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

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH, EMPLOYMENT, LABOR AND PENSIONS

COMMITTEE ON EDUCATION AND LABOR

U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

FIRST SESSION

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

Tuesday, July 10, 2007
U.S. House of Representatives
Subcommittee on Health, Employment, Labor and Pensions
Committee on Education and Labor
Washington, DC

The subcommittee met, pursuant to call, at 3:02 p.m., in room 2175, Rayburn House Office Building, Hon. Robert Andrews [chairman of the subcommittee] presiding.

Present: Representatives Andrews, Kildee, McCarthy, Loebsack, Hare, Courtney, Kline, McKeon, and Boustany.

Staff present: Aaron Albright, Press Secretary; Tylease Alli, Hearing Clerk; Jody Calemine, Labor Policy Deputy Director; Fran-Victoria Cox, Documents Clerk; Carlos Fenwick, Policy Advisor for Subcommittee on Health, Employment, Labor and Pensions; Michael Gaffin, Staff Assistant, Labor; Jeffrey Hancuff, Staff Assistant, Labor; Brian Kennedy, General Counsel; Thomas Kiley, Communications Director; Ann-Frances Lambert, Administrative Assistant to Director of Education Policy; Sara Lonardo, Staff Assistant; Joe Novotny, Chief Clerk; Megan O'Reilly, Labor Policy Advisor; Michele Varnhagen, Labor Policy Director; Cameron Coursen, Minority Assistant Communications Director; Steve Forde, Minority Communications Director; Ed Gilroy, Minority Director of Workforce Policy; Rob Gregg, Minority Legislative Assistant; Richard Hoar, Minority Professional Staff Member; Victor Klatt, Minority Staff Director; Jim Paretti, Minority Workforce Policy Counsel; Molly McLaughlin Salmi, Minority Deputy Director of Workforce Policy; Ken Serafin, Minority Professional Staff Member; and Linda Stevens, Minority Chief Clerk/Assistant to the General Counsel.

Chairman ANDREWS [presiding]. The subcommittee will be in order. I would ask if our guests could take seats.

Ladies and gentlemen, good afternoon, and welcome to what we hope will be an edifying and enlightening discussion this afternoon of some very significant legislation that has been introduced by our friend and colleague Congressman Kennedy from Rhode Island and our friend and colleague Congressman Ramstad from Minnesota.

The legislation bears the distinguished name of the late Senator Paul Wellstone of the state of Minnesota, who worked very hard for the issue of mental health parity. And that is going to be the issue that we have in front of the subcommittee this afternoon.

There are 44 million Americans who are dealing with some kind of mental health issue in their lives. But only about one-third of those Americans are receiving care from a qualified, trained, prepared mental health professional for their issues.

When asked why the other nearly 30 million did not receive care, an overwhelming majority of those individuals indicated that their problem was related either to insurance or the cost of insurance.

Eighty-seven percent of those who are not receiving mental health services but who need them indicated that there were issues with their insurance policy which precluded them from getting that care.

Eighty-one percent of those who did not receive care indicated that cost was a major consideration in their failure to access the care that they need.

Now, 42 states have understood the problems with our present insurance system, and the problem, I think, succinctly can be summarized this way.

It is presently acceptable under the law in many cases for an insurance policy to distinguish between a mental health issue and a physical health issue.

So for example, a person who injures her knee may have a $500 deductible toward dealing with the knee injury, and then after that, the insurance kicks in and pays a substantial part or all of what is yet to come.

And typically, the number of visits the person would need to get their knee fit and trim is either unlimited or doesn't have much of a limitation on it, so as many trips to the surgeon as you need, as many trips to physical therapists as you need. You get those trips until your knee is sound.

On the other hand, if a person suffers from clinical depression, and he or she needs the care of a psychiatrist, that person may find that there is a $5,000 deductible before the insurance policy begins to pay most or all of the cost of that psychiatric care.

A person may also find that if they are fortunate enough to have the psychiatric care, there may be a very low limitation on the number of visits that he or she is permitted to make in a given year.

So instead of as many visits as you need, you may find that you only get three or four or five of them, whether you are fully healed and prepared to deal with the rest of your life or not.

I think these distinctions are arbitrary and unwise, and this is a view that has gained great currency around the country. Forty-two states have enacted some form of mental health parity law.

Now, these are a mixed bag. Some of these state laws require specific mental health services. Others require a sort of parity between the care of physical and mental health issues.

And still others will deal with requirements that insurers and employers must offer mental health coverage without any requirement that the coverage actually be provided.

These are noble efforts by the states, and we are going to hear from a distinguished state insurance commissioner from Wisconsin later on the second panel about a very excellent effort in his state.

I don't think they are sufficient, for three very important reasons. The first important reason is that members of our society who

are part of ERISA plans—that is, health insurance plans governed by the federal statute over which we have jurisdiction—are not affected by or protected by these state statutes.

So the 52 percent of our workforce that works for an employer that is covered by an ERISA plan does not have the benefit of the state law statutes in these 42 states.

Second, many of these statutes are limited in their reach. They don't solve all the problems that we set out to solve.

And third, I believe that many of these statutes don't particularly fit together well with other federal efforts to deal with this problem.

So it is my view that we do need a strong and well-thought-out federal standard to guarantee mental health parity. And I am a supporter of the efforts of Congressman Kennedy and Congressman Ramstad.

I understand there are issues, and we want to hear those issues fully vetted today. But this effort by Congressman Kennedy and Congressman Ramstad has very broad bipartisan support.

It is by no means the initiative of the majority party. It is the initiative of many like-minded members on both sides of the aisle from around the country. And I believe that it takes us in a direction where we can be successful.

The final point that I want to make before I yield to my friend from Minnesota—very often when we try to expand insurance coverage, we get into a debate about whether the cost is worth it. And that is a debate we absolutely ought to have.

We are going to hear this afternoon from an actuarial expert who will provide some compelling evidence that the results from the field show that the cost of extending true parity, which is what the Kennedy-Ramstad bill does—the cost of extending true parity is very low.

The testimony will indicate that it is 0.6 percent, which is quite a low number. And I would point out that that is a gross number.

That is a number of the projected increase in the insurance premium before one takes into account productivity gains, reductions in absenteeism, other physical health gains that would take place as a result of the implementation of such a policy.

So I am very pleased that we are here this afternoon. We are going to hear first from Congressman Kennedy.

I would note for the record that Congressman Ramstad, of course, has been invited to appear to speak about his bill. His plane is evidently delayed because of bad weather conditions. But some people from Minnesota were able to soldier on and get here nevertheless.

So I will at this point yield to my friend, the ranking member.

[The statement of Mr. Andrews follows:]

Prepared Statement of Hon. Robert E. Andrews, Chairman, Subcommittee on Health, Employment, Labor and Pensions

I welcome you to the HELP Subcommittee's hearing on the "Paul Wellstone Mental Health and Addiction Act of 2007." Today, we will consider whether a federal law to provide mental health parity is necessary to close the gap in coverage for individuals who live without adequate coverage. The federal legislation we will focus our attention on today is known as the "Paul Wellstone Mental Health and Addiction Equity Act" (HR 1424), which was introduced by Congressmen Patrick Kennedy

and Jim Ramstad. This legislation is named in honor of the late former Senator Paul Wellstone, who vigorously fought for mental health parity.

I applaud both Patrick and Jim for their tireless efforts to help individuals and families who struggle with mental illness everyday. I also would like to take this opportunity to thank the former First Lady Rosalynn Carter and David Wellstone, son of the late Senator for taking time out to testify before our subcommittee today. Mrs. Carter and David Wellstone have continuously served as a public voice for those with mental illness.

Mental illness is serious and sometimes life-threatening and should be treated just like a debilitating disease. Although having a mental illness can be as serious as having a stroke, many private health insurers often provide less coverage for mental illnesses than for other medical conditions. Furthermore, health plans tend to impose lower annual or lifetime dollar limits on mental health coverage, limit the treatment of mental health illnesses by covering fewer hospital days and outpatient office visits, and increase cost sharing for mental health care by raising deductibles and co-payments.

With only one-third of the 44 million Americans who suffer from a mental health disorder receiving treatment, it is imperative that Congress act to provide adequate mental health coverage to these individuals. Congressional action must produce legislation that is cost-effective for our economy, will increase access to mental illness treatment, provide meaningful benefits by defining the scope of the benefits to be covered under a health plan, pose a nominal cost to those employers who currently offer mental health coverage and that will not preempt stronger state mental health parity laws.

I thank all the witnesses for contributing their time to today's hearing and we look forward to hearing their testimony.

Mr. KLINE. I thank you, Mr. Chairman. Some of us soldiered on last night, so we were ahead of the weather.

I am sorry that my Minnesota colleague, Mr. Ramstad, isn't here. I hope that he will be able to come sliding in from Dulles or wherever his plane safely landed.

I want to thank you, Mr. Chairman, for holding this hearing to hear about, learn about and discuss the Paul Wellstone Mental Health and Addiction Equity Act of 2007, named, I would point out, after the much-admired and beloved late senator from Minnesota.

I am very pleased to see his son is here and will, in fact, be a witness in the second panel. And I will just take this opportunity to say what a great panel it is, and we will, of course, include Mr. Kennedy sitting there all alone, waiting for Jim to show up.

But the second panel—particularly distinguished witnesses from the minority and majority side. And of course, we are honored to have the former first lady with us here today.

Legislation which provides greater parity between the health insurance coverage of mental and physical illness I think has reached the point where most members of Congress agree we need to go.

We are looking for ways to achieve that parity, and tremendous strides have been made, I think, in the last months and years in addressing the stigmas which sometimes have been attached to mental illness and its treatment. Clearly, more needs to be done.

However, there remains significant differences in how we should approach this. The chairman mentioned some of those and we will hear some of it today.

Although it is well-intentioned, this bill, and I would say very well-intentioned, I have many concerns with the legislation as it is in front of us today.

Initially, this bill constitutes an employer mandate. It seems ironic that at the time many of my colleagues in the majority profess to offer solutions to decrease the number of uninsured—it is

the number one item, I believe, on their health care agenda—they are proposing issuing coverage mandates that appear to do the exact opposite by making coverage more costly and leading to less availability.

And I don't think we want to do that. So we want to explore that here today.

Secondly, the legislation does not preempt state laws that would provide greater consumer protections than those contained in the federal legislation.

This means employers and plans could be subjected to multiple state laws, thus defeating the purpose of federal preemption of state laws and increasing plan complexity and cost.

Other problems include the bill's broad definition of mental health or substance-related disorders and its failure to specifically protect a plan's ability to manage mental health benefits and control costs.

Some of my colleagues in the Senate have introduced a mental health parity bill. Senate Bill 558 takes a little bit different approach.

It is a product of lengthy bipartisan negotiations between patient advocates, mental health providers, business organizations and insurers, and we will receive some information about that bill today from one of our witnesses.

Under the circumstances, regardless of whether you think the best answer is the Senate bill, the House bill or no bill, today's testimony should prove helpful.

I urge my colleagues to seriously consider the testimony provided today by all those, and certainly pay attention to the testimony from those talking about the Senate bill.

And again, I want to thank the chairman for holding the hearing and for our distinguished witnesses for joining us today, and I look forward to the discussion.

[The statement of Mr. Kline follows:]

Prepared Statement of Hon. John Kline, Ranking Republican Member, Subcommittee on Health, Employment, Labor, and Pensions

Good afternoon.

I'd like to thank Chairman Andrews for convening this afternoon's hearing to discuss a House bill the affects the entire behavioral health care system in this country.

I think legislation which provides greater parity between the health insurance coverage of mental and physical illnesses is a point on which all Members can agree. Tremendous strides have been made in addressing stigmas attached to mental illness and its treatment, and more needs to be done. However, there remain significant differences in the approach over how to improve health insurance for mental health.

We are here today to examine H.R. 1424, the Paul Wellstone Mental Health and Addiction Equity Act of 2007. Although it is well-intentioned, I have many concerns with this legislation, as introduced. Initially, this bill constitutes an employer mandate. It seems ironic that, at the same time my colleagues in the majority profess to offer solutions to decrease the number of the uninsured, which is the number one item on their health care agenda, they also propose issuing coverage mandates that appear to do the exact opposite by making coverage more costly and leading to less availability.

Secondly, the legislation does not preempt state laws that would provide greater consumer protections than those contained in the federal legislation. This means employers and plans could be subjected to multiple state laws, thus defeating the purpose of federal preemption of state laws and increasing plan complexity and cost. Other problems include the bill's broad definition of mental health or substance-re-

lated disorders and its failure to specifically protect a plan's ability to manage mental health benefits and control costs.

Some of my colleagues in the Senate have introduced a mental health parity bill, Senate Bill 558. That bill is the product of lengthy bipartisan negotiations between patient advocates, mental health providers, business organizations, and insurers, and we will receive detailed testimony regarding that bill.

Under the circumstances, regardless of whether you think the best answer is the Senate bill, the House bill, or no bill, today's testimony should prove helpful. I urge my colleagues to seriously consider the testimony provided today, especially from those witnesses who support the parity approach set forth in Senate bill 558, which would reflect a more balanced approach to addressing this serious issue.

I'd like to welcome our distinguished witnesses today, including two of my colleagues, Patrick Kennedy and Jim Ramstad, who are here to discuss their bill, The Paul Wellstone Mental Health and Addiction Equity Act of 2007. I look forward to everyone's testimony.

Chairman ANDREWS. Thank you.

By unanimous consent, the statement of any other member who wishes to have an opening statement will be entered into the record, present or absent.

We will begin with our first panel, and it is a pleasure to welcome, hopefully soon, both of our colleagues, but certainly one of our colleagues.

Congressman Patrick J. Kennedy is serving his seventh term in Congress as representative of the 1st District of Rhode Island. Mr. Kennedy has received numerous awards for his advocacy on behalf of the mentally ill, including the Society for Neuroscience Public Service Award, the American Psychoanalytic Association President's Award, the American Psychiatric Association's Alliance Award, and the Depression and Bipolar Support Alliance Paul Wellstone Mental Health Award.

It is a pleasure to serve with you, Patrick, as a colleague. We welcome you today, and we look forward to your statement.

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

Mr. KENNEDY. Thank you, Chairman Andrews and Ranking Member Kline. And to my distinguished colleagues, thank you all for the opportunity to invite me to testify today.

And thank you for your commitment to ending insurance coverage discrimination against those with mental illness like myself.

Let me begin by saying I suffer from the disease of alcoholism and addiction. I also suffer from bipolar disorder.

I have, through the course of my life, had periods of time where I have had a mental obsession and physical compulsion to drink and use drugs in order to cope with a mental anguish that I had felt that today I no longer have to deal with through drinking and drugging because I am a member of Congress and have access to the Federal Employees Health Benefit Plan, which has parity.

And what is before you today is a bill that will extend the same treatment coverage that I have had as a member of Congress to the rest of the American people.

So that as a member of Congress, the reason that I am able to be here today as a fully productive citizen, as opposed to someone who is still out in the society drinking and drugging and unproductive, as opposed to someone who is at work, living a full and productive life—the different is that I have treatment.

And the difference between me and some other American who doesn't have that treatment is that they don't have that access.

And what we need to do today is have parity in this country so that millions of Americans who are still out there suffering from that same disease that I have, that physical illness—that they can get the same coverage that I have and that we all have as members of Congress, and so that they can live productive lives.

And if they live productive lives, they can be contributing members of society as I hope that I am a contributing member of society.

I know I could never have imagined myself when I first ran for office coming up here and saying I was an alcoholic and addict.

I remember very clearly growing up in my family, whispering in my household as my mother suffered tremendously from this disease of alcoholism. It was a shame growing up to have this disease because of the scourge and stigma in this country that this disease has been.

But I think that it is coming out of the shadows now and that this country has finally come to a reckoning that this is no longer an issue of a moral failing.

No one can convince me, from looking at what this disease has done to my mother, or what this disease has done to millions of Americans like her that I have witnesses, let alone what I have witnessed in my own personal life, that people have chosen this life voluntarily.

No one voluntarily chooses to live the kind of sordid, painful, destructive life that people who are alcoholics and addicts or people who are depressed or people who are suffering from schizophrenia or bipolar disorder—any number of mental illnesses—obsessive-compulsive disorder—any one of those illnesses—no one could convince me that that is a voluntary choice on their part.

And essentially, that is what those on the other side of this debate would have you believe, that this is a non-illness, that this is something that is non-physical because if it were non-physical, then they could control it.

And that is essentially what they would have you suppose, because if you were to believe that, then there wouldn't be any need for there to be insurance.

But we know otherwise. The insurance system cannot hide the fact that brain science tells us otherwise. We have pictures. Modern science shows us, these pictures that are clear as a bell, that the brain is a physical organ.

And you cannot take a picture of the brain and look and say that the insurance companies can cover brain diseases like Parkinson's that affect the motor cortex and the basal ganglia and the sensory cortex and the thalamus, and then other brain diseases like depression, which affected the limbic cortex and the hypothalamus and the frontal cortex and the hippocampus—and they don't get covered.

And yet they are two centimeters or three centimeters away. How can you justify 80 percent insurance coverage for one part of the brain and 20 percent insurance coverage for two centimeters away or zero insurance coverage for two centimeters away? How in the world can you explain that?

Or you can say, "Well, no, sorry," as Mr. Kline said, "We want to have the Senate language for the second part of the brain but we want the current system of health insurance of the first part of the brain." It doesn't work. It is totally unjustifiable.

Would you say the same to someone with cancer? Are you going to play with someone's life who has cancer that way?

You take someone from your family who has the disease of cancer or diabetes, and you exchange that person's life and put in place mental illness and say that you are ready to bargain their life away.

And answer that question. Then I will be happy to sit back and let you move on with your argument. But until you can honestly look me in the face and say that you are willing to put in place and substitute a person with cancer for that argument or diabetes with that argument or cardiovascular disease with that argument, that argument is specious, because otherwise it doesn't wash, frankly.

This is a civil rights issue at its core. No one asks to have this disease. You are born with it. You have certain triggers through your environment that set it off.

We are going to find all these things out in the years to come through genomics and personal health medicine, and we are going to have great revolutionary science help to solve many of these problems.

But, Mr. Chairman and Ranking Member Kline, if we don't move now, we are going to cost millions of Americans their lives.

Thirty-four thousand Americans take their lives every year to suicide. That is twice the rate of homicide.

Think of all the people that are killed by murder in this country and think the fact that you multiply that two times, and that is how many people successfully take their own lives. That is a disgrace to this country.

Think about the fact that the largest mental health institution in this country is our jail system. What an indictment on this country.

And think about the fact that millions of Americans are not living up to their full potential all because we have a discriminatory insurance system that continues to say that people are not living up to their full potential because we are not acknowledging this illness.

I will say but for the work of Paul Wellstone and Rosalyn Carter, the former first lady, who has been working on this issue for decades, and for Jim Ramstad, we would not have come as far as we have.

And I just want to say today I am standing on the shoulders of giants. And Jim Ramstad is with us in spirit. He has been absolutely—no better champion for this cause than Jim Ramstad. And I am so honored to be his partner in this effort and a fellow on the road to recovery.

And I also want to say to David Wellstone, who is here on behalf of his father's legacy, what an honor it is to be joining him. He has done such a fantastic job in carrying on his dad's legacy.

And to the former first lady, she has dedicated her life to this issue. And the fact that she has done so with such compassion has

been so moving to all of us. And I want to thank her personally for all of her great work on this issue.

And for everybody today who is working on this issue I want to thank them as well.

And thank you, Mr. Chairman, for the time.

[The statement of Mr. Kennedy follows:]

Prepared Statement of Hon. Patrick J. Kennedy, a Representative in Congress From the State of Rhode Island

Chairman Andrews, Ranking Member Kline, 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. Let me tell you about Anna Westin. Anna Westin paid her health insurance premiums just like everyone else. But when she got sick with anorexia and needed her insurance coverage, she didn't get it. That is just not fair. And it tragically cost Anna her life.

Why did Anna's insurance fail to pay for her care? Because of stereotypes and stigma. There is no medical or policy rationale for discriminating against mental health diagnoses.

In the attached exhibits, you can see the visual evidence that these diseases are physiological brain disorders, diminishing the brain's function just as heart disease diminishes the heart's function.

