65 population. Thus, we also support the other provisions of H.R. 1663, such as reducing the current Part B beneficiary copayment for mental health services from 50% to 20% in order to achieve parity with the 20% copayment rate for other services.

Likewise, we applaud the private health plan parity provisions of H.R. 1424. As shown by a federally-funded study of the Federal Employees Health Benefit Program, parity would increase health plan costs for under-65 enrollees only about 1%, a small price to obtain financial protection for millions of Americans.

In addition, although CBO rules prohibit "dynamic" cost estimates that account for indirect savings from new legislation, there is extensive scientific research showing that mental health treatment has a substantial "offset" savings effect by reducing future costs for physical illnesses. In addition, parity will reduce employers' costs for sick leave and disability pay, and will improve the quality of life for millions of Americans. Thus, we believe behavioral health parity in both Medicare and private health plans would be cost-effective.

In summary, we applaud the Subcommittee for holding this important hearing, and thank Chairman Stark for his leadership on these issues. As shown by the bipartisan support for H.R. 820, H.R. 1588 and H.R. 1663, equity in behavioral health insurance coverage is not a partisan issue. We urge the Subcommittee to favorably report these bills at the earliest possible time and look forward to working with Subcommittee Members as you address this urgent issue. Thank you for your consideration.

Required Supplemental Sheet—Hearing on Mental Health and Substance Abuse Parity 3/27/07

Submitting Organization: American Association for Marriage and Family Therapy
Address: 112 S. Alfred St., Alexandria, VA 22314
Contact: Brian Rasmussen, Government Affairs Manager, (703) 253–0463; brasmussen@aamft.org
Fax: (703) 253–0506

Statement of Amy Kuehn, Indianapolis, Indiana

My name is Amy Kuehn and I live in Indianapolis, Indiana. I have two sons. Nicholas is 11 years old and Matthew is 8 years old. Nicholas has been diagnosed as being on the autism spectrum with Asperger's and also has ADHD. My children have Medicaid for insurance. The Governor of Indiana, Mitch Daniels, declared earlier this year that mental illnesses on the autism spectrum would no longer be covered by the Medicaid insurance. This leaves my family, along with countless others, floundering in the mental health system. Riley Children's Hospital, which has an entire department devoted to diagnosing and treating Autism Spectrum Disorders (ASD) can no longer accept children and adolescents who have Medicaid, who only qualify for this insurance because of low income, unless the parents pay the $150 appointment fee out-of-pocket. Obviously, most of us are unable to afford to do this while we are desperately trying to seek treatment for our children so that they can function to their fullest potential in society. This decision is a huge obstacle for even mediocre parents.

For our own family, Nicholas is in bi-weekly therapy, which is only being covered because his treatment team is listing ADHD as his primary diagnosis. The truth of the matter is that the ADHD is just an offshoot of his Asperger's. Nick lacks social skills, has great difficulty with school, has no friends, completely failed the standardized tests that will be used to determine if he graduates, and as things are going now, will be unable to live independently or even semi-independently upon entering adulthood. Although he is 11 years old, he is emotionally younger than my 8 year old. I sent him to a social skills day camp last summer that was on a sliding scale. Even with that scale, it was far too expensive since Medicaid would not pay at all. The only way that he was able to attend was that my parents paid for it. This is not their job. We pay the Medicaid insurance premiums but the services that we are offered are severely limited and do not meet the needs of my son. Insurance is not helping my son to grow to his potential and I have no recourse because the laws, as they stand, do not allow for it.

The rates of prevalence and incidence of autism just last year were 1 out of 166. Now it is 1 out of 150. With the increased prevalence and incidence, it would make sense that there would be a push for increased services, but the opposite is happening. Because my son needs so much one-on-one assistance for nearly everything that he does and because he has so many appointments, I am unable to work outside the home. This puts our family into even worse financial straits. Without adequate services and treatment, Nick will be a consumer of disability services throughout his adult life and will most likely be a recipient of SSI. As things stand, he will not be a productive member of society, despite his desires to do so.

I do not have any understanding how Governor Daniels was able to single out autism and stop Medicaid coverage for it. He referred to it as a mental health issue, but in truth, autism is a neurological disorder. This certainly seems counter-intuitive for a governor who places much of his reputation on being financially responsible since the obvious result from parental loss of productivity will increase leading to a greater need for public assistance for families for now. Also, as our children grow older, they will also need increasing amounts of social assistance for assisted-living and other disability services.

Passing mental health insurance parity which would include Medicaid and ASDs would help many of us to improve the quality of the lives of our children and lessen their future need for public assistance and disability benefits.

Thank you very much for taking the time to review my testimony on such an important topic. I have submitted my testimony about my own, very costly mental illness through ANAD (National Association of Anorexia Nervosa and Associated Disorders) and my insurance's failures to help me which ended up costing my family so much that we had to file for bankruptcy in the amount of $200,000 in medical bills. That was in 2001 and again, my bills are piling up because of the physical consequences of my 20+ year battle with anorexia and bulimia. This all seems never-ending even though I'm in solid recovery and committed to remaining this way. I really look forward to a positive outcome with this campaign and applaud the Honorable Patrick Kennedy and Honorable Jim Ramstad for taking the lead with this campaign.

Therapeutic Communities of America
March 27, 2007

The Honorable Fortney "Pete" Stark, Chairman
U.S. House of Representatives
Committee on Ways and Means
Subcommittee on Health
Room 1102 LHOB
Washington, DC 20515

The Honorable Dave Camp, Minority Ranking Member
U.S. House of Representatives
Committee on Ways and Means
Subcommittee on Health
Room 11139 LHOB
Washington, DC 20515

Dear Chairman Stark and Representative Camp:

As you know, only 18.2% of all Americans over the age of 12 needing treatment actually receive it. This is a startling statistic and shows the need for public policy and community efforts to end discrimination and provide access to quality care earlier for individuals with substance use and mental health disorders. Equity legislation can assist with closing this treatment gap.

Thank you for holding the hearing on March 27, 2007 on mental health and substance abuse parity. Therapeutic Communities of America (TCA) provides the following comments for your consideration. The introduction of the bill last week, to require parity in mental health services for Medicare beneficiaries and eliminate a 190-day limit on inpatient treatment and lowering the copay requirements will improve access for seniors to receive needed services that are client-based and will allow for better outcomes. It confirms the necessity to establish in publicly-funded programs equity for access and effectiveness.

TCA member programs are mostly publicly funded through an array of public programs that weave and leverage public funding to provide client-based holistic addiction and mental health services to low income Americans. TCA member programs treat low income Americans from pregnant women to seniors in need of mental health and addiction services. TCA appreciates the importance of equity for mental health coverage for Medicare recipients and is respectful of the efforts of your Committee.

Therapeutic communities receive limited third party private payer reimbursement and although not directly impacted by health plan parity bills our members through their experience know the importance to develop consistent bills that would not place additional limitations or consequence on public services by permitting reimbursement to be based on costs and not be based on patient-based clinical criteria and quality indicators. TCA has attached a list of safeguards that should be considered as any legislation is advanced for private health plan parity bills. Those concerns include preemption, medical necessity criteria, managed care, disclosure, and equity. The *Paul Wellstone Mental Health and Addiction Equity Act of 2007* recently introduced addresses those concerns and we hope that the bill is not amended to weaken any of its current safeguards, and as such, those provisions in the bill remain through final passage. Your hearing demonstrates the Committee's understanding for policy that advances appropriate care to all our citizens.

We respectfully request that as you work toward equity for mental health and substance abuse treatment and prevention services that you consider the principles of the National Institute on Drug Abuse (NIDA) for drug treatment effectiveness. NIDA research shows the importance of length of stay in treatment and other principles that should be protected to assure equity with other chronic illnesses. Some of those principles include:

- No single treatment is appropriate for all individuals.
- Effective treatment attends to multiple needs of the individual, not just his or her drug use.
- Remaining in treatment for an adequate period of time is critical for treatment effectiveness.
- Recovery from substance abuse can be a long process and frequently requires multiple episodes of treatment.
- Treatment of addiction is as successful as treatment of other chronic diseases such as diabetes, hypertension and asthma.

- Substance abuse treatment programs should be constructed on evidence-based methodologies that are outcome based and meet performance measures.[1]

Depending on the stability and support an individual with a substance use disorder has within their environment; and the progressive stage of their disease, a patient will need criteria that understands the type, kind, duration, and multiple treatment needed by that person for recovery. It is important that a skilled service provider with specific training in addiction should do assessment, referral, placement, clinical determinations, and treatment of an individual with substance use disorders. Substance abuse treatment is a process that moves from motivation and stabilization to recovery as it is with other chronic diseases.

TCA appreciates your commitment and your leadership on this important issue. Please contact us if we can provide additional information at (202) 296–3503.

Sincerely,

Linda Hay Crawford
Executive Director

Therapeutic Communities of America (TCA), founded in 1975, represents over 600 programs across the country dedicated to serving those with addiction and mental health disorders. Therapeutic Communities provide a comprehensive continuum of care to patients, many of whom have multiple barriers to recovery, such as co-occurring mental illness, the homeless, adolescents, pregnant women, and HIV/AIDS. Therapeutic Communities also strive to help individuals secure family unification and successful welfare-to-work outcomes.

The Therapeutic Community methodology of treatment was established in the late 1950's, addressing the entirety of social, psychological, cognitive, and behavioral factors in combating alcohol and drug abuse. Traditionally, Therapeutic Communities have been community-based long-term residential substance abuse treatment programs.

In recent years, TCA members have expanded their range of services, providing outpatient, prevention, education, family therapy, transitional housing, vocational training, medical services, and case management in addition to long-term residential programs. Additionally, many therapeutic communities are involved with drug courts, in-prison programs, offender re-entry programs, and continuing care.

Attachment 1

Safeguards for Equity for Mental Health and Addiction Prevention and Treatment

Preemption

Approximately 42 States have current laws that require some form of addiction and/or mental health coverage which mostly focus on addiction treatment protection and coverage. TCA strongly recommends that any legislation not preempt any State law or State provision that provides greater protection than Federal language. Such assurance needs to be correctly stated in Federal language. The House of Representatives, *Paul Wellstone Mental Health and Addiction Equity Act of 2007* bill, currently has language that safeguards for preemption so that any State laws that provide greater consumer protections, benefits, rights or remedies are not impaired or deemed not enforceable.

Medical Necessity

Criteria for medical necessity should be based on uniform clinical criteria to be developed based on quality indicators, patient assessment, and effectiveness of care and not cost alone. Managed Care plans should not be given the discretion to define uniform criteria as part of their authority. It is recommended that uniform clinical patient placement criteria are developed and that other criteria currently used by a State or the American Society of Addiction Medicine (ASAM) should be considered as a floor and a minimum in any legislation.

Managed Care

Any policy that does not recognize the unique nature of addiction and our experience with the difficulty of providing necessary services for individuals covered under

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[1] Based in part on *Principles of Drug Addiction Treatment—A Research-Based Guide*, National Institute on Drug Abuse, National Institutes of Health, and NIH Publication No. 004180.

managed care plans or schemes, which cause delays, denials, and have negative consequences to individuals needing help, should not be considered. Equity legislation should include safeguards to protect individuals with mental disease and substance use disorders from delays and denials.

Transparency and Disclosure

Any legislation should require that all plans be made available to providers and plan participants' with copies of their medical necessity criteria, procedures, appeal process, and exclusions under such plans publicly available in advance to providers considering coverage under the plan, employers considering coverage with a plan, and participants considering or currently within a plan.