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.

We provide full coverage to treat certain structures of the brain, but 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—fourteen in total.

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

That's a cost of our insurance discrimination.

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

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

These are costs of our insurance discrimination.

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

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

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

These are costs of our insurance discrimination.

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

We heard testimony from Steve Winter. He described eating breakfast as a teenager, getting a funny feeling in his chest, and looking up seeing his mother holding a gun. "I shot you, and I'm going to shoot your sister and myself so we can all be in heaven together," she said.

Steve's mother was off her anti-psychotic medications at that time due to insurance problems, and now Steve is spending the rest of his life in a wheelchair as a result, having endured a million dollars worth of surgeries, treatments, and medical equipment.

So many Americans have lost their dreams, lost years, and even lost their lives—unnecessarily. You'll hear Amy Smith's powerful testimony in a few moments about the difference treatment can make.

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

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

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

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

But frankly, the very fact that we need to debate how much it costs to end insurance discrimination is offensive. Nobody is asked to justify the cost-effectiveness of care for diabetes or heart disease or cancer. Tell Kitty Westin, Tom O'Clair, Steve Winter, 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 who are genetically predisposed to high cholesterol and eat fatty foods. We don't deny insurance coverage to diabetics who fail to control their blood sugar.

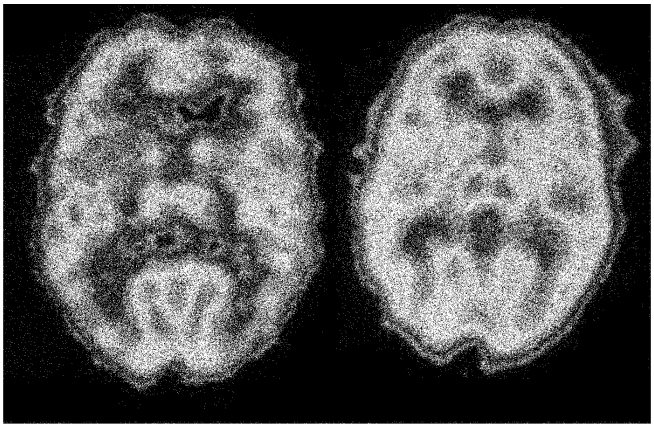
At the end of the day, this is about human dignity and whether we deliver on the promise of equal opportunity that is at the heart of what it means to be American. Nobody chooses to be born with particular genetics and anatomy, any more than they choose to be born with a particular skin color or gender. 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.

Mr. Chairman, we just celebrated July 4th and our nation's Declaration of Independence. Unlike any other country in the world, this one was founded on principles—the ideas of equality and freedom and opportunity. The history of America is the history of a country striving to live up to those self-evident truths. In pursuit

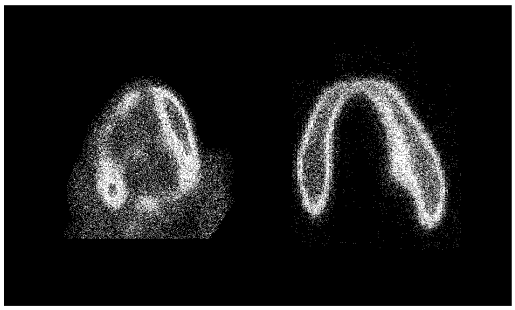
of those values we've fought a civil war, chipped away at glass ceilings, expanded the vote, renounced immigration exclusion laws, and recognized that disabilities need not be barriers. Led by one of our own colleagues, a generation of peaceful warriors forced America to look in a mirror and ask itself whether its actions matched its promise, and they changed history.

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

Thank you.



schizophrenic brain **healthy brain**



Diseased heart **Healthy heart**

[Additional material submitted by Mr. Kennedy follows:]

AMERICAN ACADEMY OF PEDIATRICS,
July 3, 2007.

Hon. PATRICK KENNEDY and Hon. JIM RAMSTAD,
U.S. House of Representatives, Washington, DC.

DEAR REPRESENTATIVES KENNEDY AND RAMSTAD: On behalf of the 60,000 primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists of the American Academy of Pediatrics, I write today to express our support for H.R. 1424, the Paul Wellstone Mental Health and Addiction Equity Act of 2007. This bill will take a significant step towards eliminating obstacles to mental health and substance abuse services for children.

The mental health needs of children and adolescents are increasing. At least 13 million children in American are in need of mental or substance abuse care. Yet while growing evidence is demonstrating the effectiveness of specific mental health services, benefit packages that offer limited mental health care are decreasing access to this vital care. Early mental health intervention and care puts children on a firm footing for adulthood and reduces the need for more expensive care later in life.

H.R. 1424 builds on the goal of parity legislation passed in 1996 by closing loopholes that allow employers to offer unequal mental health coverage in terms of various out-of-pocket expenses, co-payments, and treatment frequency limitations. The legislation also appropriately requires parity in terms of substance abuse treatment. H.R. 1424 will ensure that mental health care is recognized as an essential component of child health.

Thank you for your strong commitment to the mental health of children and all Americans. We look forward to working with you to pass this crucial legislation.

Sincerely,

JAY E. BERKELHAMER, M.D.,
FAAP President.

PARITY NOW COALITION,
July 6, 2007.

Hon. PATRICK KENNEDY AND Hon. JIM RAMSTAD,
U.S. House of Representatives, Washington, DC.

DEAR REPRESENTATIVE KENNEDY AND REPRESENTATIVE RAMSTAD: The undersigned organizations applaud you for your commitment to mental health and addiction parity legislation. We wish to thank you and your staffs for the countless hours you have dedicated to this bill thus far and look forward to working with you towards enacting the Paul Wellstone Mental Health and Addiction Equity Act of 2007 into law.

We hereby lend our formal support to this invaluable piece of legislation.

NATIONAL ORGANIZATIONS

AIDs Action Council
American Academy of Child and Adolescent Psychiatry
American Academy of Neurology
American Academy of Pediatrics
American Association for Geriatric Psychiatry
American Association for Marriage and Family Therapy
American Association for the Treatment of Opioid Dependence
American Association of Children's Residential Centers
American Association of Pastoral Counselors
American Association of Suicidology
American Counseling Association
American Federation of Teachers
American Foundation for Suicide Prevention
American Group Psychotherapy Association
American Hospital Association
American Medical Association
American Mental Health Counselors Association
American Music Therapy Association
American Occupational Therapy Association
American Psychoanalytic Association
American Probation and Parole Association
American Public Health Association
American School Health Association

American Society of Addiction Medicine
Anna Westin Foundation
Anxiety Disorders Association of America
Association for the Advancement of Psychology
Association for Ambulatory Behavioral Healthcare
Association of Jewish Family & Children's Agencies
Association of Recovery Schools
Association of University Centers on Disabilities
Bazelon Center for Mental Health Law
Betty Ford Center
Bradford Health Services
Caron Treatment Centers
Center for Clinical Social Work
Center for Science in the Public Interest
Children and Adults with Attention-Deficit/Hyperactivity Disorder
Child Welfare League of America
Clinical Social Work Association
Clinical Social Work Guild 49, OPEIU
Community Anti-Drug Coalitions of America (CADCA)
Depression and Bipolar Support Alliance
Easter Seals
Eating Disorders Coalition for Research, Policy and Action
Faces and Voices of Recovery
Families USA
Family Voices
Hazelden Foundation
Institute for the Advancement of Social Work Research
Johnson Institute
Kids Project
Legal Action Center
Mental Health America
NAADAC—The Association for Addiction Professionals
National Alliance of Methadone Advocates
National Alliance to End Homelessness
National Association for Children of Alcoholics
National Association of Addiction Treatment Providers (NAATP)
National Association of Anorexia Nervosa and Associated Disorders—ANAD
National Association of County and City Health Officials
National Association of Mental Health Planning & Advisory Councils
National Association of School Psychologists
National Association of Social Workers
National Association of State Directors of Special Education
National Association on Alcohol, Drugs and Disability, Inc.
National Council for Community Behavioral Healthcare
National Council on Alcoholism and Drug Dependence (NCADD)
National Development and Research Institutes, Inc. (NDRI)
National Educational Alliance for Borderline Personality Disorder
National Education Association
National Mental Health Awareness Campaign
National Recreation and Park Association
National Research Center for Women & Families
Obsessive Compulsive Foundation
Partnership for a Drug-Free America
School Social Work Association of America
Society for Research on Child Development
Suicide Prevention Action Network USA
State Associations of Addiction Services (SAAS)
Therapeutic Communities of America
United Jewish Community
United Methodist Church—General Board of Church and Society
U.S. Psychiatric Rehabilitation Association
Wellstone Action

LOCAL AND STATE ORGANIZATIONS

622 Communities Partnership, Inc., Minnesota Affiliate of the National Council on Alcoholism and Drug Dependence, Inc
Addiction Recovery Institute

Addiction Resource Council
Advocates for Recovery
Alabama Voices for Recovery & Drug Education Council
Alcohol and Addictions Resource Center
Alcohol and Drug Council of North Carolina
Alcoholism Council of New York
Alcoholism Council of the Cincinnati Area, NCADD
Alliance for Recovery
Alliance for Substance Abuse Prevention, Inc.
Arizona Council of Human Service Providers
Aspire of Western New York, Inc.
Barbara Schneider Foundation
BRiDGEs, Madison County Council on Alcoholism and Substance Abuse, Inc.
Bucks County Council on Alcoholism and Drug Dependence
California Association of Addiction Recovery Resources
California Association of Alcohol and Drug Program Executives
Chautauqua Alcoholism & Substance Abuse Council (CASAC)
Colorado Association of Alcohol & Drug Service Providers
Connecticut Association of Non-Profits
Council on Addictions of New York State (CANYS) Inc.
Council on Alcohol and Drug Abuse for Greater New Orleans
Council on Alcoholism and Drug Abuse of Sullivan County, Inc.
Council on Substance Abuse—NCADD
County Alcohol and Drug Program Administrators Association of California
DePaul's National Council on Alcoholism and Drug Dependence—Rochester Area
Detroit Recovery Project
Dora Weiner Foundation
Drug and Alcohol Service Providers Organization of Pennsylvania
Employee & Family Resources, Inc.
Erie County Council for the Prevention of Alcohol and Substance Abuse, Inc.
Exponents
Feeling Blue Suicide Prevention Center
Focus on Community
Faces and Voices of Recovery—Westchester
Friends of Delaware and Otsego Counties, Inc.
Friends of Recovery—Monroe County
Friends of Recovery—Vermont
Gateway Foundation
Georgia Council on Substance Abuse
GLAD House, Inc.
Greater Flint Project Vox
Greater Macomb Project Vox
Harbor Hall, Inc.
Hope4you
Illinois Alcoholism and Drug Dependence Association
Iowa Substance Abuse Program Directors' Association
Kingdom Recovery Center
Long Island Council on Alcoholism and Drug Dependence, Inc.
Maine Alliance for Addiction Recovery (MAAR)
Maine Association of Substance Abuse Programs
Maryland Chapter of the National Council on Alcoholism and Drug Dependence
McHenry County Mental Health Board (IL)
McShin Foundation
Methadone Support Org.
Michigan Association of License Substance Abuse Organizations
Missouri Recovery Network
M-Power, Inc.
Nantucket Alliance for Substance Abuse Prevention, Inc.
Nantucket Behavioral Health
National Council on Alcoholism and Drug Dependence of the San Fernando Valley
National Council on Alcoholism and Drug Abuse—St. Louis Area
National Council on Alcoholism and Drug Dependence of Greater Kansas City
National Council on Alcoholism and Drug Dependence of Northwest Florida
National Council on Alcoholism and Drug Dependence of the South Bay
National Council on Alcoholism and Drug Dependence, Greater Detroit Area
National Council on Alcoholism and Drug Dependence, New Jersey
National Council on Alcoholism and Drug Dependence, Sacramento Region Affiliate
National Council on Alcoholism and Drug Dependence—Phoenix

National Council on Alcoholism/Lansing Regional Area, Inc
NCADD in the Silicon Valley
NCADD of Middlesex County, Inc.
NCADD Tulare County, Inc.
Nebraska Association of Behavioral Health Organizations
New England National Alliance of Methadone Advocates
New Hampshire Alcohol & Other Drug Service Providers Association
NJ Advocates—NJ Chapter of NAMA
Northern California Chapter of the National Alliance of Methadone Advocates
Northern Michigan Project Vox
Ohio Citizen Advocates for Chemical Dependency Prevention & Treatment
Ohio Council of Behavioral Healthcare Providers
Oklahoma Faces and Voices of Recovery
PAR—People Advocating Recovery
Parent-To-Parent, Inc.
Pennsylvania Recovery Organization—Achieving Community Together (PRO-ACT)
Recovery Center
Recovery Consultants of Atlanta, Inc.
Recovery Resources
Rockland Council on Alcoholism and Other Drug Dependence
Samaritan Village
Substance Abuse and Addiction Recovery Alliance (SAARA) of Virginia
Suicide Awareness Voice of Education
The Council on Substance Abuse & Mental Health
The Maine Association of Substance Abuse Programs
The Maine Substance Abuse Foundation
The RASE Project/Buprenorphine Coordinator Program
The Second Road, Inc.
The Transformation Center
Turning Point Recovery Center
Upstate Cerebral Palsy (NY)
Virginia Association of Alcohol and Drug Counselors
Virginia Association of Drug and Alcohol Programs
Volunteers of America Alaska

Chairman ANDREWS. Thank you very much, Mr. Kennedy.

I think the members of the panel have agreed that we want to get to the second panel of witnesses. If anyone would like to ask Mr. Kennedy a question, they are welcome.

Mr. Loebsack?

Mr. LOEBSACK. I just want to make a quick comment. I thanked Patrick personally in the cloakroom after he was on Larry King for what he has been doing.

And I have some personal experience with mental illness, especially with my mother.

And I want to thank you again publicly for all you are doing. Thank you, Patrick.

Chairman ANDREWS. Thank you.

Patrick, what I would also like to add to that—most of us, all of us are privileged to have the opportunity to serve our country as legislators, to do what we think is right for our country by virtue of the office we hold.

It is a rare gift to be able to help because of your personal experience and your personal commitment, and you are certainly doing that today. We admire you for it. We respect you for it. And we thank you for being with us today. Thank you.

We are going to move on to the second panel. If Mr. Ramstad is able to make it, we will certainly have his testimony when he arrives.

I would ask if the second panel could come forward. I am going to begin reading their biographies as they come forward so that we can get started as they are settled.

We are deeply honored to have with us the former first lady of the United States, Ms. Rosalyn Carter. In addition to her exemplary service as our nation's first lady, Mrs. Carter created and chairs the Carter Center's Mental Health Task Force, an advisory board of experts, consumers and advocates promoting positive change in the mental health field. Each year, Mrs. Carter hosts the Rosalyn Carter Symposium on Mental Health Policy, bringing together leaders of the nation's mental health organizations to address critical issues. During the Carter administration, Mrs. Carter became active honorary chair of the President's Commission on Mental Health, which resulted in the passage of the Mental Health Systems Act of 1980.

Welcome, Mrs. Carter. It is a great privilege to have you with us today.

Paul David Wellstone, Jr., is the son of the late Senator Paul Wellstone. He is the co-chair of the Wellstone Action Advisory Board and contributes to advocacy efforts on behalf of mental health and domestic violence. He is the co-founder of Wellstone Action, a national center for training and leadership development, as well as the founding partner of Family Place Home Builders, a business dedicated to building affordable housing. David graduated from Hamline University in 1987.

It is great to have you with us, David.

Amy Smith, welcome.

Amy is the vice president of recovery programs for Mental Health America of Colorado and is the director of Wellness and Education Coalition and Advocacy Network of Colorado, which acts as a consumer network and conducts the Colorado Leadership Academy, a week-long advocacy training for consumers. Ms. Smith has been with WECAN since its inception in 2003.

Welcome, Ms. Smith. It is great to have you with us.

Neil Trautwein is the vice president and employee benefits policy counsel for the National Retail Federation. He currently chairs the Coalition on Catastrophic and Chronic Health Care Costs and co-chairs the Consumer Directed Health Care Conference. He received his B.A. in political science from the University of Louisville and his J.D. from the George Washington University.

Welcome, Mr. Trautwein.

Jon Breyfogle is currently executive principal of the Groom Law Group, where he has worked since 1992. And Jon has been a frequent witness before our committee, both this subcommittee and the full committee. Previously, he served as senior legislative officer at the Department of Labor and as special assistant to the executive director of the Pension Benefit Guaranty Corporation. He received his bachelor's from the University of Cincinnati, a master's in public affairs from Indiana University, and a J.D. from the George Mason University.

Jon, welcome back. It is great to have you with us.

Steven Melek has been a principal and consulting actuary with Milliman since 1990. He has worked extensively in the behavioral health care field and specializes in health care product develop-

ment, management, and financial analyses. He has chaired and served on various Societies of Actuaries and the American Academy of Actuaries task forces and working groups, most of which have been focused on behavioral health care issues. He has a B.A. in mathematics from the Illinois Institute of Technology.

Welcome, Mr. Melek.

And finally, Sean Dilweg is the commissioner of insurance for the state of Wisconsin. Prior to his appointment in 2007, Mr. Dilweg served as the executive assistant to the secretary of the Wisconsin Department of Administration, from 2003 to 2006. Previously, he worked as director of policy analysis at Essie Consulting Group, a major Madison consulting and lobbying firm, from 2000 to 2003. He holds a master's in public administration from the University of Wisconsin and a bachelor's in English from Lawrence University in Appleton.

This is a very distinguished panel, and we are pleased that everyone gave us their time.

For the record, the written statements that each of you has prepared will be submitted by unanimous consent to the hearing record and will be there in its entirety.

We do ask that people try to summarize their oral statement in about 5 minutes. There is a light box in front of you. When the green light is on, you are in your 5-minute period. When the yellow light goes on, it means you have a minute left. And when the red light goes on, we would ask you to sum up and stop so we can get to questions.

There is, however, a narrowly drawn exception for former first ladies of the United States of America. And so if Mrs. Reagan or Mrs. Ford or Senator Clinton—I suppose she would also fit the exception—are welcome.

And, Mrs. Carter, please take as much time as you would need so you can—you have graced us with your presence. We would welcome you. We would start with you.

STATEMENT OF ROSALYNN CARTER, FORMER FIRST LADY AND CHAIR OF THE MENTAL HEALTH TASK FORCE, THE CARTER CENTER

Mrs. CARTER. Thank you for saying that. I was worried about my remarks.

Mr. Chairman and members of the subcommittee, thank you for the opportunity to speak to you this afternoon about this legislation that is so important to so many people, millions in our country, parity in insurance.

I have been working in the mental health field for—I don't like to say it because it ages me, but for over 35 years. That is a long time.

When I began, no one understood the brain or how to treat mental illnesses. Today, everything has changed, everything except the stigma, which still holds back progress in the field.

But today, because of research and our new knowledge of the brain, mental illnesses can be diagnosed. They can be treated effectively. And the overwhelming majority of people living with these diseases can lead normal lives, being contributing citizens in our communities.

Today I join many individuals and hundreds of national organizations calling for an end to the fundamental stigmatizing inequity of providing far more limited insurance coverage for mental health care than for treatment of any other illnesses.

And again, I join forces with my friend Betty Ford in urging prompt action on this important issue. Betty and I have lobbied many times for this legislation and for care.

I have now a very good mental health program at the Carter Center. Annually, we bring together leaders to take action on a major mental health issue. We have focused many times on stigma and discrimination and the importance of ensuring adequate equitable coverage for people with mental illnesses.

To me, it is unconscionable in our country and morally unacceptable to treat at least 20 percent of our population as though they were not worthy of care.

We preach human rights and civil rights and yet we let people suffer because of an illness they did not ask for and for which there is treatment.

Then we pay the price for this folly in homelessness, lives lost, families torn apart, loss of productivity, the cost of treatment in our prisons and jails. And I could go on.

I have always believed that if insurance covered mental illnesses it would be all right to have them. This may be the reason stigma has remained so pervasive, because these illnesses are treated differently from other health conditions.

All mental illnesses are potentially devastating. In my 35 years, I have seen so many advances in knowledge about the brain and improvements in treatment.

I urge the subcommittee and sponsors to ensure coverage of all mental illnesses as defined by the DSM-IV, instead of treating some conditions as higher priority over others.

We had an intern at the Carter Center, for instance, this past spring who suffered from obsessive-compulsive disorder and depression. And when she was in high school, she once spent 2 solid weeks in her house, not able to leave or to be with her friends.

I am happy to say that she received treatment, is a college graduate with Phi Beta Kappa honors and just got a job here in Washington with the Ad Council.

Without resources and support, she could still be sick and shut in her home, which is what happens to so many who do not get the help they need, because they can't afford to pay for services. Our country loses all the many contributions of these wonderful people.

Through the research of people like Howard Goldman and Richard Frank, we know that parity in insurance benefits for behavioral health care has no significant increase in total cost when coupled with management of care.

We also know this from a number of enlightened companies such as AT&T, Delta Air Lines, Eastman Kodak, General Motors and IBM, and others, which have provided comprehensive coverage for their employees.

Tom Johnson is one of my good friends. He is the former publisher of the Los Angeles Times and former CEO of CNN, and he has struggled with depression.

He and two other prominent CEOs in the Atlanta community who have experienced depression have had an enormous impact on mental health benefits offered by businesses in the Atlanta area. I am really so pleased about that.

In the last few years, there have been several major reports released—the first ever surgeon general's report on mental health, President Bush's new Freedom Commission on Mental Health, and the Institute of Medicine, including mental and substance-use conditions, in a series of reports on the quality of American health care.

All of the reports reinforce the statement that effective treatments are available but that most people who need them do not get them.

The nation has learned a lot about the importance of mental health issues through Hurricane Katrina and the needs of our returning soldiers and National Guard troops.

We support our troops in the field, and it is critical that we continue to support them when they come home.

One other issue: Many states have moved ahead with parity. These have been long-fought battles, with some states managing wonderful successes. It is so important that any federal legislation not preempt any of these gains while we finally have mental health parity legislation in sight.

This committee has worked long and hard to bring this legislation forward. It is an example of what can be accomplished with strong bipartisan support.

When this legislation is passed, our citizens will be healthier and our nation will be stronger, more resilient and more productive.

On behalf of the millions of people affected by mental illness and substance-use disorders, I applaud your efforts. The benefits to our nation will be enormous. Thank you.

[The statement of Mrs. Carter follows:]

Prepared Statement of Rosalynn Carter, Former First Lady, Chair, Mental Health Task Force, the Carter Center

Mr. Chairman and members of the subcommittee, thank you for the opportunity to speak to you regarding legislation that will profoundly impact the lives of so many Americans.

I have been working on mental health issues for more than 35 years. When I began no one understood the brain or how to treat mental illnesses. Today everything has changed—except stigma, of course, which holds back progress in the field.

Today because of research and our new knowledge of the brain, mental illnesses can be diagnosed and treated effectively, and the overwhelming majority of those affected can lead normal lives—being contributing citizens in our communities.

I am here today, joining many individuals and hundreds of national organizations calling for an end to the fundamental, stigmatizing inequity of providing far more limited insurance coverage for mental health care than for treatment of any other illnesses. Again I join forces with my friend Betty Ford in urging action on this important issue.

Jimmy and I founded The Carter Center 25 years ago, and I have a very good Mental Health Program there. Annually we bring together leaders to take action on major mental health issues of concern to the nation. We have focused many times on stigma and discrimination and the importance of ensuring adequate, equitable coverage for people with mental illnesses.

To me, it is unconscionable in our country and morally unacceptable to treat 20 percent of our population (1 in every 5 people in our country will experience a mental illness this year) as though they were not worthy of care. We preach human rights and civil rights and yet we let people suffer because of an illness they didn't ask for and for which there is sound treatment. Then we pay the price for this folly

in homelessness, lives lost, families torn apart, loss of productivity, and the costs of treatment in our prisons and jails.

I have always believed that if insurance covered mental illnesses, it would be all right to have them. This may be why the stigma has remained so pervasive—Because these illnesses are treated differently from other health conditions.

All mental illnesses are potentially devastating. During these 35 years, I have seen so many advances in our knowledge about the brain and improvements in treatment. I urge the subcommittee and sponsors to insure coverage of ALL mental illnesses as defined by the DSM-IV (Diagnostic and Statistical Manual of Mental Disorders Fourth Edition), instead of treating some conditions as a higher priority over others.

We had an intern at The Carter Center this spring, for example, who has Obsessive Compulsive Disorder and depression. While she was in high school, she once spent two solid weeks in her house, unable to leave or be with her friends. I am happy to say that she received treatment, is a college graduate with Phi Beta Kappa honors, and just got a job here in Washington, DC. Without resources and support, she could still be sick and shut in her home, which is what happens to so many who do not get the help they need because they lack the ability to pay for services. We as a country lose all the many contributions of these wonderful people.

Through the research of people like Howard Goldman and Richard Frank, we know that parity in insurance benefits for behavioral health care has no significant increase in total costs when coupled with management of care. We also know that a number of enlightened companies such as AT&T, Delta Air Lines, Eastman Kodak, General Motors, and IBM have provided comprehensive coverage for their employees. (Report to the Office of Personnel Management by the Washington Business Group on Health)

I have the pleasure of being friends with Tom Johnson, the former publisher of the Los Angeles Times and former CEO of CNN and a person who has struggled with depression. He has been interested in the mental health benefits offered by employers in Atlanta. He and two other prominent CEOs in the Atlanta community have had an enormous impact on businesses in the area.

Since the mental health commission we held during Jimmy's presidency, there have been several major reports released including the first ever Surgeon General's Report on Mental Health, President Bush's New Freedom Commission on Mental Health, and The Institute of Medicine's inclusion of mental and substance use conditions in its series of reports on the quality of American health care. All of the reports reinforce the statement that effective treatments are available, but most people who need them do not get them.

The whole nation has learned a lot about the importance of mental health issues through the events of Hurricane Katrina and the needs of our returning soldiers and National Guard troops. We support our troops in the field, and it is critical that we continue to support them when they come home.

Finally, I would like to comment on the number of states that have moved ahead with parity. These have been long-fought battles with some states managing wonderful successes. It is so important that any federal legislation not preempt any of these gains.

After waiting for 15 years, we finally have mental health parity legislation in sight. This subcommittee has worked long and hard to bring forward this legislation, and it is an example of what we can accomplish together with strong bipartisan support. If this legislation is passed, many of our citizens will be healthier, and our nation will be stronger, more resilient, and more productive.

On behalf of the millions of people affected by mental illnesses, I applaud your efforts to pass the mental health parity legislation. I know the work has been hard, but the benefits to our nation will be enormous.

Chairman ANDREWS. Mrs. Carter, thank you very much for your statement and for your presence here today.

Mr. Wellstone, welcome.

STATEMENT OF PAUL DAVID WELLSTONE, JR., CHAIRMAN, WELLSTONE ACTION ADVISORY BOARD

Mr. WELLSTONE. Thank you very much.

Mr. Chairman and members of the subcommittee, I want to thank you for the opportunity to speak this afternoon on legislation that addresses an extremely critical health issue facing millions of

Americans, parity for the treatment of mental illness and addiction.

This legislation is very close to my heart, and I want to thank Congressman Kennedy and Congressman Ramstad, my good friend who is not here, for honoring my father's legacy in naming this bill.

My brother and I founded Wellstone Action to carry on my father's work. And through the Wellstone Action organization, thousands of people are being trained each year to develop grassroots skills in organizing and leadership.

But nothing represents my father's passion and commitment more than his work to end the discrimination against those who suffer from mental illness and addiction.

Please accept the gratitude of my family and that of Wellstone Action for this tribute to my father.

I also want to thank Mrs. Carter for her many years of leadership on this issue and many others related to mental illness.

You and my father often worked together, and he was always, always very grateful for your support and leadership.

I have been coming to Washington frequently to speak in support of this legislation, but my father started this work years ago.

Many of you are familiar with the milestones in the long history of the fight for parity—the 1996 federal law, the 1999 executive order that gave federal employees mental health and addiction parity benefits, the many successes of grassroots advocates to strengthen state parity laws, the times that Congress came very close to passing the expansion of the federal law, and the endorsement by President Bush in 2002.

For my father, these milestones were very, very personal. His dedication began when he witnessed the terrible conditions in psychiatric institutions where his own brother, my uncle, was hospitalized in the 1950s.

These conditions and the eventual catastrophic financial toll endured by my grandparents inspired my father to do everything he could to make things right for those in similar circumstances.

The legislation that my father and Senator Domenici passed in 1996 was groundbreaking, for it established in law an important first principle of parity, that those with mental illness should not be discriminated against in insurance coverage.

But my father knew that that was not enough, and he was never satisfied with the compromises that were made at that time.

That is why he immediately began the fight for a more comprehensive federal parity law, one that would include addiction parity and that would close the loophole that the insurance industry had immediately started using to reduce benefits.

His efforts over the years came close to success several times, including once during his last term in office. But despite promises then and promises made after he died, the federal parity law has not yet passed.

This law is long overdue, and that is why we are here today. The bill has been negotiated for years, and important and fair compromises and protections are in place in the proposed health legislation that is the subject of this hearing today.

It is time to move forward, for while we wait, people are suffering and dying from lack of care.

The House bill has critically important provisions that will improve care, and I want to take just a couple of minutes to mention them.

The House legislation recognizes the essential role of scientific and medical knowledge in ensuring high-quality diagnosis and treatment by requiring the widely accepted DSM as the basis for coverage.

Without this requirement, insurers and employers could decide, without the benefit of science of medical expertise, which mental illness or addiction diagnosis should be covered.

I applaud the efforts of the House sponsors to stand firm in its effort to be clear about this requirement. It is important to close this potential loophole, one that could allow discrimination by diagnoses, something that has no place anywhere, but least of all in a parity bill.

The House bill has important protections for state parity laws. In contrast to a current effort to preempt stronger state parity laws, my father advocated for the inclusion of protective language to prevent this preemption in bills he sponsored.

In keeping with the principle of protecting state law, the House legislation includes important language, and I urge you to maintain those protections.

We know from numerous reports, including one today, that the cost for parity is low, and we are going to hear that. Once cost is set aside as a reason for denial of parity, what is left is stigma and discrimination.

Fortunately for our country, there are courageous people who fight against this discrimination, people like my friend Kitty Westin, who lost her daughter Anna to an eating disorder.

Kitty's family faced this kind of discrimination but went on to help change the health care system in Minnesota and is now helping change the federal law.

My father fought hard for those who had no voice, and he had a strong personal commitment to help those with mental illness and addiction.

Congressional members honored his memory by promising to name this parity bill after my dad, and for that I am grateful. But I do know the kind of man my father was and the kind of parity bill he would have wanted finally passed into law.

The protections for patients that have been included in the House bill, such as protection for stronger state laws, full diagnosis coverage and transparency of medical necessity, are essential to the kind of strong law that he fought for, and I urge you to include them in your final markup and passage.

In the end, I am involved because this is the right thing to do. I want to do my part. This Congress has the opportunity to play a major role in history, and I urge you to do your part to finally enact a strong parity law.

Thank you for your courage and your commitment to do the right thing, and know that I will be there by your side with your efforts to pass this legislation. Thank you very much.

[The statement of Mr. Wellstone follows:]

Prepared Statement of Paul David Wellstone, Jr., Chairman, Wellstone Action Advisory Board

Mr. Chairman and members of the subcommittee, I want to thank you for the opportunity to speak to you this morning on legislation that addresses an extremely critical health issue facing millions of Americans: parity for the treatment of mental illness and substance use disorders.

This legislation is very close to my heart, and I want to thank you, and Cong. Patrick Kennedy and Cong. Jim Ramstad, for honoring my father's legacy by naming this bill in his honor. My brother and I founded Wellstone Action to carry on his work, and through the Wellstone Action organization, hundreds of people are being trained each year to run for office, and to develop grassroots skills in organizing and leadership. But nothing represents my father's passion and commitment more than his work to pass legislation that would end the discrimination against those who suffer from mental illness and substance use disorders. Please accept the gratitude of my family and that of Wellstone Action, for this tribute to my father and our family.

I also want to thank Mrs. Carter for her many years of leadership on this issue and many other issues related to mental illness. She and my father worked closely together on this issue and he was always grateful for her support and leadership.

I have been coming to Washington frequently to speak on behalf of this legislation and a strong mental health and addiction parity bill. But my father started this work years ago.

History

Parity has a long history. Many of you are familiar with its milestones: the 1996 federal law; the 1999 Executive Order that gave federal employees mental health and addiction parity benefits; the many successes at the state level to strengthen their parity laws; the times that Congress came very close to passing the expansion of the federal law; and the endorsement by President Bush in 2002. For my father, these milestones were very personal. His dedication stemmed from his personal observations of the terrible conditions in psychiatric institutions when his own brother, my uncle, was hospitalized in the 1950s. These conditions, and the eventual catastrophic financial toll that my grandparents had to bear, inspired my father to do everything he could to make things right for those in similar circumstances. The legislation that my father and Sen. Domenici passed in 1996 was groundbreaking and important, for it established in law an important first principle of parity—that those with mental illness should not be discriminated against in insurance coverage. But my father knew that it was not enough, and he was never satisfied with the compromises that were made at the time. That is why he immediately began the fight for a more comprehensive federal parity law, one that would include substance use disorders and that would close the loopholes that the insurance industry had immediately started using.

His efforts over the years came close to success several times, including once during his last term in office. But despite promises then, and promises made after he died, the federal parity law has not yet passed. This law is long overdue, and that is why we are here today. The bill has been negotiated for years, and important compromises and protections have been put in place in the proposed House legislation that is the subject of this hearing today. It is time to move forward, and to recognize that while we delay, people are suffering and dying from lack of care.

This bill is the critically important next step toward ending the persistent discrimination against people who suffer from mental illness and addiction. In the past, some opponents have been satisfied with the reauthorization of the 1996 law, and there is the danger that this could happen again. It is my view that to merely reauthorize the 1996 law is worse than simply allowing the law to lapse. Why? Because we know that the discrimination against the mentally ill and addiction has worsened. As was reported in a GAO report in 2000 (GAO-HEHS-00-95), despite the limited objectives of the 1996 law, there were numerous examples of violations of not only the spirit, but even the letter of the law. GAO found that although most employers complied with the Act, they expanded other discriminatory coverage limits. Eighty-seven percent of the surveyed employers had a limit on mental health benefits lower than what is offered for other medical/surgical benefits, and several states were noncompliant. In a recent study of employer provided benefits, reported in Health Affairs (2007), the cost-sharing for addiction benefits was 46% higher for addiction benefits than for medical or surgical benefits and there were no out of pocket spending caps for addiction spending in 44 % of the plans studied. It is clear from these reports that the gains intended by the 1996 law have not yet been at-

tained and that further federal legislation strengthening and expanding the 1996 law is still badly needed.

Many of you knew my dad, and so you would be aware of how often he expressed his outrage at the injustice that is rampant throughout the health care system in its failure to adequately cover mental illness and addiction care. Over the years, the opposition to the many legislative efforts focused on whatever they could to prevent the bill from going forward, including misinformation, scare tactics, and stalling. Today, although we have made progress, we expect increased opposition as we move forward to ensure patient protections that are in the House bill. I urge you all to stay strong, to fight for the patient protections are in the House bill, to do the right thing, and make this bill the law of the land.

I especially want to commend House and Senate sponsors for their inclusion of substance use disorders in the parity bills. My dad always worked closely with Cong. Ramstad to push for parity for treatment of substance use disorders throughout his Senate terms. This inclusion is long overdue. In recent years, we know that spending for addiction treatment has been drastically shifted from the private sector to the federal government. Private insurance accounts for just 9% of substance use disorders expenditures (Levit et al, 2006). It is past time for the private sector to do its fair share. As my friend, William Moyers, Vice President of the Hazelden Foundation said at the parity field hearing in Minnesota, many individuals who seek addiction treatment also suffer from mental illnesses, and that it is "folly to treat one illness and not the other." I would add that it is also folly to allow insurers and employers to determine in advance, outside of medical considerations, which diagnoses they deem worthy of coverage. And so I am pleased to see that HR 1424 includes substance use disorders, and that it requires that the standard diagnostic manual—the one used by physicians, researchers, government agencies, and insurance companies themselves as the standard for diagnosis, treatment, and reimbursement—be the standard for mental health and addiction coverage in this bill.

Need

Many of you know the disturbing statistics concerning mental illness and addiction for adults and children with these diseases. The current estimate from the National Institute of Mental Health is that about 26 percent of the U.S. adult population—over 78 million Americans—suffer from a diagnosable mental disorder in a given year. Twenty-there million people and their families struggle to recover from the shattered lives that result from untreated addiction. Although the research on children is not as well-documented, the percentage of children affected by mental or emotional disorders is very similar, at 20 percent, with 9 percent severely affected.

We know that mental illness is a real, painful, and sometimes fatal disease. It is also a treatable disease. My father used to say, acknowledging the wisdom of his friend, Dr. Kay Redfield Jamison, that the gap between what we know and what we do is lethal. Available medications and psychological treatments, alone or in combination, can help most people who suffer from mental illness and addiction. But without adequate treatment, these illnesses can continue or worsen in severity. Suicide is the third leading cause of death of young people in the U.S. Each year, 30,000 Americans take their lives, hundreds of thousands attempt to do so, and in 90% of these situations, the cause is untreated mental illness. This is one of the true costs of delaying this legislation: Every 16 minutes, a child or adult takes their lives because of the unmitigated, searing pain of depression or another mental illness.

HR 1424—Important Provisions

The House bill has other very important provisions that will improve care for mental health and addiction patients.

DSM

I have mentioned the diagnostic manual that has long been used to guide diagnostic and treatment decisions. Much debate has occurred around this manual, the Diagnostic and Statistical Manual (DSM), a handbook and codebook that lists mental illness disorders and the diagnostic criteria for each based on current research. The DSM is the coding manual that is used by many government agencies, researchers, physicians, and the public and private insurance industry to code mandatory health data, understand and diagnose illness, frame research, and develop treatment guidelines. The House legislation recognizes the essential role of the DSM in ensuring high quality treatment and diagnostic decision-making by requiring the DSM as the basis for coverage. Without this clarity, insurers and employers could decide, without the benefit of science or medical expertise, what kinds of mental or addictive disorders should be covered. I applaud the efforts of the House sponsors

to stand firm in its effort to ensure that mental illness and addiction are treated no differently than medical/surgical conditions. The DSM is part of the International Classification of Disease (ICD), a similar manual that includes codes for over 12,000 medical and surgical conditions. The DSM, by contrast, has a few hundred codes. It is essential that the scientific and research findings that developed the DSM, and contribute to high quality care, be the basis for mental health and addiction treatment. When it became clear in past negotiations that the insurers may undermine the parity legislation by restricting coverage by diagnosis, my father fought hard against these weakening amendments that could turn into a dangerous loophole. I urge you to stand firm on this principle and prevent any effort to allow discrimination by diagnosis. The way to do so is to keep the standard of the science as the standard in this bill.

State Protections

HR 1424 also has important protections for parity laws in the states. One positive outcome of the 1996 law was a major surge in the passage of parity-related laws in a majority of the states. These laws reflect the positive efforts of grass-roots advocacy whereby those in need can seek democratic change with their local elected representatives. Though not all of these laws are stronger than the proposed federal law, many of them are. Unfortunately, in the current debate, there is an effort underway to have the federal parity law preempt stronger state laws. Contrary to this view, my father vehemently opposed any effort to preempt stronger state laws, and even advocated for the inclusion of such protective language to prevent this in earlier versions of the bills he sponsored. Such preemption would severely undermine the benefits of health coverage for those for whom the federal law would not apply, as attested to in recent analysis by Mila Kaufman of Georgetown University. In keeping with this principle of protecting state law, the House legislation includes important language, and I would urge you to keep those protections. I ask you to consider what kind of federal parity law it would be if it were to change decades of health care protections in the states, and do so on the backs of those with mental illness and substance use disorders.