Disease Equity

Any legislation should require group health plans to provide mental disease and substance use disorder treatment benefits in parity with other diseases, illnesses and medical conditions. The timeliness of treatment can impact the early identification and recovery of an individual seeking treatment. Unfortunately, TCA members often see clients after they have lost their jobs and families. An individual with access to treatment earlier in their addiction should be given every chance to be treated with equity and without clinical discrimination.

Statement of Mike Fitzpatrick

Chairman Stark, Representative Camp and Members of the Subcommittee, on behalf of the 210,000 members and 1,200 affiliates of the National Alliance on Mental Illness (NAMI), I want to thank you for convening this important hearing on the need for parity for mental illness and substance abuse parity in the Medicare program and private sector health plans. As the Nation's largest organization representing people living with serious mental illness and their families, NAMI would like to offer strong support for equitable coverage for mental illness treatment across all public and private sector programs.

Since NAMI's inception in 1979, we have always supported enactment of standards that ensure nondiscriminatory coverage of treatments for illnesses such as schizophrenia, schizo-affective disorder, bipolar disorder, major depression and severe anxiety disorders. This demand for parity level coverage is rooted in basic principles in the founding of NAMI as a consumer and family organization. NAMI believes strongly that:

1. mental illnesses are real,
2. treatment for mental illness works—if you can access it, and
3. there is simply no medical or economic justification for public sector programs or private health insurance plans to cover treatment for mental illness on different terms or conditions than any other illness.

The Costs of Untreated Mental Illness Are Overwhelming for Our Nation

- Mental disorders are the leading cause of disability in the U.S. for ages 15–44.
- Suicide is the eleventh leading cause of death in the U.S., but is the third leading cause of death for people 10 to 24 years old. More than 90 percent of people who die by suicide have a history of mental illness.
- Adults with serious mental illness die 25 years younger than other Americans. A man with serious mental illness is likely to die by age 53, compared with the average male life expectancy of 78 years.
- Approximately 50 percent of students with a mental disorder age 14 and older drop out of high school; this is the highest dropout rate of any disability group.
- Twenty-four percent of State prison and 21 percent of local jail inmates have a recent history of a mental health disorder. An alarming 65 percent of boys and 75 percent of girls in juvenile detention have at least one mental disorder.
- Between 2000 and 2003, emergency department (ED) visits with a primary diagnosis of mental illness increased at four times the rate of other ED visits.
- The annual economic, indirect cost of mental illnesses is estimated to be $79 billion. Most of that amount—approximately $63 billion—reflects the loss of productivity as a result of illnesses.

NAMI Strongly Supports H.R. 1663

Chairman Stark, NAMI would like to congratulate you and your colleagues for bringing the Medicare Mental Health Modernization of 2007 (H.R. 1663) forward. For many years you have been the leader in Congress in pushing for equitable coverage for mental illness treatment in the Medicare program. As you know, Medicare

has perhaps the out-of-date and discriminatory benefit for mental illness and substance abuse treatment of any public or private sector program. The most widely recognized restrictions are the discriminatory limit of 190 lifetime days on inpatient care under Part A and the 50% cost sharing requirement for outpatient services under Part B.

These restrictions—which apply only to mental illness treatment—were unacceptably intolerable in 1965, and are even more troubling in 2007. Over the past 40 years we have witnessed enormous advances in treatment for mental illness. Treatment for disorders such as schizophrenia, bipolar disorder and major depression rival those for heart disease and hypertension in terms of efficacy and effectiveness. More importantly, the public health burden associated with major mental illnesses far exceeds that for many other medical disorders. It is simply unacceptable for the Medicare program—a critical public sector program that serves the most vulnerable and disabled individuals in our Nation—to impose discriminatory limits on mental illness treatment.

Mr. Chairman, H.R. 1663 contains a number of important provisions that you have championed for years:

- Reduction of the discriminatory 50% copayment for outpatient mental health services to 20%, and
- Elimination of the arbitrary 190-day lifetime limit on inpatient psychiatric care.

As in the past, NAMI strongly supports your leadership in moving to eliminate these outdated and unfair limits on treatment coverage. In addition, NAMI would also like to express support for long overdue improvements to the Medicare program in H.R. 1663 designed to update the program and make it consistent with evidence-based practice for treatment of mental illness. Among these critical improvements is the addition of new community-based residential and intensive outpatient mental health services.

These important community-based services are part of the most widely recognized evidence-based, recovery-oriented service delivery model, programs of Assertive Community Treatment (ACT). Many States are currently using the Medicaid program to finance ACT services for the most disabled individuals living with mental illness. Unfortunately, changes to the Medicaid Rehabilitation Option now actively under consideration at the Centers for Medicare and Medicaid Services (CMS) would devastate the ability of States to fund these critical services. These changes have not been endorsed by Congress and NAMI would urge you and your colleagues to continue oversight efforts to hold CMS accountable for enacting these unauthorized and destructive changes. In the meantime, passage of H.R. 1663 will go a long way toward broadening access to intensive community-based services for Medicare beneficiaries—both elderly and non-elderly people with disabilities receiving SSDI—living with severe mental illness. Finally, NAMI also applauds the efforts of this legislation to address the shortage of mental health professionals in rural and medically underserved regions.

Parity for Private Sector Health Insurance Plans Should Be a Top Priority for the 110th Congress

Mr. Chairman, as you know Congress has been debating enactment of a Federal standard for equitable coverage of mental illness treatment in group health insurance plans since the early 1990s. This has included enactment of the Mental Health Parity Act in 1996 that required parity, but only for annual and lifetime dollar limits. Since 1996, various bills have been introduced—some of which made progress—to require full parity, i.e. by adding durational treatment limitations (limits on inpatient days and outpatient visits that apply only to mental illness) and financial limits (higher cost sharing, deductibles and out-of-pocket limits that apply only to mental illness).

Mr. Chairman, as you know there are separate House and Senate parity bills (S. 558 and H.R. 1424) that have broad bipartisan support. While there are differences between the bills, they are remarkably similar.