Medical necessity

With this legislation, the devil is always in the details and that is why the details in HR 1424 are so important. The more I have talked with people about the need for this legislation, the more I have understood that the problems go beyond just parity, as critically important as this is. Decisions around so-called "medical necessity" are often the basis for denial of care, and while these problems may continue even after a strong parity bill is enacted, I want to applaud the sponsors of this bill for recognizing that patients have a right to know on what basis their care is being denied, and that this information should be transparent and made quickly available to patients. When Kitty Westin's daughter Anna's daughter was in the hospital, critically ill, she was denied care and sent home while the insurer determined whether it was 'medically necessary' to treat her severe eating disorder. This kind of callous disregard for her disease and her life contributed to enormous suffering for her and her family, and in the end, Anna died from her disease, leaving behind a grieving family to endure this loss and this injustice.

I have had the honor to get to know Kitty, one of my father's closest friends. She is a fellow Minnesotan, the founder of the Anna Westin Foundation, the President of the Eating Disorders Coalition, and most importantly, the mother of Anna. Kitty and I have met with many of you, and you have heard about the tragedy that her family endured, when Anna was repeatedly denied insurance coverage for her eating disorder. What happened to Anna and her family, and millions of others, embodies the outrage my father spoke about so often. Kitty spoke at the recent House Ways and Means subcommittee hearing on this bill, and despite her tragic loss, she spoke about hope. She talked about her hope that the system can and will change, hope that those in need will finally have access to care, and hope that the voices of those who are suffering will be heard. The passage of this bill is a life or death issue for millions of Americans. This is fact that we can understand in our minds. Kitty and her family live with that tragic reality every day. As a country, we owe Kitty and her family a debt of gratitude for coming forward with their story and their grief, in order to make positive changes in Minnesota, and to make positive changes in the federal law.

Cost

Another issue we often hear about in relation to this bill is cost. Today, you will hear powerful testimony about how badly this treatment coverage is needed, how mental illness and substance use disorder have affected the lives of so many Americans throughout our country, and how the costs for such treatment are very low.

Numerous past reports have shown that fair and equitable mental health treatment can be offered as part of a health benefit package without escalating costs. Today, we have even more compelling evidence that this is so. There should be no further doubt that treatment for mental illness and substance use disorder is a health care benefit that our country can afford, and even more important, it is one that the our country should and must provide for the millions of Americans covered by private insurance. It is time to lay the issue of cost to rest, for we know that with the appropriate medical oversight, costs are low. It is no longer a question of can we afford it, but rather, can we afford not to provide health care for the millions who suffer from mental illness and addiction?

Many employers already do recognize this basic fact. A series of articles published in the Wall Street Journal in 2001 recounted the growing recognition of employers that mental illness is a reality in the workplace and can be documented as a workplace cost. At the same time, the articles noted that when employees are given access and benefits to receive proper treatment, companies are able to retain highly able and productive employees. The articles noted that the stigma associated with mental illness can lead to untreated illnesses that turn up as other healthcare costs, lost productivity, or absenteeism, so that attempts to reduce overall health care costs by targeting those with mental illness may in fact lead to other workplace costs, in addition to greater suffering. I have provided citation information for these articles below.

In terms of cost, parity legislation has already been tested for years. Testimony by Dr. Howard Goldman in the House Energy and Commerce subcommittee on June 15, 2007, attested to the low cost of the federal employee parity provision, the fact that no plans dropped out of the federal program, and that there was a significant decline in out of pocket spending on the part of patients.

The opponents who still cite cost issues do not recognize these low treatment costs, nor do they acknowledge that proper treatment of mental illness actually saves money. They fail to recognize that untreated mental illness and addiction costs over $100 billion per year, and that our country picks up the cost of untreated mental illness and addiction in any case, for untreated illnesses don't just go away. Children with mental illness and addiction disorders often end up in public institutions, foster care, or jail because their parents cannot afford their care. Adults who have private insurance are often forced into public health care systems financed through State governments, Medicare, and Medicaid. These systems are then forced to take scarce resources from those who have no insurance. Families are forced into bankruptcy; lives are broken; and lives are lost.

Stigma

When cost is set aside as the reason for denial of parity, what is left is stigma and discrimination. In our country, mental illness and substance use disorder continue to be stigmatized as diseases for which one should feel shame. People are made to feel that they are lucky or should feel grateful when they get any coverage, even when they are routinely denied adequate treatment. Why? The stigma associated with the illness is one reason, for it not only doubly burdens the person who suffers from this illness, but it makes it easier for insurance companies to deny treatment, knowing that the person may not want to or be able to file public appeals or bring this matter to their employer. A cloak of secrecy has surrounded this disease, and people with mental illness and addiction are often ashamed and afraid to seek treatment. They fear that they may lose their jobs or even their friends and family. For those "lucky" enough to obtain care, the benefit is discriminatory—with co-payments, deductibles and day and visit limits that are both higher and more restrictive than for any other illness. When more care is needed, the cost is borne by others, i.e., families, taxpayers, or the generosity of donors, as John Schwarzlose from the Betty Ford Center recently testified. This is, plain and simple, unjust and unfair. And sometimes, it is lethal. People die when care is denied, as in the case of Kitty Westin's daughter, Anna.

Historic Opportunity

Congress has a chance with this legislation to play an important historic role. The movement for parity for treatment for mental illness and substance use disorders is growing. Over these past years, the principle of parity in insurance coverage for mental health and addiction treatment has received the strong support of numerous administrations, including President Bush and his New Freedom Commission on Mental Health, the Surgeon General, and many leading figures in medicine, business, government, journalism, and entertainment who have suffered from mental illness and addiction and have been successfully treated. Federal employees, including members of Congress, receive full mental health and substance abuse treatment

parity. Many states have stronger state laws or are moving toward enacting them. Mental health and addiction hearings on the Hill have frequently highlighted recent major advances in scientific information about the diseases, the biological causes or consequences of mental illness and addiction, the effectiveness and low cost of treatment, as well as many painful, personal stories of people, including children, who have been denied treatment. Changes are being made or proposed in mental health and addiction coverage in other systems of health care, such as the military, the VA, Medicare, and children's health insurance. We do not discriminate against other illnesses where the brain is affected. Why do we continue to discriminate against mental illness and addiction? It is time for the federal government to enact legislation that will help move us toward full treatment parity for mental illness and addiction. This Congress has the chance to be remembered as the one that had the courage and leadership to complete this effort.

Conclusion

People have asked me while I'm here in Washington why I am so involved in this issue. I am involved because of my father, of course. I loved him and I miss him, and I have learned that many others here in Washington and throughout the country miss him too, especially his courage and his compassion. He fought hard for those who had no voice, and he had a strong personal commitment to helping those with mental illness and addiction. Congressional members honored him and my family by promising to name the parity bill after my dad, and I am grateful. But I do know the kind of man my father was, and the kind of parity bill he would have wanted finally passed into law, and I wanted to help ensure that the final bill is one worthy of his name. The protections for patients that have been included in HR 1424, such as protections of stronger state laws, full diagnosis coverage, and transparency of medical necessity, are essential to a strong law and I urge you to include them in your final markup and passage.

I, along with millions of Americans, look forward to the day when people with mental illness and substance use disorder receive decent, humane, and timely care for mental illness and substance use disorders. Thank you for your courage and commitment to do the right thing, and know that I will be by your side throughout your efforts to pass this legislation.

Thank you.

CITATIONS

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Levit, K.R., et al. (2006). Projections of National Expenditures for Mental Health Services and Substance Abuse Treatment, 2004-2014. SAMHSA Publication. Rockville, MD.

Gabel, J.R., Whitmore, H., Pickreign, J.D., Levit, K.R., Coffey, R.M., and Vandivort-Warren, R. (2007). Substance abuse benefits: Still limited after all these years. Health Affairs, 26 (4), pg. 474-482.

[The Congressional Research Service report, "The Mental Health Parity Act: A Legislative History," is available on the committee website at the following Internet address:]

http://edlabor.house.gov/testimony/071007MentalHealthParityCRSReport.pdf

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Chairman ANDREWS. David, thank you very, very much for your statement.

You know, your father was kind of shy and retiring. It was hard to get him worked up to speak for something, but I sure did hear him speak with great passion and commitment about this issue.

We miss him very much. But I think we can honor the legacy of his life by moving forward. We are glad that you are here.

Ms. Smith, I know you have had a long journey to get here today, in more ways than one. We are very happy to have you with us, and welcome.

STATEMENT OF AMY SMITH, VICE PRESIDENT, MENTAL HEALTH ASSOCIATION OF COLORADO

Ms. SMITH. Thank you. Chairman Andrews, Ranking Member Kline and distinguished members of the committee, thank you very, very much for this opportunity to tell my story.

My name is Amy Smith, and I have lived my life with a serious psychiatric disorder. Most of my life was spent in a murky, confusing ocean of extreme emotions. I cycled in and out of mental hospitals, jail and rather desperate attempts to lead a so-called life. Looking back on my childhood, I realize that I was already under the influence of mental illness.

I remember a time when I was afraid to leave my bed in the morning to go to school because I was convinced there was an evil woman clad in flowing black robes and riding a black horse right outside my door that was going to get me. I did not relate to my peers, and I led a very lonely young life.

As a young adult, my disorder, schizoaffective disorder, really blossomed. I had no idea what was happening to me as I became increasingly out of touch with reality and began a dark descent into profound depression.

I quickly discovered that drugs and alcohol alleviated some of my symptoms. My solution to my difficulties was to stay high and drunk all the time, from the moment I woke up in the morning until I fell asleep at night.

I found it increasingly difficult to attend my college classes and consequently lost my grants, scholarships and loans. I became a drug dealer to support myself.

And after I was arrested, I became homeless for the first time, living in an abandoned trailer that had no doors or windows in the middle of a large field.

As homeless shelters went, it was pretty luxurious. I was able to keep a small amount of possessions, and I didn't have to worry about other homeless people stealing my stuff or attacking me.

One of the characteristics of severe mental illness is it is a very cyclical disorder, and I would experience brief windows of lucidity and clarity from time to time.

When I was a young person, when that happened, I would experience momentous surges of hope and, thinking that all the darkness was lifted at last, I would craft extravagant plans for my life, not realizing that my schemes were grandiose and unachievable.

As I became a more seasoned player in life, I would give myself over to my addictions in these times and just quit trying.

The worst product of a severe mental illness, in my opinion, is the debilitating loneliness. Even as a very young child, I could not connect with the people around me, and it only got worse as I aged.

I tried and tried to build a network of people around me, to no avail. I remember one time I was attending a potluck and I had

managed to wear some reasonable clothes and I brought a dish to share. I was so proud of myself.

I was in this crowded room filled with prospective friends, and I went to sit on the couch with a plate of food. As I was sitting down, I glanced down at the couch and saw that it was covered with hundreds of naked, squirming babies.

I made a horrible sound and leapt up, my food flying. It was humiliating beyond belief, but fairly typical of my stabs at making friendships.

I did, however, manage to have a child, and I did attempt to build a family around me. As life went on, my condition became worse and worse. I clearly looked like someone to avoid at all costs.

I had dreams about what to wear, and if I didn't have a dream, I would wear the same outlandish outfits over and over again, sometimes for weeks at a time, so I had hygiene issues.

I would either shuffle or stride up and down the street, depending on my mood, muttering to myself and occasionally verbally attacking passers-by.

My son, who turned out to be a person with a psychiatric disorder himself, was living in mental hospitals and residential treatment centers. I could not keep him safe and lost partial custody of him to social services. My situation was pretty bleak.

Finally, I had just had enough. I made a plan to kill both myself and my son. Fortunately, I told someone of my plan, and I was whisked away to a community mental health hospital.

As I was on Medicaid, I entered into the Colorado community mental health system and immediately started receiving excellent care. I was determined to turn my life around.

Working with my doctors and therapists, I started taking care of myself, sleeping appropriately and eating decent food.

It took a long time, but we found the cocktail of psychotropic medications that worked for me, alleviating my symptoms with very few side effects. I regained full custody of my son and started working.

Today, I am a vice president at Mental Health America of Colorado. As happy as I am today, I am heartbroken that 45 years of my life were lost.

The jobs I managed to hold down had no mental health insurance and certainly no substance abuse care available. I had to go on welfare to get the care I needed.

Things that people take for granted, like getting married, holding down a real job, driving a car, volunteering in the community, were beyond me most of my life. I was nothing but a drain on society.

Today I am a taxpaying citizen with private insurance. I am no longer ashamed to be the person who I am. We are very lucky in Colorado because we just passed a mental health and addiction parity bill.

You have the same opportunity to do the same here so people's lives are not wasted as mine was. Thank you.

[The statement of Ms. Smith follows:]

Prepared Statement of Amy Smith, Vice President, Mental Health Association of Colorado

Chairman Andrews, Ranking Member Kline, and distinguished Members of the Committee, my name is Amy Smith and I have lived my life with a serious psy-

chiatric disorder. Most of my life was spent in a murky, confusing ocean of extreme emotions. I cycled in and out of mental hospitals, jail and rather desperate attempts to live a so-called "life".

Looking back to my childhood, I realize now I was already under the influence of mental illness. I remember a time when I was afraid to leave my bed in the morning because I was convinced there was an evil woman clad in flowing black robes and riding a black horse right outside my door that was out to get me. I did not relate to my peers and lived a lonely young life.

As a young adult my disorder, schizoaffective disorder, really blossomed. I had no idea what was happening to me as I became increasingly out of touch with reality and began a dark descent into profound depression. I quickly discovered drugs and alcohol alleviated some of my symptoms. My solution to my difficulties was to stay high and drunk all the time, from the minute I woke up in the morning till I fell asleep at night. I found it increasingly difficult to attend my college classes and consequentially lost my grants, scholarships and loans. I became a drug dealer to support myself, and after I was arrested I became homeless for the first time, living in an abandoned trailer that had no doors or windows in the middle of a large field. As homeless shelters went, it was pretty luxurious. I was able to keep a small amount of possessions and didn't have to worry about other homeless people stealing my stuff or attacking me.

One of the characteristics of severe mental illness is it's a very cyclical disorder, and I would experience brief windows of lucidity and clarity from time to time. When I was a young person, I would experience momentous surges of hope, and thinking that all that darkness was lifted at last, I would craft extravagant plans for my life, not realizing that my schemes were grandiose and unachievable. As I became a more seasoned player in life, I would give myself over to my additions in these times, and just quit trying.

The worst by-product of a severe mental illness, in my opinion, is the debilitating loneliness. Even as a very young child, I could not connect with the people around me and it only got worse as I aged. I tried and tried to build a network of people around me to no avail. I remember one time I was attending a potluck and I had managed to wear some reasonable clothes and brought a dish to share. (I was so proud of myself!) So I'm in this crowded living room, filled with prospective friends, and I went to sit on the couch with a plate of food. As I was sitting down I glanced down at the couch and saw it was covered with hundreds of naked, squirming, silent babies. I made a horrible sound and leapt up, my food flying. It was humiliating beyond belief but fairly typical of my stabs at making friendships. I did manage to have a child in an attempt to build a family around me.

As life went on, my condition became worse and worse. I clearly looked like someone to avoid at all costs. I had dreams about what to wear, and if I didn't have a dream, I would wear the same outlandish outfits over and over, sometimes for weeks at a time. So I had hygiene issues. I would either shuffle or stride up and down the street, depending on my mood, muttering to myself and occasionally verbally attacking passers-by. My son, who turned out to be a person with a psychiatric disorder himself, was living in mental hospitals and residential treatment centers. I could not keep him safe and lost partial custody of him to social services. My situation was pretty bleak.

Finally I had just had enough. I made a plan to kill both myself and my son. Fortunately I told someone of my plan and I was whisked away to a community mental health hospital. As I was on Medicaid, I entered into the Colorado community mental health system and immediately started receiving excellent care. I was determined to turn my life around. Working with my doctors and therapists, I started taking care of myself, sleeping appropriately and eating decent food. It took a long time, but we found a cocktail of psychotropic medications that worked for me, alleviating my symptoms with very few side effects. I regained full custody of my son and started working. Today, I am a Vice-President at Mental Health America of Colorado!

As happy as I am today, I am heartbroken that 45 years of my life were lost. The jobs I managed to hold down had no mental health insurance and certainly no substance abuse care available. I had to go on welfare to get the care I needed. Things that people take for granted—like getting married, holding down a real job, driving a car, volunteering in the community—were beyond me most of my life. I was nothing but a drain on society.

Today I am a tax-paying citizen with private insurance! I am no longer to be ashamed to be the person I am. Thank you.

Chairman ANDREWS. Ms. Smith, thank you very, very much. As I said, you have had quite a journey to get here, and we are inspired by your testimony. I have great, profound admiration for you. We are very happy you are with us today. Thank you.

Ms. SMITH. Thank you.

Chairman ANDREWS. Mr. Trautwein, thank you for being with us, and we look forward to your statement.

STATEMENT OF NEIL TRAUTWEIN, VICE PRESIDENT, NATIONAL RETAIL FEDERATION

Mr. TRAUTWEIN. Thank you, Mr. Chairman and Ranking Member Kline and members of the committee.

I appreciate the opportunity to appear before you today. By way of introduction, the National Retail Federation is the world's largest retail organization.

We have a membership that comprises all different lines of distribution, all retail formats. I think there is a good chance you or your families know our members well.

We are an industry with more than 1.6 million retail establishments across the country, more than 24 million employees, about one in five workers.

As a labor-intensive industry, we are very concerned about good quality health care, keeping our workers healthy and productive and in place.

As a labor-intensive industry that unfortunately endures wafer-thin profit margins from time to time, we are also well-acquainted with the need to manage the collective cost of labor in as cost-effective a manner as possible.

Maintaining the balance between these two different imperatives is not the easiest job. In fact, sometimes it is darn near impossible.

Mandated coverage for benefits tends to disrupt that balance and makes it more difficult for our members to provide jobs and benefits both, so we have tended to oppose benefit mandates.

Indeed, we oppose the legislation before you today, H.R. 1424. But our opposition to this bill doesn't mean we oppose all mental health parity legislation.

In fact, we are supporters of the Senate bill, and specifically the manager's amendment to S. 588, the bipartisan Mental Health Parity Act.

We think the Senate bill would make the better law by far and would support that law being enacted and support that bill being enacted into law.

We feel that the House bill is similar in many respects to the previous bills that we have opposed on both the House and the Senate side. In some ways, it is a little bit worse than the bills that we have worked on in the past.

We oppose H.R. 1424 primarily because of its broad benefit mandate, its lack of protection for medical management, provisions allowing the states to enact more extensive provisions and provisions mandating out-of-network coverage.

In the interest of time, I am going to concentrate on the first issue and then discuss why I think the collaborative Senate process has developed a better bill and one that has gotten us working arm in arm with the mental health community.

Again, as noted, it is fairly confusing, as the House bill doesn't specifically address the DSM but instead links to the most widely subscribed Federal Employees Health Benefit Plan program. That, in turn, references the DSM, so it is really a circular process.

Although advocates of the House bill tend to point to the fact that the FEHB Plans have been able to deal with the cost of coverage without great cost impact, I would point out that the FEHB Plans enjoy the ability to medically manage that benefit and do so fairly aggressively.

And that is why we are particularly troubled by the lack of a specific protection for medical management in the House bill.

In addition, I would note that no other profession has had its professional manual enshrined into benefit coverage in the way that the House bill would, by indirection, enshrine the DSM.

Typically, insurance plans tend to work the opposite direction, by exclusion of specific conditions rather than inclusion of conditions. So it is really out of place in benefit coverage today.

We think the better approach has been taken by the Senate because it allows plans to define the scope of coverage. It also allows the states to continue to define coverage for state regulated insurance plans.

This debate has been long and fierce. It has lasted through many, many years. I worked with Mr. Wellstone's father in the past on this issue. Certainly, the rhetoric has been tough. I have contributed my share of that.

It is really a shame, because it has obscured what has been really a shared purpose to help people get the kind of coverage that they need in the process.

That shared objective has really encouraged the dialogue between the different sides and with the Senate sponsors.

I would particularly like to give thanks to Senator Kennedy, Senator Domenici and Senator Enzi for being good negotiating partners and fair advocates for both sides of this debate.