The separate House and Senate bills contain a number of major similarities. Both bills:

1. Expand on the limited 1996 Mental Health Parity Act that requires equitable coverage for mental illness only with respect to annual and lifetime dollar limits. Both expand on these requirements by requiring parity for treatment limitations (limits on inpatient days and outpatient visits that apply only to mental illness and substance abuse) and financial limitations (higher cost sharing, copayments or deductibles that applied to mental illness or substance abuse treatment).

2. Impose a parity standard as a coverage condition, i.e. neither bill mandates coverage of mental health or substance abuse treatment, but instead requires that if mental health and substance abuse benefits are offered, they must be on equal terms with medical surgical benefits. In other words, both bills allow employers and health plans to avoid the parity requirement by simply dropping mental health and substance abuse coverage altogether.
3. Amend the laws governing self-insured ERISA plans and fully insured plans regulated by the States. This means that parity would reach the 82 million covered lives in self-insured plans that are beyond the reach of State parity laws. Likewise, both bills amend the Federal Public Health Services Act (PHSA) to reach fully insured plans in States that have not passed parity laws. By amending both ERISA and the PHSA will ensure that parity reaches an estimated 130 million Americans (82 million covered lives in ERISA plans and 45 million in State regulated plans under the PHSA, 25 million of whom are in the 42 States with parity laws).
4. Achieve parity for both mental illness and substance abuse disorders, a major step forward for individuals with co-occurring mental illness and substance abuse disorders.
5. Exempt group health plans sponsored by small employers, those with 50 or fewer workers, from the requirements of parity coverage.
6. Allow for employers or group health plans to seek an exemption if costs rise more than 2% as a result of compliance with the parity requirement. Both require health plans to first comply with the law for 6 months before seeking this cost increase exemption, and both would require plans getting an exemption to come back into compliance the following year.

At the same time, there are differences between the House and Senate bills on a number of important issues. These differences include:

- Scope of Benefits—Whether or not to define a list of required mental health and substance abuse diagnoses that must be covered by all health plans, or whether to defer to health plans and employers to define mental health and substance abuse benefits as under current law.
- State Preemption—How a new Federal standard for mental health and substance abuse parity should interact with the existing 42 State parity law, i.e. whether or not a new Federal standard should displace all or part of a State law.
- Out-of-Network Coverage—Both bills require parity for out-of-network benefits (i.e., equal treatment limits and equal cost sharing). However, the House bill goes further and requires plans to have an out-of-network benefit for mental health and substance abuse if it exists on the medical-surgical side.

Mr. Chairman, NAMI has endorsed the Senate bill. It is a product of significant work by all sides in this debate and has already been reported by the Senate Health, Education, Labor and Pensions (HELP) Committee by an 18–3 vote. The Senate bill also has the support of groups representing employers and health plans that have fiercely resisted parity legislation in the past. The House bill also has broad support, with more than 250 cosponsors.

In NAMI's view, these circumstances create an enormous opportunity for agreement from all sides—

- Democrats and Republicans in both the House and Senate,
- President Bush,
- Groups representing employers and health plans, and
- NAMI's colleagues among the advocacy groups representing consumers, families, providers and professionals.

This is the moment for mental illness and substance abuse insurance parity. The differences between the House and Senate bills are narrow and can easily be bridged if the political will is there among all sides. More importantly, the broad bipartisan support for this legislation exceeds that for any other major health care proposal in the 110th Congress. Enactment of mental illness parity will demonstrate that Congress and the President can come together to produce meaningful health care reform for the American people. It is imperative that equitable coverage for mental illness treatment reach the 82 million Americans in ERISA self-insured plans that are beyond the reach of the 42 State parity laws.

Conclusion

Mr. Chairman, thank you for convening this important hearing. NAMI looks forward to working with you to achieve enactment of both H.R. 1663 and S. 558–H.R. 1402 this year.

Statement of National Association of Anorexia Nervosa and Associated Disorders

The National Association of Anorexia Nervosa and Associated Disorders ("ANAD") is the Nation's oldest nonprofit organization dedicated to education, early detection, and prevention of anorexia nervosa, bulimia nervosa, binge-eating disorder, and obesity. ANAD was founded in 1976 by Vivian Meehan, RN, DSc. At that time, there was literally no information for sufferers or families and no support systems for people with eating disorders.

Over the past 30 years, ANAD has grown into a national and international association with education and support systems in 50 States and several foreign countries. ANAD responds to over 5,000 **hotline calls yearly, provides counseling and referrals, sponsors a national network of free support groups, and offers education and prevention programs to promote self-acceptance and healthy lifestyles**. Together with over 250 support groups, victims, families, laypersons, and health care professionals, ANAD advocates on behalf of the countless individuals and families who have been or will be impacted by eating disorders in their lifetimes.

Eating disorders are at epidemic levels in America. An estimated seven million women and one million men suffer from eating disorders, and they impact all segments of society—the young and old, the rich and poor, and all ethnic groups including African American, Latino, Asian and Native American. Eating disorders cause tremendous suffering for victims and families. Anorexia nervosa has the highest mortality rate of any mental illness; the most frequent causes of death, according to the NIMH, are complications of the disorder, including cardiac arrest or electrolyte imbalance and suicide. Eating disorders are treatable and sufferers can recover provided that they receive adequate treatment.

ANAD receives hundreds of calls from individuals and their families who have been denied health insurance coverage and are desperately seeking access to appropriate treatment for their illnesses. If not properly treated, victims, like **Amy Kuehn, Co-leader of ANAD's Indiana Eating Disorders Coalition**, suffer irreparable harm and find themselves requiring more and more costly health services throughout their lives.

Amy Kuehn actively suffered from eating disorders for over 20 years. Her personal account illustrates how discriminatory insurance practices pose major barriers to appropriate mental health treatment. All too often the burden of inequitable mental health coverage is unfairly borne by individuals like Amy resulting in devastating personal and financial losses. Amy may have been more fortunate than people in the majority of States in the U.S. who have no health care coverage for their eating disorders. But if Amy had access to appropriate care at the onset of her illnesses, she may have avoided more than 20 years of costly and inadequate treatment for her eating disorders.

With the overwhelming number of personal tragedies that occur absent or with unequal mental health coverage, ANAD urges passage of H.R. 1424, the Paul Wellstone Mental Health and Addiction Equity Act of 2007. Federal mental health parity now can make the difference between life and death for a person with an eating disorder. The inclusion of eating disorders under the Paul Wellstone Mental Health and Addiction Equity Act of 2007 means the removal of major restrictions and limitations throughout the Nation to early detection and access to treatment, which offers the best chance for recovery and prevention of the lifelong effects of these potentially chronic and disabling illnesses.

A Personal Account: How Inequitable Mental Health Coverage Creates Major Barriers To Appropriate Treatment for Eating Disorders

My name is Amy Kuehn. I am 36 years old, a mother of two, college graduate, and in recovery from anorexia nervosa and bulimia nervosa. I actively suffered from my eating disorders for over 20 years before I started my long-term recovery. My eating disorders have caused short-term and chronic medical complications. I have suffered from kidney failure, bleeding ulcerations in my esophagus and stomach, and extremely low blood pressure and heart rate. I was diagnosed with osteoporosis at age 30, and with chronic anemia, chronic GERD, gastric ulcers, dental erosion, and heart conditions.

My eating disorders began when I was 10 years old. Under my parents' insurance, I received treatment that was misguided and inadequate as a result of existing discriminatory insurance practices. I entered an adolescent psychiatric inpatient facility for 6 weeks during my senior year of high school. I spent that time with other adolescents who carried diagnoses of conduct disorder, drug addiction, alcohol addiction, oppositional-defiant disorder, and depression but nobody else there shared my

diagnoses of anorexia and bulimia, except for one nurse who confided in me that she often vomited after eating.

While in college in 1991, I was no longer eligible for my parents' insurance and had to obtain my own. Between 1991 and 2003, when I started my long-term recovery, I had numerous psychiatric hospitalizations for anorexia nervosa, bulimia nervosa, severe depression with and without suicidal ideation, and suicide attempts. Insurance dictated whom I could see which meant that at times, I still had to settle for extremely unqualified psychiatrists and doctors and inpatient psychiatric hospitalizations designed for persons with bipolar, schizophrenia and other mental illnesses unrelated to my eating disorders.

While my insurance covered parts of those hospitalizations, there were enormous expenses that were not covered. I was married in 1993 so this became marital debt. I also had my children in 1995 and 1998 so finances became difficult to manage. Finally, in January 2001, we had no choice but to file for bankruptcy on my approximately $200,000 of bills related to care, however inadequate, for my eating disorders.

I can only imagine how things could have been different for me if my insurance would have covered eating-disorders specific treatment when I was young. The enormous personal and financial costs incurred for years of suffering from my illnesses, expensive, unnecessary, and inappropriate psychiatric hospitalizations, physical deterioration caused by my anorexia and bulimia, and the emotional toll of fighting with my insurance company could have been avoided if only I had insurance coverage that provided access to treatment for eating disorders.

I do not consider my own story to be better or worse than others' stories, just representative. I am one of many persons who either have no health insurance coverage for eating disorders or insurance coverage that restricts access to treatment for my life-threatening conditions. While I cannot regain over 20 years of disability or reverse the permanent physical effects of my eating disorders, this Federal mental health parity legislation before you can offer the increasing number of victims, including children as young as 6 years of age, equitable access to early and specialized care and the promise of early recovery that was so unavailable to me.

For more information, please contact Mary Elsner, ANAD's Director of Advocacy and Government Affairs.

Statement of National Association of Health Underwriters, Arlington, VA

The National Association of Health Underwriters (NAHU) is the leading professional trade association for health insurance agents and brokers, representing more than 20,000 health insurance producers and employee benefit specialists nationally. Our members service the health insurance policies of millions of Americans and work on a daily basis to help individuals and employers purchase health insurance coverage. As such, we know first-hand how much the cost of health insurance coverage is impacting our Nation's employers and the overall economy. NAHU feels that any measure to expand Federal mental health parity requirements should take into consideration the impact that such legislation could have on the cost of group health insurance and the ability of employers to continue to provide coverage for their employees.

NAHU believes that the current Federal law for mental health parity has served group plans well. The current efforts in Congress to craft a new parity requirement, however, have come a long way to bridge the differences that have stifled passage of changes to the current parity requirements in the past. We are particularly pleased with the provisions in both S. 558 and H.R. 1424 to preserve plan medical-management practices and the exemption for individual and small-group plans from the proposed requirements.

However, NAHU is concerned about provisions in H.R. 1424 that differ from the Senate bill and would use the *DSM–IV* for purposes of coverage determinations. We believe such a Federal coverage mandate on employers would drive up costs, and is unprecedented in terms of other medical specialties. The DSM–IV was developed as a teaching tool; it was never intended to be a diagnostic coding guide for reimbursement. Furthermore, many of the most comprehensive plan designs maintain differences between categories of mental health conditions, and only provide coverage to biologically-based mental illnesses, as opposed to some of the more arbitrary problems outlined in the DSM–IV like caffeine addiction and jet-lag. Employer-sponsored health plans need the flexibility to experiment with differing coverage options to control costs, and mandating coverage like this would take this needed flexibility from employers. NAHU feels that the language in S. 558, which

allows insurers and employers to decide which mental health benefits they will cover, is far preferable.