The balanced Senate compromise I have highlighted through this testimony has been the product of those negotiations.

What is particularly interesting—and to try to sum up—has been that it is not only typical allies like the American Benefits Council, like the chamber, like the NAM, but we are also working with the National Alliance of Mental Illness, the American Psychiatric and Psychological Associations, the hospitals and many others.

And you will find a copy of our joint letter together at the end of my written testimony.

Again, I appreciate the opportunity to appear before you today and hope we can continue to make progress on this. And hopefully, we would like to work with you to see the Senate bill enacted.

Thank you, Mr. Chairman.

[The statement of Mr. Trautwein follows:]

Prepared Statement of E. Neil Trautwein, Vice President and Employee Benefits Policy Counsel, National Retail Federation

Mr. Chairman and members of the Health, Employment, Labor and Pensions Subcommittee, I thank you for the opportunity to appear before you today and to share our views regarding the Paul Wellstone Mental Health and Addiction Equity Act of 2007. My name is Neil Trautwein and I am Vice President and Employee Benefits Policy Counsel of the National Retail Federation (NRF).

The National Retail Federation is the world's largest retail trade association, with membership that comprises all retail formats and channels of distribution including department, specialty, discount, catalog, Internet, independent stores, chain restaurants, drug stores and grocery stores as well as the industry's key trading partners of retail goods and services. NRF represents an industry with more than 1.6 million U.S. retail establishments, more than 24 million employees—about one in five American workers—and 2006 sales of $4.7 trillion. As the industry umbrella group, NRF also represents more than 100 state, national and international retail associations.

As a labor-intensive industry, retailers are strong advocates of quality health coverage for both physical and behavioral needs in order to help keep our employees healthy and productive. As an industry that frequently endures wafer-thin profit margins, we are also well acquainted with the need to manage the collective cost of labor in as cost-effective a manner as is possible. Maintaining balance between these two imperatives is not always easy—it's borderline impossible.

Mandated coverage for benefits and other government interventions disrupts this balance and increases the cost of health coverage for retailer and employee alike. Thus we have tended to resist benefit mandates both generally and specifically. Indeed, we strongly oppose H.R. 1424, the Paul Wellstone Mental Health and Addiction Equity Act of 2007.

However, our opposition to mental health parity legislation is not simply reflexive. We support the manager's amendment to the Senate bipartisan Mental Health Parity Act of 2007, S. 558. Our first preference always is for no governmental intervention into benefit design. But, should Congress determine to act, then the Senate bill would make the better law by far—an outcome we could support. I will discuss our views on these competing approaches in greater depth below.

NRF Opposes House Parity Bill

The House bill [H.R. 1424, the Paul Wellstone Mental Health and Addiction Equity Act of 2007, introduced by Representatives Patrick Kennedy (D-RI) and Jim Ramstad (RMN)] is similar in many respects to the bills we have opposed in the past. In some respects, it is worse. We strongly oppose H.R. 1424, principally because of its broad benefit mandate, its lack of protection for medical management, provisions allowing the states to enact more extensive provisions and provisions mandating out-of-network coverage.

Broad Coverage Mandate

H.R. 1424 appears on the surface to be less expansive of coverage than previous bills, but that appearance is deceiving. Previous mental health parity bills have tied coverage to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). Under H.R. 1424, no coverage for behavioral needs must be offered, but if any coverage is offered, then coverage must match all that offered under the most heavily subscribed plan under the Federal Employee Health Benefit Program (FEHB). All FEHB plans must cover all the conditions listed in DSM-IV. Thus, H.R. 1424 still ties coverage to DSM-IV. Although advocates of the House bill will point to FEHB's low cost impact implementation of DSM-IV, I will also note that FEHB plans are allowed to medically manage covered benefits—a significant failing of H.R. 1424, which does not meet the FEHB standard.

My purpose today is not to make sport of any specific category or condition under DSM IV. Employer-sponsored plans cover conditions broadly but target to the needs of specific employee populations to help keep employees healthy and productive. But, this blanket DSM-IV coverage mandate is out of place in a bill addressing parity in covered days and reimbursement. It is also out of place in both the benefits world and the insurance world. To my knowledge, no other professional manual is enshrined as mandated coverage. I suspect other professions would quickly beat a path to your door to secure similar treatment if H.R. 1424 were to be enacted.

The better approach is taken by the manager's amendment to S. 558. This bill continues to allow employer plans to define the scope of covered benefits in their plan. In keeping with the states' traditional role in regulating insurance, individual states can define the coverage regulated insurers must offer. We favor this status quo approach because it works in practice today.

No Protection for Medical Management

We are troubled by the lack of specific protection for the medical management of benefits in H.R. 1424. Previous House and Senate bills have included such protections; indeed, such protection was at the heart of proponents' arguments that parity legislation would not greatly increase health coverage costs. Surely the sponsors of H.R. 1424 are not advocating unfettered access to coverage and reimbursement, are they?

Medical management is at the heart of coverage for millions of retail employees today: a process of matching the type and level of coverage to individual need. Most of the states and the FEHB explicitly allow for the medical management of benefits. Medical management is critical to the provision of good quality and affordable benefits. We urge that H.R. 1424 be amended to specifically protect the medical management of covered benefits.

Role of the States

We are also worried by provisions of H.R. 1424 that would allow the states to provide "greater consumer protections, benefits, methods of access to benefits, rights or remedies" than those in the bill. H.R. 1424 would create an uneven patchwork between the states that could ultimately undermine the federal ERISA law which serves as the backbone of employer-sponsored coverage.

Relatively few members of the broad retail community represented by NRF are confined to a single state. The ability to maintain common benefit designs in stores located in several states is critical to the retail community's ability to compete in today's demanding economy. We strongly oppose the "federal floor/state ceiling" approach taken by H.R. 1424 as inherently unworkable.

Our first preference would be for a completely preemptive federal standard covering all plans in all markets. But, good faith negotiations brought us to this balanced outcome. We support the final negotiated compromise on preemption outlined in the manager's amendment to S. 558 that essentially preserves the status quo between federal standards for employee benefits and state regulated insurance products. Anything that seeks to alter this negotiated compromise would be unacceptable to us.

Out-of-Network Coverage

Finally, I would like to join in drawing attention to the provision of H.R. 1424 that mandates out-of-network coverage. As noted by others, this provision exceeds that required of FEHB plans and would greatly undercut employers' ability to manage networks of providers and thus would result in increased costs to everyone, including patients and employees. Our shared preference would be for H.R. 1424 to either conform to the FEHB standard (parity required only for in-network services) or to the manager's amendment to S. 558 (out-of-network coverage not required, but parity coverage in financial requirements and treatment limitations required if so).

Collaborative Senate Process

The mental health parity debate has been both long and fierce. I have been an advocate in this debate for a number of years, both before and after the 1996 law addressing parity in annual and lifetime limits. We all have contributed heated rhetoric to this debate. Unfortunately, it has really obscured our shared objective of helping individuals get the coverage and care they needed.

It is this last point that has encouraged a running dialogue between the advocates and Senate sponsors. I have been privileged to have participated over a number of years as a principal representative of the employer community in intense discussions and negotiations with both the Senate sponsors as well as advocates for the mental health and addiction communities. I would like to give special thanks to Senators Ted Kennedy (D-MA), Michael Enzi (R-WY) and Pete Domenici (R-NM) for their longstanding advocacy on this legislation as well as for their willing ear and fair and responsive negotiations through the years.

The Senate compromise that I have highlighted throughout this testimony is the product of those negotiations. It has also created a broad coalition among erstwhile opponents—surely somewhat of a distinction.

NRF is joined in this coalition not only by traditional allies like the American Benefits Council, Aetna, the U.S. Chamber of Commerce and the National Association of Manufacturers (among others) but also by the National Alliance on Mental Illness, the American Psychiatric and the American Psychological Associations and the American Hospital Association and the Federation of American Hospitals (among others). I have attached a copy of our joint letter at the conclusion of my testimony. I respectfully ask that it be made part of the hearing record.

Conclusion

Again, NRF greatly appreciates the opportunity to appear before you today. Though we oppose the legislation before you (H.R. 1424), we are not opposed to all parity legislation. We support the balanced Senate compromise legislation and would gladly work with you to see it enacted into law this year.

We would also welcome an opportunity to work with you and the House sponsors of H.R. 1424 on similar issues in the future. In fact, it is our hope that our collaborative work in the Senate will be a model for future debates and issues. Who

knows—perhaps there is a collaborative federal cure for common gridlock after all. We hope so! I thank you and will look forward to your questions.

ATTACHMENT

June 14, 2007.

Hon. EDWARD M. KENNEDY; Hon. MICHAEL B. ENZI; Hon. PETE V. DOMENICI;
U.S. Senate, Washington, DC.

DEAR CHAIRMAN KENNEDY AND SENATORS ENZI AND DOMENICI: We write in joint and strong support of prompt Senate action on the manager's amendment to the bipartisan Mental Health Parity Act of 2007, S. 558. We support enactment of your balanced legislation into law this year.

Organizations representing consumers, family members, health professionals, and health care systems and administrators, business associations and insurance organizations negotiated in good faith with you and your staff over an extended period to produce this bill. We believe that it is a strong bill that will advance the interests of the greater mental health community while balancing the interests of employers who voluntarily sponsor benefit coverage. This bill also respects the role of the states in the regulation of insurance.

We urge its prompt adoption by the full Senate and will join you in opposing unacceptable or weakening amendments during the Senate debate and will remain committed to this bipartisan approach as this legislation moves forward. Thank you again for your joint leadership on this important issue.

Sincerely,

NATIONAL RETAIL FEDERATION.
AMERICAN PSYCHOLOGICAL ASSOCIATION.
NATIONAL ASSOCIATION OF WHOLESALER-DISTRIBUTORS.
ASSOCIATION FOR BEHAVIORAL HEALTH AND WELLNESS.
NATIONAL ASSOCIATION OF HEALTH UNDERWRITERS.
FEDERATION OF AMERICAN HOSPITALS.
NATIONAL ALLIANCE ON MENTAL ILLNESS.
SOCIETY FOR HUMAN RESOURCE MANAGEMENT.
NATIONAL ASSOCIATION OF PSYCHIATRIC HEALTH SYSTEMS.
NATIONAL ASSOCIATION OF MANUFACTURERS.
NATIONAL FEDERATION OF INDEPENDENT BUSINESS.
AETNA.
U.S. CHAMBER OF COMMERCE.
BLUECROSS BLUESHIELD ASSOCIATION.
CIGNA.
AMERICAN HOSPITAL ASSOCIATION.
AMERICAN PSYCHIATRIC ASSOCIATION.

Chairman ANDREWS. Mr. Trautwein, thank you for your very thoughtful and comprehensive statement. We appreciate it.

And, Mr. Breyfogle, welcome back to the committee. We are happy to have you with us.

STATEMENT OF JON BREYFOGLE, EXECUTIVE PRINCIPAL, GROOM LAW GROUP

Mr. BREYFOGLE. Thank you, Mr. Chairman, Mr. Kline, members of the committee. It is really an honor to be on this panel with such a distinguished group, people with a long history in this subject. It is an important subject. It is something that employers view as important.

The American Benefits Council represents predominantly large employers and people who provide services to employer plans. The plans that the American Benefits Council represents cover over 100 million Americans.

The vast majority of employers and virtually all large employers cover mental health in their health plan.

At the outset, I would like to say that we have been privileged to be part of the same negotiation process in the Senate in the Sen-

ate bill that is being supported by this coalition. It is a substantial expansion of the parity requirements.

Current law only requires parity for annual limits and lifetime limits. We are supporting a bill that would extend parity requirements to virtually all treatment limits and financial requirements.

It is also a bill that would expand the definition of mental health to include substance abuse. It is also a bill that would substantially narrow the cost exception.

So under any measure against current law, it is a large expansion. It is a large expansion against many state laws. Very few state laws measure up to this kind of parity rule.

There are some basic principles that the council has in evaluating this legislation. They are basically the following.

We need to have some flexibility in how we design our health plans in terms of what is covered and what is not.

We need to have the flexibility to manage health benefits so that if we are going to cover something we can attempt to control the cost and maintain quality.

We would like to have uniform federal rules where there is a comprehensive federal standard, like the parity rule would be in the Senate, while protecting the roles of the states in the insurance world where they want to mandate mental health benefits and the like.

Another basic principle is we want to avoid expansions of new, special purpose remedies, new lawsuits, new damages provisions.

When we look at the Senate bill, it basically meets our requirements. It is not everything that the employer community wants. It goes, frankly, much farther than the employer community has been over time.

And I think under any measure it would be a major victory for mental health advocates and it would benefit from the consensus approach.

The things that the Senate bill doesn't do that we appreciate is that it doesn't have effectively a benefit mandate, because it leaves it up to employers to define what their health plans cover, so it doesn't follow the DSM-IV rule.

I read a study. I think only 12 of the states that have parity rules follow DSM-IV. So it is not as widely accepted as you might think.

The Senate bill makes clear that medical management principles are preserved, at least for self-insured plans. It does have a narrow and targeted preemption rule, but just for the parity requirements.

So there are special rules in the Senate that protect state authority, traditional state insurance authority, in many, many respects.

I would like to mention there was a pretty comprehensive analysis of the Senate's preemption rules done by Professor Rosenbaum of G.W.'s School of Public Health, which is, I think, reflective of the same analysis that we are providing.

And she and, I think, we concluded the following, that mental health mandates are clearly preserved in the Senate bill. Where there are parity requirements coupled with mandates, the mandates would be preserved.

Individual and small group market parity laws are preserved from preemption. State authority to define mental health benefits for insured plans are preempted.

State laws that would mandate insurers offer out-of-network coverage for mental health would be preempted. So state laws that limit the ability of insurers to manage mental health benefits would not be preempted.

So there is this whole body of state insurance law that is not preempted under the Senate bill.

So in terms of the House bill, I think our concerns are pretty much mirror-image points. The House bill would limit the ability of employers to define what benefits are covered by reference to the DSM-IV, through the methodology that Neil pointed out.

It also has no specific protection for medical management. It actually shares the same treatment financial limits rules. It shares the same cost exemption. So it has many of the same basic rules in it.

There is another major concern we have with the House bill, which is that there is a provision in it that specifically excepts from preemption remedies, greater consumer protections benefits, methods of access to benefits, rights or remedies.

That is very different than current law. That is not the sort of floor-ceiling HIPAA rule, for the technicians in the audience.

The House bill is amending an ERISA provision that already preserves state insurance laws, but this provision would arguably allow for state lawsuits and remedies just with respect to mental health benefits.

And that is very different from the current rule under ERISA, where ERISA provides the exclusive set of remedies as a federal statute.

Thank you for your time. I look forward to the questions.

[The statement of Mr. Breyfogle follows:]

Prepared Statement of Jon W. Breyfogle, Groom Law Group, Chartered, on Behalf of the American Benefits Council

ABSTRACT

The American Benefits Council's members have long recognized the importance of effective health coverage for the treatment of both physical and behavioral disorders. Employers understand the importance of quality mental health coverage for their employees and to maintaining a productive, healthy workforce.

Because of the importance our members place on these services, we have repeatedly urged Congress not to expand the current federal parity requirements in a way that would add to plan costs or increase the complexity of plan administration. Doing so could unintentionally risk a reduction in coverage for these or other benefits provided to employees and their families.

The American Benefits Council strongly prefers S. 558 over other parity measures that have been considered by the Senate, as well as H.R. 1424, the parity bill that is the subject of this hearing. Unlike H.R. 1424, the Senate proposal does not mandate that health plans cover specific mental health benefits. It leaves those decisions up to employers and in the case of fully insured health plans, permits States to continue to determine whether to require any particular benefits. The Senate bill makes clear that medical management of mental health benefits is not prohibited and preserves flexibility for employers and health plans in the formation of networks of health care providers who deliver these services. These provisions are vitally important because they allow employers to appropriately design and manage the health coverage they offer to meet their employees' needs.

Finally, the Senate bill provides for a very targeted and narrow preemption of State insurance law (applicable to fully insured plans, as well as to self-insured

plans) that assures a uniform federal rule for the specific parity requirements of S. 558 (e.g., treatment limits, financial requirements, cost exemption), while preserving the traditional role of the States to regulate mental health benefits provided under insurance policies in all other respects.

Unfortunately, the House parity bill does not address the issues of key concern to employers in the same balanced fashion as the Senate bill. The American Benefits Council has played a constructive and active role in the multi-stakeholder negotiations that have helped shape the Senate mental health parity bill and are prepared to do the same with the House bill to make the changes we believe are necessary to achieve a more balanced approach to expansion of federal mental health parity requirements.

PREPARED STATEMENT

Mr. Chairman and members of the Subcommittee, thank you for the opportunity to share the views of the American Benefits Council on the Paul Wellstone Mental Health and Addiction Equity Act of 2007. My name is Jon Breyfogle. I am the Executive Principal of the Groom Law Group. Groom Law Group is a Washington DC based law firm that specializes exclusively in employee benefits law. In my practice, I represent a wide range of large employers and insurers on the legal issues surrounding sponsoring health plans and offering services to health plans. I am a member of the Board of Directors of the American Benefits Council and am testifying on behalf of the Council.

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

Employers Recognize the Importance of Behavioral Health Care

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

We also recognize that much has changed in the behavioral health care field over the past decade since the enactment of the current federal mental health parity requirements in 1996. Better medical evidence on behavioral health conditions has become available and better treatment options have advanced during this period. In many cases, the way in which behavioral health conditions are covered by health plans has also changed, particularly with the emergence of health plan administrators that specialize in the management of behavioral health care services in a wide range of outpatient and inpatient settings.

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

Senate Parity Legislation

Before I address the concerns we have with the House of Representatives mental health parity bill, H.R. 1424, I want to emphasize that employers understand and appreciate how vitally important effective behavioral health care is for millions of Americans. Employers spend considerable sums of money providing behavioral health care coverage and are not irrevocably opposed to any legislation enhancing parity requirements.

Over the past several months, three Senate sponsors of mental health parity legislation (Mental Health Parity Act of 2007—S. 558)—Senate HELP Committee Chair-

man Kennedy, HELP Committee ranking member Senator Enzi and Senator Domenici—have tried to resolve the difficult and important issue of changing the current federal parity requirements. Their bill has been developed through an inclusive and thorough process that has given all the major stakeholders on this issue—employers, health plans, behavioral health care providers and patient advocates—the opportunity to have their concerns heard and addressed.

The American Benefits Council has been privileged to have participated in this process as a representative of employer interests. While these discussions have been demanding and have required much give and take on all sides, we also think that it has resulted in a bill that balances the interests of a divergent set of stakeholders. We believe the process employed could serve as a model for how Congress might be able to tackle other similarly challenging health policy issues.

S. 558 is not perfect from our perspective, but no true compromise proposal ever is. That said, the Senate parity measure has gained the support of mental health parity proponents and a broad range of organizations representing employers and insurers. In that regard, the Senate bill is unique. We hope this good faith effort sends an important message that employers will support legislation where their priority concerns are addressed in a thoughtful manner and with careful attention to details, even when our preferred outcome would be no new legislation or an even better bill.

Here are the key reasons why the American Benefits Council strongly prefers the Senate bill over other parity measures that have been considered by the Senate, as well as H.R. 1424, the parity bill that is the subject of this hearing.

First, the Senate proposal does not mandate that health plans cover specific mental health benefits. It leaves those decisions up to employers. In the case of fully insured health plans, however, the Senate bill permits States to continue to determine whether to require any particular benefits.

Second, the Senate bill includes a provision making clear that medical management of mental health benefits is not prohibited and preserves flexibility for employers and health plans in the formation of networks of health care providers who deliver these services. These provisions are vitally important because they allow employers to appropriately design and manage the health coverage they offer to meet their employees' needs.

Finally, the Senate bill provides for a very targeted and narrow preemption of State insurance law (applicable to fully insured plans, as well as to self-insured plans) that assures a uniform federal rule for the specific parity requirements of S. 558 (e.g., treatment limits, financial requirements, cost exemption).