As you consider this important legislation, please keep in mind that employers are struggling to continue to provide health insurance benefits to employees, as costs continue to increase each year. Parity requirements will not benefit consumers if their cost creates a barrier to entry and causes employers to drop coverage. The language in S. 558 reflects a fair and carefully crafted compromise involving all interested parties, including employers, insurers and mental health parity advocates. It provides needed consumer protections in a way that won't cause excessive cost increases. NAHU urges the Committee to consider making changes to H.R. 1424 so that it will more closely mirror its counterpart legislation, S. 558.

Thank you for the opportunity to provide comment on H.R. 1424. If you have any questions, or if NAHU could be of further assistance, please do not hesitate to contact me.

National Association of Pediatric Nurse Practitioners
March 27, 2007

The Honorable Pete Stark, Chairman
Ways and Means Health Subcommittee
1136 Longworth House Office Building
Washington, D.C. 20515–6349

Dear Chairman Stark:

The National Association of Pediatric Nurse Practitioners (NAPNAP) represents approximately 7,000 members as the professional association for pediatric nurse practitioners and other advanced practice nurses who care for children. Pediatric nurse practitioners are registered nurses with advanced education and clinical experience and provide primary care services to children from birth to 21 years of age.

We write to you today to provide support for the Subcommittee's March 27 hearing on mental health parity. Although the hearing's focus was predominantly on mental health and substance abuse parity for the Medicare program, we understand all too well that Medicare coverage decisions often have a profound effect on commercial health coverage decisions.

The incidence of children and adolescents with mental health problems in the United States is significant—with as many as one in five children with a diagnosable mental, emotional or behavior disorder. An estimated two-thirds of all young people with mental health problems are not receiving the help they need. The National Association of Pediatric Nurse Practitioners is working to raise public awareness of these problems, correct common misperceptions, and implement preventive interventions targeted in children through its ***KySS^{sm} Program*** *(Keep your children/yourself Safe and Secure)*.

NAPNAP strongly values educational-behavioral interventions to teach children, youth, and their parents all aspects of physical and emotional safety and to build self-esteem, as well as other developmental assets. The ***KySS^{sm}*** Program promoted the mental health of children and adolescents through:

- integration of mental health promotion, screening, and early evidence-based interventions;
- health care that includes prevention, early recognition and treatment of mental health problems in childhood;
- promotion of optimal level of functioning and development that will form the foundation for productive adult years.

We have not yet had the opportunity to review your legislation, H.R. 1663 to address mental health parity, but look forward to offering our support. We support H.R 1367 by Representative Patrick Kennedy, a bill that requires equity in the provision of mental health and substance-related disorder benefits under group health plans.

If we can be of assistance to the Committee on this issue, please feel free to contact our Washington Representative, Amy Demske.

Sincerely,

Patricia Clinton, PhD, RN, ARNP, FAANP
President

Statement of Kathleen Grant, Portland, Oregon

The Research Society on Alcoholism (RSA) welcomes the opportunity to submit this statement in support of Congress' consideration of the "Paul Wellstone Mental Health and Addiction Equity Act" (H.R. 1424) to improve the overall health of all Americans. RSA is a professional research organization whose 1,600 members conduct basic, clinical, and psychosocial research on alcoholism and alcohol abuse. RSA's physicians, scientists, researchers, clinicians, and other experts work closely with National Institutes of Health (NIH) and National Institute on Alcohol Abuse and Alcoholism (NIAAA) to stimulate critical and innovative research initiatives in an effort to address this Nation's myriad of health problems that are directly attributable to heavy alcohol use, alcohol abuse, and alcoholism.

Alcoholism is a serious disease that affects the lives of millions of Americans, devastates families, compromises national preparedness, and burdens the country's health care systems. It is beyond cavil, that each dollar spent on alcoholism research will pay huge dividends for all Americans. RSA applauds the efforts by Congressmen Patrick Kennedy (D–RI) and Jim Ramstad (R–MN) to require health plans offering mental health benefits to cover an array of mental health and addiction disorders. By increasing access to care, the costly toll on society and the hindrance it places on families can be reduced.

Epidemiologic studies have shown that substance abuse affects an estimated 25 million Americans. The monetary cost to the public and the economy because of reduced productivity, property damage, accidents, and health care are astounding. For this reason, RSA respectfully urges Members of the Ways and Means Committee to ensure that sufficient steps are taken to prevent and treat alcoholism and the illnesses, injuries, and personal loss associated with the abuse of alcohol.

Parity is needed for the coverage of both mental health and substance use services, because people in all stratums of the population are at risk for serious mental illnesses and alcohol problems. According to the National Conference of State Legislatures, 42 States now offer some form of limited parity for the treatment of mental health disorders. Although, only 21 of those States include coverage for substance abuse, alcohol or drug addiction.

Alcoholism is a tragedy that touches virtually all Americans. More than half of all adults have a family history of alcoholism or problem drinking. One in ten Americans will suffer from alcoholism or alcohol abuse and their drinking will impact their families, the community, and society as a whole. Untreated addiction costs America $400 billion annually and recent research indicates that alcoholism and alcohol abuse alone, cost the Nation approximately $185 billion annually. One-tenth of this pays for treatment; the rest is the cost of lost productivity, accidents, violence, and premature death.

The Centers for Disease Control and Prevention (CDC) ranks alcohol as the third leading cause of preventable death in the United States. Heavy drinking, for example, defined as having five or more drinks at least once a week, contributes to illness in each of the top three causes of death: heart disease, cancer, and stroke.

The CDC also links excessive alcohol use, such as heavy drinking and binge drinking, to numerous immediate health risks that pose a menace not only to those consuming alcohol, but those surrounding them including traffic fatalities, unintentional firearm injuries, domestic violence and child maltreatment, risky sexual behaviors, sexual assault, miscarriage and stillbirth, and a combination physical and mental birth defects that last throughout the life of a child. As a case in point, fetal alcohol syndrome is the leading known cause of mental retardation.

Statistically, alcohol is a factor in 50 percent of all homicides, 40 percent of motor vehicle fatalities, 30 percent of all suicides, and 30 percent of all accidental deaths. The long-term effects of alcohol abuse are just as extreme, leading to chronic organ diseases, bone loss, neurological and cardiovascular impairment as well as social and psychiatric problems including depression, suicidality and anxiety.

The NIAAA, along with the National Institute on Drug Abuse (NIDA), and the Substance Abuse & Mental Health Services Administration (SAMSHA), have conducted research that demonstrates that substance abuse is particularly problematic in younger adolescents because it is the time when individuals are most vulnerable to addiction. According to the CDC, people aged 12 to 20 years drink almost 20% of all alcohol consumed in the United States. The NIAAA's National Epidemiologic Survey on Alcohol-Related Conditions (NESARC) states that 18 million Americans (8.5% of the population age 18 and older) suffer from alcohol use disorders (AUD), and only 7.1% of these individuals have received any treatment for their AUD in the past year. According to SAMHSA, in 2005, 20.9 million Americans needed treatment for AUD but did not receive it.

The U.S. scientific community is addressing alcoholism and addiction disorders at many different levels, starting at the earliest stages of human development. For instance, the NIAAA's NESARC survey sampled across the adult lifespan to allow researchers to identify how the emergence and progression of drinking behavior is influenced by changes in biology, psychology, and in exposure to social and environmental inputs over a person's lifetime. Scientists at NIH are supporting research to promulgate preemptive care for fetuses, early childhood, and adolescents; since children who engage in early alcohol use also typically display a wide range of adverse behavioral outcomes such as teenage pregnancy, delinquency, other substance use problems, and poor school achievement.

NIAAA has been working closely with SAMHSA to play a leading role for the work of the Interagency Coordinating Committee for the Prevention of Underage Drinking established under the Sober Truth on Preventing Underage Drinking Act or STOP Act (P.L. 109–422), and for the forthcoming Surgeon General's Call to Action on underage drinking.

The data on alcohol abuse are particularly disquieting in a subsection of the population that is unique for observing the effects of alcohol over a large cross-section of individuals. In the military, the costs of alcoholism and alcohol abuse are enormous. The 2005 results of the Department of Defense's (DoD) 2005 Survey of Health Related Behaviors among Active Duty Military Personnel demonstrate that the rates of heavy drinking remain elevated among U.S. military personnel. This was the first time that this survey series has evaluated behaviors related to mental well-being, work stress and family stress associated with deployment to Iraq, Afghanistan, and other theaters of operation.

The prevalence of heavy drinking is higher in the military population (16.1%) than in the civilian population (12.9%). About one in four Marines (25.4%) and Army soldiers (24.5%) engages in heavy drinking; such a high prevalence of heavy alcohol use may be cause for concern about military readiness. Furthermore, each individual Service branch showed an *increasing* pattern of heavy drinking from 2002 to 2005. These patterns of alcohol abuse, which are often acquired in the military, frequently persist after discharge and are associated with the high rate of alcohol-related health disorders in the veteran population.

The Department of Veterans Affairs (VA) states that 10 to 33 percent of survivors of accidental, illness, or disaster trauma report problematic alcohol use, especially if they are troubled by persistent health problems or pain. Also, individuals with a combination of posttraumatic stress disorder (PTSD) and alcohol use problems often have additional mental or physical health problems. According to the VA, as many as 10 to 50 percent of adults with alcohol use disorders and PTSD also have one or more of the following serious disorders: anxiety disorders (such as panic attacks, phobias, incapacitating worry, or compulsions), mood disorders (such as major depression or a dysthymic disorder), disruptive behavior disorders (such as attention deficit or antisocial personality disorder), addictive disorders (such as addiction to or abuse of street or prescription drugs), and chronic physical illness (such as diabetes, heart disease, or liver disease).

While the high rates of use and abuse of alcohol are alarming, the good news is that this Nation is poised to capitalize on unprecedented opportunities in alcohol research, opportunities which must be seized. Scientists are currently exploring new and exciting ways to prevent alcohol-associated accidents and violence. Importantly, prevention trials are developing methods to effectively address problem alcohol use. Further, scientists have identified discrete regions of the human genome that contribute to the inheritance of alcoholism. Our improved genetic research will accelerate the rational design of medications to treat alcoholism and also improve our understanding of the interaction and importance of heredity and environment in the development of alcoholism.

The field of neuroscience is another important and promising area of alcohol research. The development of more effective drug therapies for alcoholism requires an improved understanding of how alcohol changes brain function to produce craving, loss of control over drinking behavior, tolerance to alcohol's effects, and the alcohol withdrawal syndrome. NIAAA is testing therapeutic agents that target different neurobiological substrates of alcohol dependence.

The Research Society on Alcoholism believes that enactment of the legislation proposed by Congressmen Kennedy and Ramstad will provide the appropriate health coverage for those individuals who are in need of urgent care and treatment of alcohol use disorders.

Therapeutic Communities of America
March 27, 2007

The Honorable Fortney "Pete" Stark, Chairman
U.S. House of Representatives
Committee on Ways and Means
Subcommittee on Health
Room 1102 LHOB
Washington, DC 20515

The Honorable Dave Camp, Minority Ranking Member
U.S. House of Representatives
Committee on Ways and Means
Subcommittee on Health
Room 11139 LHOB
Washington, DC 20515

Dear Chairman Stark and Representative Camp:

As you know, only 18.2% of all Americans over the age of 12 needing treatment actually receive it. This is a startling statistic and shows the need for public policy and community efforts to end discrimination and provide access to quality care earlier for individuals with substance use and mental health disorders. Equity legislation can assist with closing this treatment gap.

Thank you for holding the hearing on March 27, 2007 on Mental Health and Substance Abuse Parity. Therapeutic Communities of America (TCA) provides the following comments for your consideration. The introduction of the bill last week, to require parity in mental health services for Medicare beneficiaries and eliminate a 190-day limit on inpatient treatment and lowering the copay requirements will improve access for seniors to receive needed services that are client-based and will allow for better outcomes. It confirms the necessity to establish in publicly-funded programs equity for access and effectiveness.