We recognize that this modest preemption rule in the Senate bill has generated some criticism and that the provision deviates from the "federal floor/state ceiling" preemption rule that currently applies to fully insured plans under the existing federal mental health parity requirements in section 712 of the Employee Retirement Income Security Act (ERISA). However, this provision is targeted and well justified. This narrow preemption rule was included in S. 558 because the sponsors of the legislation recognize that the parity rules of the Senate bill are very comprehensive and deserving of a uniform Federal approach. In fact, it is hard to imagine a broader parity requirement pertaining to treatment limits and financial requirements. Indeed, S. 558 would extend broad new parity requirements to participants in insured plans in the 8 states that currently have no parity requirement and expand upon the parity requirements applicable to insured plans in approximately 17 other states.

The sponsors of the Senate bill have approached this matter with great thought and care to ensure that the targeted new preemption rule preserves the traditional role of the States to regulate mental health benefits provided under insurance policies in all other respects. For example, special rules are included in the bill that ensure that:

- State laws that mandate mental health benefits for fully insured plans are preserved;
- State laws that include parity requirements together with non-parity requirements (e.g., some form of mandated benefit) will not be completely preempted as they apply to fully insured plans—only the State's specific and different parity requirements will be preempted and the other aspects of State law will be preserved;
- State laws that set parity requirements for insurance offered in the small group market are preserved;
- State laws that set parity requirements for the individual insurance market are preserved;
- State laws that define the term "mental health benefits" will not be preempted for fully insured plans;

• State laws that require that insurers offer out of network coverage for mental health benefits are not preempted; and

• State laws that regulate the ability of insurers to manage mental health benefits for fully insured plans are not preempted.

To ensure that there are no unintended preemption consequences associated with the Senate bill, the sponsors of the Senate bill have set out all of these rules explicitly in the text of S. 558. In my view, these provisions are belts and suspenders to begin with—arguably they are not even needed because the basic preemption rule in the bill is narrowly targeted to begin with. The fact that employers have worked closely with the Senate sponsors in the crafting of these comprehensive clarifications relating to State insurance laws demonstrates the good faith negotiations that have occurred. As a practicing lawyer in this area, there is no doubt in my mind that any court or regulator that would be called on to interpret the Senate bill will fully understand that the Congress went out of its way to preserve and respect the traditional role of the States to set standards for participants of fully insured plans. Any arguments to the contrary are simply without merit.

Employer Concerns with the House Mental Health Parity Bill

Unfortunately, the House parity bill does not address the issues of key concern to employers in the same balanced fashion as the Senate bill. As such, we urge that several changes be made to the legislation as it is further considered. The primary issues which we believe need to be addressed are the following:

1. Flexibility Needed in Covered Benefits

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

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

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

2. Protection for Medical Management Practices

Another major concern with the House bill is that, unlike the current Senate measure, there is no specific protection for medical management practices for self-insured plans. It is important to preserve the ability of plans to manage coverage for mental health conditions and substance-related disorders. We believe that employers should be able to design plans so that proposed treatments for these conditions are, whenever possible, consistent with standards for evidence-based care. Indeed, in our view, the Senate bill's protection for medical management does not go far enough—we would have greatly preferred that the Senate bill preempt State insurance laws that limit the ability of insurers to manage mental health benefits for fully insured plans. But not doing so is one of the many compromises included in the Senate bill.

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

We need to be careful to ensure that neither State nor federal laws undercut or diminish efforts by plans to try to ensure that the health care services received by plan participants are medically necessary and appropriate for their conditions. Some health plans contract with managed behavioral health care organizations for this purpose while others perform medical management services as part of their core plan operations. Either way, it is essential to safeguard these important activities so that plans are able to ensure that coverage is provided for quality health care services and protect themselves and their participants from unnecessary costs. Advocates of H.R. 1424 maintain that it is not their intention to interfere with medical management and that nothing in the legislation would explicitly do so (i.e., the bill is simply silent on the matter). This is very encouraging, but to ensure that result, we urge the House to amend H.R. 1424 to include the Senate bill's specific language to make that point absolutely clear.

3. Discretion Needed for Out-of-Network Coverage

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

We would recommend that the House bill adopt the Senate approach which includes a federal standard that calls for parity in plan financial requirements and treatment limitations for any out-of-network mental health coverage provided by a plan, but the Senate provision does not require plans to offer outof-network coverage even where out-of-network coverage is offered for other medical benefits. As noted above, the Senate bill preserves the traditional role of the States to regulate fully insured health plans in this area, so it does not interfere with State laws which may require insurers to offer out-of-network mental health coverage.

4. Changes Needed to Preemption Provisions

We have significant concerns with the provisions in the House parity bill which would authorize States to provide "greater consumer protections, benefits, methods of access to benefits, rights or remedies" than the provisions set out in the legislation. Clearly, this language gives States the ability to develop parity laws, at least for fully insured health plans, that are more extensive than the federal standards provided in the House bill. We prefer the approach adopted in the Senate bill, which would establish uniform federal parity rules applicable to treatment limitations and financial requirements for both self-insured and insured plans while preserving the traditional authority of States to require fully insured plans to provide mental health coverage.

The more troubling aspect of this provision in the House bill is that it opens the door for greater State law remedies for disputes involving mental health benefits for participants in insured plans. The Supreme Court has issued numerous rulings making clear that ERISA's enforcement scheme is exclusive for both fully insured and self-insured plans and completely preempts alternative State remedial schemes. It makes no sense whatsoever to allow access to State law remedies for one category of benefits—i.e., participants in fully insured plans for disputes over mental health benefits. To the extent the House bill is interpreted to revise remedies for all types of benefit disputes, H.R. 1424 is certainly not the vehicle to do so. The debate over ERISA's remedies has occurred over many years, generally in the context of the Patients' Bill of Rights. Such a fundamental issue as ERISA's remedial scheme should not be an adjunct to a bill whose purpose is to address mental health parity.

The uniformity that ERISA establishes for employer-sponsored coverage, including its enforcement and remedies scheme, is sound public policy and is something employers consider crucial to their voluntary decision to offer health coverage to their employees. If Congress believes that changes are needed in this area, such

changes should be debated on their own merits rather than included as one of many provisions of a mental health parity bill.

House and Senate Parity Bills Fail to Apply to Federal Programs

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

We believe it is indefensible for Congress to impose parity requirements on employer-sponsored health coverage, for both private sector employers and state and local government health plans, while ignoring the same issues in the programs that the Federal government sponsors and pays for. If either the House or Senate bills were enacted, mental health parity would be the law for employer-sponsored coverage and, through previous action by Executive Order, for coverage offered to federal employees (including members of Congress), but not for those covered under Medicare or Medicaid.

It would send a fundamentally different message to employers if mental health parity was not simply something that Congress was seeking to apply solely to employer-sponsored health coverage, but was being done as part of a more omnibus effort to achieve the same standards in all federal health programs as well.

Conclusion

Thank you for the opportunity to testify today and share our views with you on these important issues. Employers understand the importance of quality mental health coverage for their employees and to maintaining a productive, healthy workforce. We also fully understand the strong sentiment in Congress to expand upon the current federal mental health parity requirements. The American Benefits Council has played a constructive and active role in the multi-stakeholder negotiations that have helped shape the Senate mental health parity bill. We are prepared to do the same with the House bill if a similar approach is taken to making what we believe are important and needed changes to ensure a more balanced proposal.

Chairman ANDREWS. Thank you very much, Mr. Breyfogle. As usual, very well-prepared.

Mr. Melek, welcome to the committee. We look forward to hearing your statement.

STATEMENT OF STEVE MELEK, ACTUARY, MILLIMAN, INC.

Mr. MELEK. Good afternoon, Chairman Andrews and members of the Subcommittee on Health, Employment, Labor and Pensions. It is my pleasure and honor to testify before you on the Paul Wellstone Mental Health and Addiction Equity Act of 2007.

My name is Steve Melek, and I am a fellow of the Society of Actuaries and member of the American Academy of Actuaries. I am a health care actuary with Milliman, which is a leading actuarial consulting firm that consults to virtually all health insurers and managed care plans in the U.S. and many employers.

I have been with Milliman for 17 years and have specialized in actuarial work related to behavioral health care. Our report contains the findings of the Milliman authors. Please note that Milliman does not endorse legislation.

My work with parity dates back to the analysis of the Health Insurance Reform Act of 1995. I personally helped health insurers, providers, employers, managed behavioral health care organizations and state governments price behavioral health benefits, including legislation in Nebraska and Washington state within the last year.

Milliman was commissioned by Capital Decisions Inc. on behalf of several behavioral provider organizations. Our full report contains important details about our findings, sources and methodology.

From an actuarial standpoint, parity will bring the benefit limits and cost-sharing for behavioral health care in line with medical benefits. For example, a benefit plan might have a $10 co-pay for an office visit for a medical condition but a $25 co-pay for a therapy visit to a psychologist.

In addition, a benefit plan might limit behavioral therapy to 20 visits per year but have no physician visit limits for medical conditions.

Obviously, that can increase costs for the insurer or employer, and it will decrease the amount the patient pays out of pocket.

Our estimates show that the cost increase is modest relative to total health care costs and to the ongoing annual cost increases of health benefits.

We estimate this legislation would increase per capita health insurance premiums of typical health plans in 2008 by an average of 0.6 percent, or $2.40 per member per month, in our baseline scenario.

In that scenario, we assume that employers and health plans will take no steps to compensate for the added cost, such as increasing cost-sharing or increasing utilization management. Thus, our estimate is conservative, meaning it is on the high side.

Employers and insurers commonly try to compensate for increased cost by reducing benefits or increasing employee premium contributions. The CBO, in its cost analysis of Senate Bill 558, considered that employer responses will remove about 60 percent of the cost increase.

Applying this CBO figure to our baseline scenario increase of 0.6 percent reduces the net cost increase to about 0.2 percent.

Another response of employers and insurers to increased cost is to increase the intensity of utilization management. The legislation does not appear to prevent the use of utilization management, or U.M.

We developed another scenario, our increased U.M. scenario, where payers would tighten their behavioral health care utilization management. In this scenario, our cost estimates result in an aggregate premium increase of less than 0.1 percent, or three cents, per member per month.

As members of the subcommittee are well aware, there is enormous variation in the health system, and the increase for any specific insurance plan will vary with many factors.

While we can't construct a set of circumstances where the cost increase for a specific plan could be 1 percent to 2 percent or more, we believe such plans cover a small portion of the people with group health coverage, probably less than 5 percent.

Increasing benefits for behavioral health care services may result in reductions in other health care and employer costs. This is because better behavioral health care can improve a person's medical conditions.

It may also lead to an increase in the use of psychotropic drugs. We did not consider these effects in our report.

We assumed coverage consistent with DSM-IV, but we did not include treatment for tobacco use, obesity or the side effects of medication.

We provide some information references regarding the well-established evidence base for diagnosis and treatment of mental and substance-related disorders which is on par with that for diagnosis and treatment of medical and surgical conditions.

We also summarized how this evidence should be used for medical necessity determinations by payers in the utilization management process.

We also present summary information from Thompson Health Care's work for SAMHSA. It shows that spending trend increase for mental health and substance abuse-related services was less than that for total health care spending between 1993 and 2003.

Future growth in behavioral spending is also projected to lag other health care spending, partly because there is less new technology expected for behavioral than for medical care.

Another trend we report is that the private insurance portion of national mental health spending increased from 21 percent in 1986 to 24 percent in 2006, while substance abuse disorder spending decreased from 30 percent to 9 percent.

Thank you again for the opportunity to present our report today.

[The statement of Mr. Melek follows:]

An Actuarial Analysis of the Impact of H.R. 1424, by Stephen P. Melek, et al, Milliman, Inc.

I. Executive Summary

Milliman, Inc. was commissioned by Capitol Decisions, Inc. to perform an independent study and actuarial analysis of the impact of behavioral health insurance parity legislation on behalf of several interested parties.[1] This report contains the authors' analysis of HR 1424, cited as the "Paul Wellstone Mental Health and Addiction Equity Act of 2007".

HR 1424 would require that each group health plan or health insurance issuer offering group health insurance coverage to employers with more than 50 employees provide "parity" benefits for the diagnosis and treatment of all behavioral healthcare. In particular, the mental health and substance-related disorder benefits would have to be covered on the same terms as for the diagnosis and treatment of all physical health conditions. This includes the same treatment limits and beneficiary cost sharing for both in-network and out-of-network benefits. Additionally, HR 1424 defines a minimum scope of coverage for mental health and substance-related disorders as the same range of mental illnesses and addiction disorders covered by the health plan with the largest enrollment of federal employees (under chapter 89 of title 5, United States Code).

Findings

- Our estimates indicate that the legislation will increase per capita health insurance premiums of "typical" plans in 2008 by 0.6%, or $2.40 per member per month, if no increase in utilization management activities occurs in response to parity. This is our "Baseline Scenario."
- The legislation does not appear to prevent the use of utilization management (UM), and under our "Increased UM Scenario", where all benefit plans would choose to further tighten their degree of behavioral healthcare management, our cost estimates result in an aggregate premium increase less than 0.1%, or $0.03 per member per month. Since some insured plans will likely increase their utilization management while others will not, the actual cost increase will likely fall between the less than 0.1% and 0.6% aggregate results.
- The Congressional Budget Office (CBO) has estimated that typical employer responses to required coverages will result in cost reductions of about 60% of the gross cost estimate.[2] Applying this CBO estimate, aggregate employer contributions for health costs would rise by about 0.2% under our baseline scenario, and by less than 0.1% under our increased UM scenario.

• We project that utilization of facility-based behavioral healthcare services would increase by 9.7%, while professional services would increase by 30.0% under the Baseline Scenario. Our Increased Utilization Management (UM) Scenario shows much different results: a 21.3% decrease in use of facility-based services (the majority from mental health services) and a 3.1% increase for professional services.

• We project that member out-of-pocket costs for behavioral health services will decrease by 18%, or about $0.20 per member per month under the baseline scenario. This reflects a balance between an increase in total out-of-pocket costs from higher service use by members under the higher parity benefit limits and a decrease in out-of-pocket costs per unit due to lower parity cost-sharing. For every 100,000 fully insured lives, member out-of-pocket costs are estimated to drop by $240,000 annually.

• We projected increased administrative costs in proportion to the benefit cost increases due to parity. Administrative costs account for about 15% of the total increase, or $0.36 or less per member per month.

• Increasing benefits for behavioral healthcare services may result in cost offsets from other healthcare services, particularly visits to primary care physicians and emergent/urgent care visits. Increasing benefits may also result in increased use of pharmaceuticals. We did not consider the effects of any such offsets or dynamics.

Limitations

Our analysis used actuarial data that reflect the experience of individuals covered through commercially available benefit plans. To represent current coverage, we selected "typical" PPO and HMO benefit plans.[3] We utilized a distribution of covered members by type of benefit plan.[4] The estimates represent averages that may not be applicable to any individual underlying population segment or any one plan.

Because the economy and the healthcare system are dynamic, there is an intrinsic uncertainty in projecting healthcare costs, especially under healthcare reform, and that uncertainty applies to our work. The estimates presented here are based on a number of assumptions as described in Appendix A. Other researchers who use other assumptions and methods may present different estimates, and the actual costs may depend in part on factors we have not considered.

This report is not intended to support or detract from any particular legislation. It is intended for the exclusive use of the parties who commissioned the study and not intended to benefit any third party. This report should not be distributed without the permission of Milliman, and any distribution should be of the report in its entirety. This report reflects the authors' analysis and should not be interpreted as representing Milliman's endorsement.

II. Key Actuarial-Related Elements of HR 1424

HR 1424 would bring parity in coverage for behavioral health benefits. HR 1424 would only apply to large group business, with small group business covering 50 employees or less and individual business being excluded from the requirement.

HR 1424 specifies that each group health plan or health insurance issuer offering health insurance coverage in connection with a group health plan provided to employers, provide benefits for the diagnosis and treatment of all behavioral healthcare, including mental health and substance-related disorders, on the same terms and conditions as those provided under the policy for the diagnosis and treatment of all physical health conditions. This includes the same treatment limits and beneficiary financial requirements. For coverage of inpatient hospital services, outpatient services and medication, the same coinsurance, copayments, other cost-sharing, limits on out-of-pocket expenses, and individual and family deductibles must apply equally to medical-surgical benefits and to mental health and substance-related disorder benefits. This requirement applies to in-network benefits and out-of-network benefits.

We have assumed that for parity benefits to apply, a licensed clinician would have to provide the diagnosis and treatment, which is a typical requirement for any covered benefit. We have also assumed that if a plan covers clinical trials or investigational treatments for physical conditions, then such coverage would also apply to behavioral conditions.

We have assumed that covered substance-related disorders are consistent with those described in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (SM-IV). However, in our analysis, we do not include treatment for tobacco use, treatment of obesity or side effects of medication.

We have assumed the legislation would not prevent insurers from negotiating terms with behavioral health care providers on reimbursement rates and other service delivery terms, managing the provision of benefits, the use of pre-admission screening, step therapy, or other mechanisms to enforce medical necessity requirements, or enforcing the terms and conditions of a policy or plan of benefits.

III. Healthcare Cost and Premium Impact

HR 1424's mental health and substance-related disorder parity provisions would affect commercial health plans' costs principally by:

- Removing benefit limitations that often apply to mental illness and substance related conditions, but not physical medical conditions
- Requiring beneficiary cost-sharing provisions for such services is equal to those for care for all other physical diseases and disorders.

These plan changes would also likely result in increased premium rates in the absence of compensating changes to plan design or plan operations.

We estimate that, under our Baseline Scenario, adding full parity to behavioral healthcare benefits will increase costs, on average, by 0.6% for plans affected by the legislation. We estimate that an average health plan in the United States will have 2008 monthly premiums of about $450 for an employee with single coverage and about $1,200 for an employee with family coverage. The increases in monthly premiums due to parity are estimated to be $2.80 for single coverage and $7.40 for family coverage.

The increase for any specific insurance plan would vary, depending on the type of benefit plan (PPO, HMO, etc.), the scope and design of behavioral and other benefits currently covered, demographics of covered members, and the level of managed care applied to the behavioral health benefits. While the cost increase for a specific plan or employer under certain circumstances could be 1% to 2% or more (such as a plan without managed care that currently has very little coverage for behavioral healthcare services), we believe such plans cover a small portion of the people with group plans (probably less than 5%).

Following is a detailed discussion of our methodology, assumptions and findings.

A. Cost Estimation Approach and Baseline Results

To estimate the cost associated with HR 1424, we built actuarial models that reflect current, typical healthcare coverage and then estimated the cost changes due to parity. We assumed national average cost and utilization levels and note that both utilization and cost can vary dramatically by location, and health insurance coverage varies greatly in the scope of covered services and member cost-sharing.

We used two model benefit designs to represent typical insured plan benefits. One is a PPO plan and the other an HMO plan, and the benefit designs are consistent with the benefit plan descriptions in Milliman's annual Group Health Insurance Survey. Approximately 190 HMO plans and 210 PPO plans participated in the Survey in 2006.

We used these two model plans to represent the plan types and behavioral benefits that are common today. They vary in benefit structure, limitations on choice of providers, and level of managed care.

For both model plans, we estimated current average per member per month (PMPM) costs and average premiums charged by insurers. We also estimated the costs and premium levels if the behavioral health benefits of these plans were increased to comply with the modeled parity provisions.

We show percentage changes in premiums. The same percentage changes would also apply to administrative expenses of health insurers or health plans, which reflects our assumption that administrative expenses would change proportionately to the underlying change in benefit costs. For benefit cost changes of the relatively small magnitude presented in this report, we believe this proportionate assumption is reasonable.

In developing these estimates, we used the Milliman Health Cost Guidelines,[5] our proprietary actuarial pricing guidelines. We also used certain trend, utilization and cost data provided by health plans to the Milliman Group Health Insurance Survey for 2006.[6] Appendix A provides more detailed information on our assumptions and approach.

Table 1 presents the estimated change in premium rates resulting from the expected behavioral parity legislation for both model plans. These estimates assume no change in benefits other than the behavioral health benefits, and they assume no change in the level of utilization management within each plan. We refer to this as our "Baseline Scenario".

We estimated the distribution of members for our model plans from information contained in the Survey of Employer Health Benefits 2006, as published by the Henry J. Kaiser Family Foundation and the Health Research and Educational Trust.[7] This distribution is shown in Table 1 along with the resulting overall premium increase across our model plans.

TABLE 1.—ESTIMATED 2008 CHANGE IN PREMIUM RATES FOR MODEL PLANS

[BASELINE SCENARIO—NO CHANGE IN UTILIZATION MANAGEMENT]

Model Plan Type	Estimated Premium Change	Membership Distribution
HMO Plan	0.6%	25%
PPO Plan	0.6%	75%
Total	0.6%	100%

It is important to note that these premium estimates reflect the assumptions we have made regarding average plan benefits. Based on the information available and our knowledge of today's health insurance marketplace, we believe these results represent a reasonable estimate of overall average premium changes. However, actual plan provisions involve a great deal more variation than exhibited by our model plans. If we could evaluate all benefit plans actually applicable to U.S. residents, we would find a greater range of premium changes than illustrated in Table 1. In particular, some plans have more limited behavioral benefits than we have modeled, and the corresponding cost increases under parity for these plans could be 1% to 2% or higher, while other plans will have very small cost increases of under 0.2%.

B. Role of Managed Care

Many HMOs and PPOs delegate management and administration of their behavioral healthcare coverage to a specialty managed behavioral healthcare organization (MBHO), often paying the MBHO a fixed, "capitated" premium. These business arrangements are sometimes called "carve-outs." MBHOs may apply utilization management techniques and use provider payment arrangements to manage costs. Health plans that do not use MBHOs may also apply these techniques "in-house."

Under either the carve-out or in-house approach, we have observed managed behavioral healthcare costs are often 25% to 50% lower than costs of non-managed benefit packages. When legislative mandates require parity for mental health and substance-related disorder services, increases in costs are significantly lower for managed care plans.

Because of this dynamic, behavioral healthcare parity tends to encourage health insurers to tighten utilization management controls, which is allowed by HR 1424. Typical actions would include greater application of pre-authorization and concurrent review, including stricter adherence to evidence-based clinical protocols. Employers may choose to modify some of the benefit plans they offer to their employees, substituting plans with greater degrees of managed care provisions. This could involve greater use of carve-out MBHO vendors, or substituting HMO plans for PPO plans.

To illustrate the potential impact of such tightening of managed care, we developed a scenario that reflects a greater application of utilization management (UM). This is our "Increased UM Scenario". Appendix A provides an explanation of the managed care levels described.

The Baseline Scenario levels of managed care were chosen based on reported utilization rates of behavioral healthcare services of health plans that participated in the national Milliman Group Health Insurance Survey of 2006 and our knowledge of the managed behavioral healthcare industry. Table 3 summarizes the estimated premium changes under the Increased UM Scenario and compares them with those of the Baseline Scenario.

TABLE 3.—ESTIMATED 2008 CHANGE IN PREMIUM RATES FOR MODEL PLANS

[INCREASED UM AND BASELINE SCENARIOS]

Model Plan Type	Estimated Premium Change	
	Baseline Scenario	Increased UM Scenario
HMO Plan	0.6%	< 0.0%
PPO Plan	0.6%	< 0.1%
Total	0.6%	< 0.1%

Under the increased UM scenario, the cost of the additional parity benefits is offset by savings from utilization management. Costs for the HMO Plan and PPO Plans would be expected to barely change, despite the increase in benefits. This is consistent with our experience, where introduction of managed care or increased in-

tensity of managed care related to behavioral healthcare services often produces significant reductions in costs.

Some plans will react in the fashion described, while others may not make a change (either because they are already managing their behavioral healthcare benefits or because they would choose to not change after parity). Thus, the actual aggregate impact of the parity legislation on premium rates would likely fall between the two high and low values (<0.1% for the Increased UM Scenario and 0.6% for the Baseline Scenario).

When managed care is tightened for behavioral healthcare benefits, prescription drug use for treatment of mental illness may increase as psychotherapy visits and facility-based care fall. Some believe the cost of increased prescription drug utilization offsets some of the savings due to increased managed care, although the widespread availability of generic drugs could ameliorate this drug cost. We are not aware of studies of this dynamic, and our cost estimates do not reflect any such increases in prescription drug costs.

C. Impact on Employers

The increase in premium rates for specific employers will depend on the benefit plan(s) and the level of coverage currently provided. Employers already providing full parity for these benefits would incur no cost increase.

Employers could respond to a parity cost increase by changing benefit plans or by increasing employee premium contributions, rather than absorbing the full increase. In particular, they may choose to offer plans with greater levels of managed care or higher insured cost-sharing. The Congressional Budget Office (CBO) addressed the issue of potential employer responses to behavioral health parity in a 1996 report.[8] While CBO estimates that approximately 60% of the gross increases would be offset by reductions in benefits, the report also discusses the uncertainty inherent in such estimates, as follows:

"Projections of the relative magnitude of the possible responses are, inevitably, speculative. The best studies of the effects of mandates on health insurance coverage have large margins of error associated with their estimates. Some empirical questions, such as the degree to which other components of health benefits would be dropped in response to a mandate about a specific component of coverage, have simply not been addressed by academic studies."

The CBO continued to use this 60% offset assumption in their cost estimate of the Mental Health Parity Act of 2007, S. 558.[9]

IV. Impact on Access and Use of Behavioral Health Services

We expect access to and utilization of certain behavioral healthcare services to increase with the proposed behavioral health parity because of two dynamics:

1. Calendar limits on the maximum number of covered inpatient hospital days, outpatient professional visits and any other benefit limits for behavioral health benefits cannot differ from those used for all physical health benefits. While health plans currently include such limits on behavioral healthcare benefits, members typically have access to unlimited inpatient and outpatient physical healthcare.

2. Insured copayments and cost-sharing must be on par with physical health benefits. Behavioral healthcare benefits often have higher levels of insured cost-sharing, and higher out-of-pocket costs tend to discourage behavioral healthcare use. However, members may more frequently visit psychotherapists if the per visit copay is $10 rather than $25.

In our model, we estimated the impact behavioral healthcare parity would have on facility-based services (inpatient hospital, partial hospital and other outpatient hospital) and on professional services (diagnosis, evaluation, therapies and medication management). Facility-based utilization would increase by 9.7% and professional utilization would increase by 30.0% under our Baseline Scenario. These increases reflect both higher numbers of users of behavioral healthcare and greater numbers of services used by some patients.

The expected utilization change would be much lower under the Increased UM Scenario. Utilization management can significantly reduce utilization of behavioral healthcare services—specifically those that may be deemed as not medically necessary. This typically results in fewer and shorter inpatient hospital admissions, shifting some use to outpatient settings, and shorter treatment duration for selected patients. In the Increased UM scenario, we estimate that facility-based service utilization would decrease by about 21.3%. Professional service utilization would increase by about 3.1%.

V. Impact on Member Out-of-Pocket Costs

As described above, behavioral healthcare parity is expected to reduce insured member out-of-pocket costs as a result of lower cost-sharing. We modeled the impact

of behavioral health parity on these costs, using the benefit designs in Appendix B. We project that insured out-of-pocket costs will decrease by 18%, or about $0.20 per member per month under the Baseline Scenario. This is the net result of increase in member costs due to additional service use and decreases in out-of-pocket costs per unit due to higher coverage levels. For every 100,000 fully insured lives, insured out-of-pocket costs are estimated to drop by about $245,000 per year under this scenario. These figures are for behavioral health care only, but are spread across the entire covered membership, not just the users of behavioral health benefits.

Our model PPO plan has an integrated out-of-pocket limit for all services (including behavioral). If cost sharing shrinks for behavioral care, the contributions of this cost sharing toward out of-pocket limits decreases. On average, across a population of covered lives, this dynamic produces a very small increase in cost sharing for non-behavioral services.

VI. Impact on Health Plan Administrative Costs, Risk Margins and Profits

Health plans' administrative expenses consist of true administrative cost, risk margins and profits, and we assumed these would change proportionately to the change in benefit costs. This reflects the expected impact on claims processing, utilization management and other administrative functions, and risk margins. While a detailed examination of administrative expense may show particular additional changes due to parity, the relatively small magnitude of the changes relative to total plan expenditures make the proportionate assumption reasonable. We note that this assumption should be revisited when considering organizations such as managed behavioral health carve-out companies, because their business is concentrated in areas affected by parity.

We have assumed that the covered services net of cost sharing represent 85% of the total Health Plan premiums. Therefore, the remaining 15% of premium is for administrative costs, risk margins and profits. We note that some programs may have smaller or larger costs for these elements. In particular, self-funded programs often have different cost structures, and the application of our figures to those programs may require adjustments.

We project that administrative costs, risk margins and profits will increase by 0.6% under the Baseline Scenario and by less than 0.1% under the Increased UM Scenario. On a per member per month (PMPM) basis, these increases account for $0.36 or less. By contrast, 15% of total premium for our 2006 Survey data trended to 2008 is about $59 PMPM, and the expected annual trend forecast is about 12%.

VII. Medical Cost Offsets

Many behavioral health advocates promote the concept that effective behavioral healthcare can reduce medical costs, but this "cost offset" has been a controversial subject. There is strong evidence that behavioral problems and medical problems are associated with one another.[10,11,12] Some of these associations have been recognized by recommended medical practices; for example, screening for post-partum depression, depression following heart attack, or alcoholism screening.[13,14] In addition, the behavioral component of wellness and disease management programs is well-recognized. For example, behavioral components are recognized as important elements of smoking cessation and obesity programs.[15,16] Advocates believe the impact of effective behavioral healthcare extends beyond these examples. Some health insurers are developing integrated approaches to covering medical and behavioral illnesses.

Because specialty behavioral healthcare is generally a small component of total medical spending, even a small percent reduction in medical costs through parity benefits could amount to a significant cost offset relative to the increased cost of parity benefits. However, we did not include any such offsets in this work.

VIII. Preemption of State Laws

HR 1424 does not appear to preempt any State law that provides greater consumer protections, benefits, methods of access to benefits, rights or remedies than would occur under HR 1424. Therefore, any State laws that include broader requirements for access or coverage of mental health or substance-related disorder benefits, such as additional mental conditions or diagnoses or applicability to groups of 50 or less employees, are not preempted by this legislation.

IX. Evidence Based Practices and Medical Management

Evidence Based Practices

The evidence base for diagnosis and treatment of mental and substance-related disorders is well established and on par with the medical evidence for diagnosis and treatment of medical and surgical conditions. Mental and substance-related clinical practice guidelines are broadly accepted in the medical community including the

American Psychiatric Association's evidence based practice guidelines,[17] those of American Academy of Child and Adolescent Psychiatry[18] and those of the American Society of Addiction Medicine Patient Placement Criteria.[19]

Along with the expansion in the documentation of the science base of treatments for mental and substance-related disorders, two recent seminal reports strengthen the message that mental health is fundamental to health and that mental disorders are real health conditions that are equally as important as general health conditions. The 1999 Surgeon General's Report on Mental Health[20] provides a review of the research supporting the fact that evidence based mental health treatments are well established. According to the Report,

- "The efficacy of mental health treatments is well documented, and
- A range of treatments exists for most mental disorders"

The 2006 Institute of Medicine (IOM) report Improving the Quality of Health Care for Mental and Substance-Use Conditions[21] takes the discussion a step further to examine how well evidence based mental health treatments are being delivered. The report also examines how the framework and strategies to improve the quality of health care delivery, proposed in the IOM 2001 report Crossing the Quality Chasm: A New Health System for the 21st Century,[22] should be applied to mental health care. The IOM 2006 report highlights the lack of adherence to established clinical practice guidelines for many mental health conditions and the importance of attending to the quality problems using the recommendations in the IOM 2001 report.

Medical Management of Mental and Substance-Related Conditions

Medical management practices by payers can apply to medical as well as mental health and substance-related utilization. As a matter of cost and quality control, payers often use a process known as medical necessity determinations to identify particular patients who do not meet indications for needing a particular service.[23] Medical necessity determinations are intended to prevent inappropriate utilization of services which can increase utilization and cost without improving quality.[24] Narrowly speaking, medical necessity determinations do not affect the benefit design but influence utilization of covered benefits for individuals. To oversimplify, although an MRI may be a covered service, an insurer will not pay for the MRI unless it is reasonably needed for the patient's diagnosis or treatment. This distinction between covered benefits and administration of benefits also applies to behavioral health.

Payers making medical necessity determinations should rely on evidence based guidelines[25] or treatment protocols and indicate such in contracts with providers. HR 1424 does not appear to interfere with the ability of payers to make medical necessity coverage determinations and we expect that some payers will increase their application of this process in response to parity. As we note above, this application of managed care could actually reduce costs under parity for some payers to below the pre-parity level. Payers are in a position to assist in the measurement of effective evidence based practice in mental health, a deficiency identified in the IOM 2006 report. Payers are also positioned to incentivize providers to provide quality mental health care delivery. Under parity, delivering evidence based mental health care and measuring the quality of mental health care delivery would no longer be restricted by benefit limits.

X. National Mental Health and Substance-Related Disorder Spending Trends[26]

National expenditures for the treatment of mental health and substance related disorders (MHSRD) disorders increased to $121 billion in 2003, up from $70 billion in 1993—an average annual growth rate of 5.6%. This was lower than the 6.5% average annual growth rate during this period for all health services. The projected MHSRD expenditures for 2006 were $145 billion. Future growth in MHSRD expenditures are expected to continue to lag the growth in all health services, due in part to the lesser impact of cost-increasing technology on MHSRD service delivery.

Mental health expenditures make up the majority of the MHSRD expenditures. In 1993, they accounted for 78.6% of MHSRD spending at $55 billion, and grew to 82.9% of 2003 MHSRD spending at $100 billion. The 2006 projection is at 83.8% or $122 billion. The rapid rise in prescription drug spending for mental disorders contributes substantially to this trend.

Prescription drug costs within mental health service delivery have risen rapidly from just 7% of total mental health spending in 1986 to 23% in 2003, and are projected to hit 30% of all mental health spending by 2014. Meanwhile, total hospital costs (including inpatient acute services and outpatient services such as day treatment) dropped from 41% in 1986 to 28% of total mental health spending in 2003. Physician services increased from 11% in 1986 to 14% in 2003.

The distribution of expenditures by public-private payer differs significantly between mental health and substance-related disorder services. Private payers (includes private insurance, out-of-pocket, and other private sources) accounted for 46% of mental health expenditures in 1986, reduced to 42% by 2003, and is currently expected to remain at that level for many years. Private insurance accounts for 24% of all mental health expenditures. Public payers (includes Medicare, Medicaid, other federal, and other state and local payers) accounted for 54% in 1986 and 58% in 2003. The addition of the Medicare Part D benefits increased the Medicare component from 7% in 2003 to an estimated 11% in 2006, while the Medicaid component dropped from 26% in 2003 to 24% in 2006.

Private payers accounted for 50% of all substance-related disorder expenditures in 1986 but dropped to 23% by 2003, while the public payers accounted for 50% in 1986 and 77% in 2003. Private insurance accounts for just 9% of substance-related disorder expenditures. Other state and local payers are the largest payer group of substance-related disorder benefits at 46% in 2003. Current projections show the public portion of substance-related disorder expenditures continuing to grow under current conditions, up to 83% by 2014.

The largest category of expenditures for substance-related disorder treatment are specialty substance-related disorder clinics, increasing from 19% in 1986 to 41% in 2003, while total hospital costs dropped from 48% of total substance-related disorder expenditures to 24% in 2003. Those levels are projected to remain fairly flat in the future.

Appendix A.—Assumptions

This section describes key assumptions and sources for our estimates. We also present cautions about how the estimates should be interpreted and used.

We estimated costs for the currently insured commercial population in the United States. This does not include individuals covered by Medicaid or Medicare. We used standard Milliman demographic assumptions, intended to represent the age and gender mix of a typical commercially-insured employee group with the demographics of the U.S. labor force population.

We estimated per capita costs for two different typical benefit plans in the United States commercial marketplace today—a PPO plan and an HMO plan. We applied the benefit plan specification details described in Milliman's 2006 Group Health Insurance Survey, to set pre-parity benefit specifications. These details are summarized in Appendix B. We also used an expected annual trend estimate from the Survey to project costs to 2008. We note that trend for behavioral health benefits has been lower than for medical benefits as a whole, and this means our trend assumption may cause our estimates for 2008 to be overstated somewhat.

We used a 25%/75% distribution between the HMO and PPO plan designs, based on information contained in the Survey of Employer Health Benefits 2006,[27] published by the Henry J. Kaiser Family Foundation and the Health Research and Educational Trust.

We applied cost estimates using Milliman's 2006 Health Cost Guidelines (HCGs). The HCGs are Milliman's actuarial guidelines that show how the components of per capita medical claim costs vary with benefit design, demography, location, provider reimbursement arrangements, degree of managed care delivery, and other factors. In most instances, these cost assumptions are based on our evaluation of several data sources, and are not specifically attributable to a single data source. The HCGs are used by scores of client insurance companies and health plans for premium rate setting, evaluating health insurance products, and for financial management.

We used adjustment factors from the HCGs to modify our utilization and unit cost assumptions for the modeled plans and included a typical allowance for administrative costs, risk margins and profits. We incorporated estimates of the effect of managed care delivery within each plan. We also applied our knowledge of the managed behavioral healthcare delivery systems.

If HR 1424 were enacted, health insurers will likely choose to tighten utilization management controls within their existing benefit plans, which is allowed under the legislation. They would typically increase use of pre-authorization and concurrent review requirements for mental health and substance-related disorder benefits, as well as require stricter adherence to clinical criteria. In addition, employers may choose to modify some of the benefit plans they offer to their employees, substituting plans with greater degrees of managed care provisions (for example, more restrictive networks) in place of plans with lesser degrees of managed care provisions. This could involve greater use of carve-out MBHO vendors, or substituting HMO plans for PPO plans.

Discounted fees are common in HMO and PPO plans for in-network healthcare providers. We have assumed that the health plans could negotiate a discount of 25%

for all in-network professional behavioral services, 40% for all in-network facility services for alcoholism and substance-related disorders, and 60% for all in-network facility services for mental health disorders. These discounts are consistent with what we have observed in managed behavioral healthcare contracts recently. We assumed that no discount would be obtained for any out-of-network services provided in the PPO plans.

In our premium rate estimates, we considered the following items and benefit features as appropriate:

- The maximum number of inpatient days and outpatient visits for treatment for mental illness and substance-related disorders
- Deductible, copay, coinsurance, and out-of-pocket maximum adjustments appropriate to various benefits
- Increases in utilization by service category due to benefit richness and induced demand

Table 3 summarizes the estimated change in premium rates due to the behavioral health parity provisions of the expected legislation under the Baseline Scenario and the Increased UM Scenario. The premium values are on a per member per month basis, meaning an overall average across all adults and children. Note that the premium amounts for both individual and family coverage would be higher than these member values.

TABLE 3.—ESTIMATED CHANGE IN 2008 PREMIUM RATES FOR MODEL PLANS AFTER PARITY

Model Plan Type	Average Monthly Premium per Member for Behavioral Healthcare Services		Increase in Premium		
	Before Parity	After Parity	Amount	% of Behavioral Health	% of Total Premium
BASELINE SCENARIO					
HMO Plan	$7.25	$9.60	$2.36	32.5%	0.6%
PPO Plan	$8.15	$10.56	$2.41	29.6%	0.6%
TOTAL	$7.92	$10.32	$2.40	30.2%	0.6%
INCREASED UM SCENARIO					
HMO Plan	$7.25	$7.25	$0.00	0.0%	0.0%
PPO Plan	$8.15	$8.19	$0.04	0.5%	<0.1%
TOTAL	$7.92	$7.95	$0.03	0.4%	<0.1%

Appendix B.—Summary of Modeled Benefit Plan Provisions

Pre-Parity Benefit Designs

PLAN NO. 1.—HMO PLAN

Benefit Description	Medical/Surgical	Behavioral
Deductible	None	None
Out-of-Pocket Limit	None	None
Coverage	100% Inpatient after $0 copay, 100% Outpatient after $10 copay	100% Inpatient after $0 copay, 100% Outpatient after $25 copay
Limits	No other limits	30 IP days/CY, 20 OP visits/CY

PLAN NO. 2.—PPO PLAN

Benefit Description	Medical/Surgical		Behavioral	
	In-Network Benefits	Out-of-Network Benefits	In-Network Benefits	Out-of-Network Benefits
Deductible	$250	$500	$250	$500
Out-of-Pocket Limit	$1,000	$2,000	$1,000	$2,000
Coverage	90% Inpatient 100% Outpatient after $10 copay	70% Inpatient 70% Outpatient	90% Inpatient 100% Outpatient after $25 copay	70% Inpatient 70% Outpatient
Limits	No other limits	No other limits	30 IP days/CY, 20 OP visits/CY	30 IP days/CY, 20 OP visits/CY

About Milliman

Milliman serves business, financial, government, and healthcare organizations with expertise in managing and analyzing financial and other risk. Milliman employs more than 900 qualified consultants and actuaries. The Milliman Care Guidelines are the leading evidence-based clinical guidelines used by managed care organizations. The company is owned only by its principals, not by an insurer, outsourcing company, bank or accounting firm. Milliman does not sell insurance or benefits programs or broker deals. The firm has helped thousands of managed care organizations, insurance companies, payers, and healthcare providers measure their financial status, appraise business opportunities, develop new products, and determine premium rates.