TCA member programs are mostly publicly funded through an array of public programs that weave and leverage public funding to provide client-based holistic addiction and mental health services to low income Americans. TCA member programs treat low income Americans from pregnant women to seniors in need of mental health and addiction services. TCA appreciates the importance of equity for mental health coverage for Medicare recipients and is respectful of the efforts of your Committee.

Therapeutic communities receive limited third party private payer reimbursement and although not directly impacted by health plan parity bills our members through their experience know the importance to develop consistent bills that would not place additional limitations or consequence on public services by permitting reimbursement to be based on costs and not be based on patient-based clinical criteria and quality indicators. TCA has attached a list of safeguards that should be considered as any legislation is advanced for private health plan parity bills. Those concerns include preemption, medical necessity criteria, managed care, disclosure, and equity. The *Paul Wellstone Mental Health and Addiction Equity Act of 2007* recently introduced addresses those concerns and we hope that the bill is not amended to weaken any of its current safeguards, and as such, those provisions in the bill remain through final passage. Your hearing demonstrates the Committee's understanding for policy that advances appropriate care to all our citizens.

We respectfully request that as you work toward equity for mental health and substance abuse treatment and prevention services that you consider the principles of the National Institute on Drug Abuse (NIDA) for drug treatment effectiveness. NIDA research shows the importance of length of stay in treatment and other principles that should be protected to assure equity with other chronic illnesses. Some of those principles include:

- No single treatment is appropriate for all individuals.
- Effective treatment attends to multiple needs of the individual, not just his or her drug use.
- Remaining in treatment for an adequate period of time is critical for treatment effectiveness.
- Recovery from substance abuse can be a long process and frequently requires multiple episodes of treatment.
- Treatment of addiction is as successful as treatment of other chronic diseases such as diabetes, hypertension and asthma.

- Substance abuse treatment programs should be constructed on evidence-based methodologies that are outcome based and meet performance measures.[1]

Depending on the stability and support an individual with a substance use disorder has within their environment; and the progressive stage of their disease, a patient will need criteria that understands the type, kind, duration, and multiple treatment needed by that person for recovery. It is important that a skilled service provider with specific training in addiction should do assessment, referral, placement, clinical determinations, and treatment of an individual with substance use disorders. Substance abuse treatment is a process that moves from motivation and stabilization to recovery as it is with other chronic diseases.

TCA appreciates your commitment and your leadership on this important issue. Please contact us if we can provide additional information at (202) 296–3503.

Sincerely,

Linda Hay Crawford
Executive Director

Therapeutic Communities of America (TCA), founded in 1975, represents over 600 programs across the country dedicated to serving those with addiction and mental health disorders. Therapeutic Communities provide a comprehensive continuum of care to patients, many of whom have multiple barriers to recovery, such as co-occurring mental illness, the homeless, adolescents, pregnant women, and HIV/AIDS. Therapeutic Communities also strive to help individuals secure family unification and successful welfare-to-work outcomes.

The Therapeutic Community methodology of treatment was established in the late 1950's, addressing the entirety of social, psychological, cognitive, and behavioral factors in combating alcohol and drug abuse. Traditionally, Therapeutic Communities have been community-based long-term residential substance abuse treatment programs.

In recent years, TCA members have expanded their range of services, providing outpatient, prevention, education, family therapy, transitional housing, vocational training, medical services, and case management in addition to long-term residential programs. Additionally, many therapeutic communities are involved with drug courts, in-prison programs, offender re-entry programs, and continuing care.

Attachment 1

Safeguards for Equity for Mental Health and Addiction Prevention and Treatment

Preemption

Approximately 42 States have current laws that require some form of addiction and/or mental health coverage which mostly focus on addiction treatment protection and coverage. TCA strongly recommends that any legislation not preempt any State law or State provision that provides greater protection than Federal language. Such assurance needs to be correctly stated in Federal language. The House of Representatives, *Paul Wellstone Mental Health and Addiction Equity Act of 2007* bill, currently has language that safeguards for preemption so that any State laws that provide greater consumer protections, benefits, rights or remedies are not impaired or deemed not enforceable.

Medical Necessity

Criteria for medical necessity should be based on uniform clinical criteria to be developed based on quality indicators, patient assessment, and effectiveness of care and not cost alone. Managed Care plans should not be given the discretion to define uniform criteria as part of their authority. It is recommended that uniform clinical patient placement criteria are developed and that other criteria currently used by a State or the American Society of Addiction Medicine (ASAM) should be considered as a floor and a minimum in any legislation.

Managed Care

Any policy that does not recognize the unique nature of addiction and our experience with the difficulty of providing necessary services for individuals covered under

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[1] Based in part on *Principles of Drug Addiction Treatment—A Research-Based Guide*, National Institute on Drug Abuse, National Institutes of Health, and NIH Publication No. 004180.

managed care plans or schemes, which cause delays, denials, and have negative consequences to individuals needing help, should not be considered. Equity legislation should include safeguards to protect individuals with mental disease and substance use disorders from delays and denials.

Transparency and Disclosure

Any legislation should require that all plans be made available to providers and plan participants' with copies of their medical necessity criteria, procedures, appeal process, and exclusions under such plans publicly available in advance to providers considering coverage under the plan, employers considering coverage with a plan, and participants considering or currently within a plan.

Disease Equity

Any legislation should require group health plans to provide mental disease and substance use disorder treatment benefits in parity with other diseases, illnesses and medical conditions. The timeliness of treatment can impact the early identification and recovery of an individual seeking treatment. Unfortunately, TCA members often see clients after they have lost their jobs and families. An individual with access to treatment earlier in their addiction should be given every chance to be treated with equity and without clinical discrimination.