ENDNOTES

[1] American Association for Child and Adolescent Psychiatry, American Counseling Association, American Society of Addiction Medicine, Bradford Health Services, Caron Treatment Centers, Hazelden Foundation, NAADAC—The Association for Addiction Professionals, National Association of Addiction Treatment Providers, National Board for Certified Counselors, and National Council for Community Behavioral Healthcare.

[2] Congressional Budget Office Cost Estimate, S.558 Mental Health Parity Act of 2007, March 20, 2007

[3] We used the plan designs in Milliman's annual Group Health Insurance Survey. See www.Milliman.com

[4] The Survey of Employer Health Benefits 2006 includes detailed trend information on health insurance enrollment, premiums and contributions between 1988 and 2006. See www.kff.org/insurance/7527/.

[5] The Milliman, Inc. Health Cost Guidelines provide a flexible but consistent basis for the determination of claim costs and premium rates for a wide variety of health benefit plans. The Guidelines are developed as a result of Milliman's continuing research on health care costs. First developed in 1954, the Guidelines have been updated and expanded annually. These Guidelines are continually monitored; Milliman consultants and many insurers use the Guidelines for a variety of actuarial and financial management purposes.

[6] The 15th annual Milliman, Inc. survey of the nation's HMOs and fully-insured PPOs. Over one-third of all companies responded to the 2006 survey. Data collected includes manual premium rates, employee tiered rates, renewal rate changes anticipated, medical trend rates, inpatient utilization data, cost per utilization data, physician reimbursement rates as a percent of Medicare RBRVS, and medical expense ratios. Data reported in the survey includes straight average results, 25th percentile results, and 75th percentile results from all contributing companies.

[7] The Survey of Employer Health Benefits 2006. Op cit.

[8] Congressional Budget Office Cost Estimate, Estimates of the Impact on Employers of the Mental Health Parity Amendment in HR3103; May 13, 1996

[9] CBO Cost Estimate, S558, op cit.

[10] World Health Organization press release; October 8, 2004; Dr. Matt Muijen, Acting Regional Adviser for Mental Health

[11] David Whitehouse, MD, Improving Total Health & Well-Being: An Innovative Approach That Integrates Behavioral Health Across the Health Care Continuum, Open Minds, September 2006

[12] Patrick R. Finley, et al "Impact of a Collaborative Care Model on Depression in a Primary Care Setting: A Randomized Controlled Trial, Pharmacotherapy 23(9):1175-1185, 2003.

[13] Agency for Healthcare Research and Quality, Research Activities, November 2006, No. 315, "Depression among heart attack survivors can persist for a year after leaving the hospital"

[14] United States Preventive Services Task Force, Guide to Clinical Preventive Services. *http://www.ahrq.gov/clinic/cps3dix.htm.*

[15] Fiore MD, Bailey WC, Cohen SJ et al. Treating tobacco use and dependence. Clinical Practice Guidelines. Rockville, MD. US Department of Health and Human Services. Public Health Service. June 2000.

[16] Centers for Medicare and Medicaid Services, Decision Memo for Bariatric Surgery for the Treatment of Morbid Obesity (CAG-00250R), February 21, 2006. Available at *http://www.cms.hhs.gov/mcd/overview.asp*

[17] APA Practice Guidelines available at *http://www.psych.org/psych—pract/treatg/pg/prac—guide.cfm*

[18] AACAP Practice Guidelines. *http://www.aacap.org/page.ww?section=Practice+Parameters&name =Practice+Parameters*

[19] *http://www.asam.org/PatientPlacementCriteria.html*

[20] U. S Department of Health and Human Services. Mental Health: A Report of the Surgeon General—Executive Summary. 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.

[21] Institute of Medicine, Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders. Improving the quality of health care for mental and substance-use conditions. 2006. The National Academies Press. Washington, D.C.

[22] Institute of Medicine Committee on Quality of Health Care in America, Crossing the quality chasm: A new health system for the 21st century. 2001. The National Academies Press. Washington, D.C.

[23] For example, see Regence Blue Shield, www.or.regence.com/provider/clinicalCorner/docs/behavioralHealthPracticeGuideline.pdf

[24] Dartmouth Atlas, *http://www.dartmouthatlas.org/*

[25] Sackett, DL, Rosenberg WM, Gray JA et al. Evidence based medicine: what it is and what it is not. BMJ. 1996;312:71-72.

[26] Levit KR et al. Projections of National Expenditures for Mental Health Services and Substance Abuse Treatment, 2004-2014. SAMHSA Publication. Rockville, MD, 2006

[27] The Survey of Employer Health Benefits 2006, op cit.

Chairman ANDREWS. Mr. Melek, thank you very much. And as I say, your entire statement has been entered into the record.

Mr. Dilweg, welcome to the committee all the way from Wisconsin. We are happy to have you.

STATEMENT OF SEAN DILWEG, WISCONSIN INSURANCE COMMISSIONER

Mr. DILWEG. Thank you, Chairman Andrews, Ranking Member Kline and members of the committee.

My name is Sean Dilweg. I am the insurance commissioner from the state of Wisconsin. Thank you for inviting me to testify this afternoon on the Paul Wellstone Mental Health and Addiction Equity Act of 2007.

Today I will speak to the importance of parity legislation and highlight the importance of H.R. 1424 in addressing unequal coverage limitations on mental health services.

In addition, I will express my concern with preemption language included in the amended Senate mental health parity bill, which leaves Wisconsin's mental health mandate and laws in other states vulnerable to court interpretation.

There are currently 46 states with laws requiring some level of mental health coverage and 27 states with full parity laws. I have had discussions with other state commissioners who are strongly concerned with the Senate language.

Individuals diagnosed with a mental illness are too often limited in their ability to access treatment due to insufficient insurance coverage.

Such treatment limitations force this population to look to their own finances or public programs as means to cover expenses. In the worst cases, people forego services altogether, given the debilitating nature of many mental illnesses.

Individuals find they cannot maintain employment, health conditions related to mental health illness go untreated, and people generally find themselves unable to maintain the quality of life most of us enjoy.

The House bill will greatly improve access to mental health services by ensuring individuals the same level of insurance coverage for their mental health needs as would be available for their treatment of other medical conditions.

In Wisconsin, group health insurers providing coverage for inpatient hospital treatment, outpatient treatment or both must also provide coverage for mental health and alcohol and other drug abuse services.

This means insurance companies selling health insurance coverage to employers in Wisconsin must include coverage for mental health-related care.

State law requires a minimum of $7,000 in coverage be provided for these services but also allows plans to limit benefits to the statutory amount.

These coverage requirements do not go far, especially for those who have a severe mental illness or dual diagnosis. This has been in place for 30 years.

I have seen Democratically controlled Senate, House and governor in our body and also Republican-controlled, and we have never been able to change this to full parity. I welcome the fact that you are pursuing full parity under the preempted ERISA plans.

The gaps in coverage across the nation with regard to mental health services are vast. There are also disparities between what group health insurers and the self-insured are required to pay within states across the nation.

Some employers have been known to move to a self-insured plan specifically to avoid the state mandates. Once again, I welcome the federal mental health parity law and look forward to action on this bill.

I also commend Representatives Kennedy and Ramstad in their efforts to improve coverage of mental health benefits in private health insurance while ensuring that federal standards serve as a floor, not a ceiling.

This is consistent with the preemption language in the Health Insurance Portability and Accountability Act of 1996.

HIPAA's portability and access provisions affecting private health coverage has been a model for how federal and state health coverage reforms can work together, with states having the flexibility to supplement federal standards to better protect consumers when necessary.

In moving forward toward equity in coverage for mental health services, it is important to maintain the recognition that state policy makers may determine it necessary to have a stronger set of standards to ensure the protection of patients in state-regulated health insurance policies.

Under the Senate version, it would be very problematic for Wisconsin and other states if the House were to move in the direction of the Senate with regard to preemption.

The Senate version preempts any state mental health parity standard or requirement which differs from the mental health parity standards required in the bill. Wisconsin and other states are struggling to predict how the preemption language may impact our current parity laws.

Concerns have been expressed on the impact to mental health mandates in states including Washington, Vermont, Oregon, Connecticut—I just spoke with California this morning—Montana, Maryland and Nevada.

In states such as Wisconsin, California, Maryland and Montana, where the mental health parity laws apply generally to health insurance coverage, and there is no distinction between small and large group coverage, it is questionable whether courts will uphold these laws as they apply to individual and small group policies if challenged under ERISA.

As a result, the legislative intent in the bill to save state individual and small group coverage from preemption may not be accomplished.

Washington and Connecticut have a mandated benefit and require parity with medical coverage. If these mandated benefits are preempted by unclear language of the manager's amendment, carriers would not be required to provide mental health benefits, leaving consumers at risk of losing coverage they currently rely on.

In conclusion, as the insurance commissioner charged with protecting consumers, I have a responsibility to bring to light issues that may put consumers at risk. The intent of the House and Senate bill is laudable.

However, the Senate preemption language opens the door for an all-or-nothing situation in Wisconsin and other states with similar mental health mandates.

I have raised several preemption questions. There are others that may come to light as other states more carefully review the proposed language. These could be open to interpretation and based on new ERISA-related litigation that will come at a high price tag for people who may lose benefits while waiting years for courts to determine if state laws are preempted.

The preemption language included in the House is clear and will preserve and strengthen Wisconsin and other states' mental health mandates as well as many mental health parity laws across the nation.

Thank you again for this opportunity to testify.

[The statement of Mr. Dilweg follows:]

Prepared Statement of Sean Dilweg, Wisconsin Insurance Commissioner

Good afternoon Chairman Andrews, Ranking Member Kline, and members of the committee. My name is Sean Dilweg and I am the Insurance Commissioner from the State of Wisconsin. Thank you for inviting me to testify this afternoon on H.R. 1424, the Paul Wellstone Mental Health and Addiction Equity Act of 2007.

Today I will speak to the importance of parity legislation and highlight the importance of H.R. 1424 in addressing unequal coverage limitations on mental health services. In addition, I will express my concern with preemption language included in S. 558 (June 13, 2007 draft manager's amendment), the Senate Mental Health Parity bill, which leaves Wisconsin's mental health mandate and laws in other states vulnerable to court interpretation. There are 46 states with laws requiring some level of mental health coverage and 27 states with full parity laws.

Importance of Parity

Individuals diagnosed with a mental illness are too often limited in their ability to access treatment due to insufficient insurance coverage. Coverage limits for mental health services are generally more restrictive than those applied to other medical conditions. Such treatment limitations force this population to look to their own finances or public programs as a means to cover expenses. In the worst cases, people forgo services altogether. Given the debilitating nature of many mental illnesses, in-

dividuals find they cannot maintain employment, health conditions related to the mental illness go untreated and people generally find themselves unable to maintain the quality of life most of us enjoy. It is estimated the indirect cost of mental illness is $79 billion, with $63 billion of that amount related to lost productivity.[1] H.R. 1424 will greatly improve access to mental health services by ensuring individuals the same level of insurance coverage for their mental health needs as would be available for their treatment of other medical conditions.

In Wisconsin, group health insurers providing coverage of inpatient hospital treatment, outpatient treatment or both, must also provide coverage for mental health and alcohol and other drug abuse services. This means that insurance companies selling health insurance coverage to employers in Wisconsin must include coverage for mental health related care. Current state law requires a minimum of $7,000 in coverage be provided for these services, but also allows plans to limit benefits to this statutory amount. The law allows insurers to offer better coverage, but in most cases, policies with more coverage are not available.[2] These coverage requirements do not go far, especially for those who have a severe mental illness or duel diagnoses.

H.R. 1424

I commend Representatives Kennedy and Ramstad in their efforts to improve coverage of mental health benefits in private health insurance while ensuring that federal standards serve as a "floor", not a "ceiling." As currently drafted, the House bill specifically states that nothing in the federal legislation "shall be construed to preempt any State law that provides greater consumer protections, benefits, methods of access to benefits, rights or remedies." This language is consistent with the preemption language in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) which has been very successful in expanding important access protections throughout the country. HIPAA's portability and access provisions affecting private health coverage has also been a model for how federal and state health coverage reforms can work together, with states having the flexibility to supplement federal standards to better protect consumers, when necessary.

In moving forward toward equity in coverage for mental health services, it is important to maintain the recognition that state policymakers may determine it necessary to have a stronger set of standards to ensure the protection of patients in state-regulated health insurance policies. For example, H.R. 1424 would not mandate that group health insurance policies provide mental health benefits; it, however, would set standards for group health plans that choose to provide benefits for mental health. Wisconsin's policymakers have determined that a mandate is necessary to ensure that some mental health benefits are provided in all group policies. Wisconsin's requirement to cover mental health care coupled with the proposed federal parity is the way to ensure that state-regulated insurance policies provide necessary coverage to patients with mental illnesses.

S.558 and Preemption

It would be very problematic for Wisconsin and other states if the House were to move in the direction of the Senate with regard to preemption. The Senate version preempts, subject to certain exceptions, any state mental health parity standard or requirement which differs from the mental health parity standards or requirements as defined in subsections (a), (b), or (e) of section 712A." The Senate Mental Health Parity Bill (manager's amendment draft June 13, 2007), would completely preempt all state protections in the following areas:

- Parity in financial requirements, i.e. coverage limits, co-pays, deductibles; and
- Exemptions to parity requirements due to increased costs.

Wisconsin and other states are struggling to predict how the preemption language might impact current parity laws. Short of litigation in federal court, it is unclear who decides if the state law differs from the federal law and what a state's options are if the state disagrees with that decision. There are 46 states with laws requiring some level of mental health coverage and 27 states have full parity laws, requiring insurers to provide the same level of mental health benefits as medical and surgical benefits. Coverage in most of these states, to varying degrees, is at risk of being weakened or completely eliminated by the Senate preemption language. Concerns have been expressed on the impact to mental health mandates in states, including, Washington, Vermont, Oregon, Connecticut, California, Montana, Maryland and Nevada.[3] Insurance Commissioners in Connecticut, Vermont, Washington and Oregon have shared written concerns with their Senate members. Copies are attached for your review.

National Association of Insurance Commissioners

In a letter to Chairman Kennedy and Ranking Member Enzi of the Senate Health, Education, Labor and Pensions Committee, dated May 2, 2007 analyzing S. 558 as voted out of committee, the National Association of Insurance Commissioners stated that the nation's insurance commissioners find the Senate bill's preemption language "both excessive and unnecessary." They go on to recommend that, "should the Senate decide to include any preemption language in the bill, we would prefer the language in the Mental Health Parity bill currently being considered in the House of Representatives." I acknowledge that the June 13th language is significantly better; however it does not address all preemption concerns and would still leave state laws open to potential preemption challenges.

Wisconsin's Mental Health Mandate

Of particular concern for Wisconsin is the extent to which preemption will impact the state's current requirement that a group health insurance policy provide coverage of mental health services. Our state mandate for coverage and the coverage limits are tied together under the same statutory provision. If a Senate Mental Health Parity bill preempts coverage requirements, such as Wisconsin's required $7,000 minimum, a court must determine whether the entire statutory provision (the minimum coverage amount and the requirement to provide services) or only the provision mandating a minimum "floor" of $7,000 is preempted.

Generally, statutory provisions are "severable" so one provision may avoid preemption even if a related provision is preempted. However, the court must determine whether the resulting statutory language is consistent with the "intent of the legislature."

The statute resulting from "partial" preemption would be a mandate to provide mental health benefits up to at least the maximum limits otherwise available under the policy. However, the Wisconsin legislature specifically included limits on its mandate to provide mental health benefits. This may lead a court to rule the entire statute preempted because to do otherwise would be inconsistent with the intent of the legislature.

The senate bill raises several questions relating to Wisconsin's mandate, and if passed would leave consumers extremely vulnerable to losing coverage, as it is anticipated a great number of employers and/or insurers would take advantage of the new flexibility by challenging state law and dropping coverage for mental health. As I mentioned earlier, under H.R. 1424, Wisconsin's mandate and those in other states would be preserved.

The argument has been made that laws like Wisconsin's would be protected under the exception that reads:

"* * * nothing in section 712(A) shall be construed to require a group health plan to provide the following: (i) Any mental health benefits, except that State insurance laws applicable to health insurance coverage that require coverage of specific items, benefits, or services (including specific mental health conditions) are specifically not preempted * * *"

While the intent behind the exception may be to preserve state mental health mandate laws, the proposed language does not go far enough in clearly excluding states from the preemption provisions in the bill. It is my understanding that, before this exception can be applied, a state's coverage provisions must be consistent with the federal parity provision. As I mentioned earlier, Wisconsin's statute says coverage "need not exceed $7,000" while the proposed federal provision requires coverage equal to the medical maximum limit.

A court would have to determine that the new proposed limits qualify as a requirement for a "specific benefit" within the exception. In other words, if Wisconsin will have to impose the coverage limits in the bill, and those new coverage limits are considered "specific benefits," Wisconsin's mandate for providing coverage of mental health services is preserved under the exception. The federal parity would then "overlay" the state mandate to separately require higher maximum limits.

The risk under this language is that my state as well as other state mental health laws would be preempted. New legislation would be necessary to reinstate Wisconsin's mandate; however, one only needs to look to the past few sessions in the Wisconsin Legislature to see the political will is not there to pass legislation that results in parity. Under this scenario, consumers will be left with fewer protections than they have under the current model.

Other states with similar mental health mandate requirements would face similar preemption problems. Therefore, the risk of consumers losing existing state-based minimum coverage guarantees goes beyond Wisconsin's borders.

Cost Exemption

Preemption with regard to the cost exemption is also extremely problematic given Wisconsin and many other states with some level of parity do not allow insurers to end coverage if a cost increase is demonstrated. S. 558 does not apply if a plan's cost in the first year goes up by 2% and 1% in subsequent plan years. S. 558 would preempt any state law to the contrary, thus severely weakening Wisconsin's mandate to provide coverage. In addition, it will be extremely challenging to question plans' allegations with regard to cost increases given the exemption does not require actuarial analysis to be independent or publicly available.[4]

There are approximately 12 states' mental health parity laws which contain provisions exempting certain employers from the parity requirements if they can demonstrate a certain level of increased costs due to those requirements.[5] Approximately half of those states impose a cost exemption with more stringent standards than those found in this legislation.

The state of Indiana, for example, requires that insurers demonstrate a 4% increase in premiums due to mental health parity requirements,[6] Michigan requires a 3% increase due to substance abuse treatments,[7] and both Nevada and Oklahoma require a 2% increase in each year.[8,9] Each of these exemption provisions would be replaced by the less-consumer friendly federal standard, and 34 states would have the cost exemption language imposed upon them for the first time. By contrast, under the House bill only those states laws providing fewer protections to consumers would be affected.

Conclusion

As the Insurance Commissioner charged with protecting consumers, I have a responsibility to bring to light issues that may put consumers at risk.

I have raised several preemption questions; there are others that may come to light as other states more carefully review the proposed language and the approach the Senate takes. These could be open to interpretation and based on a long and difficult history of ERISA-related preemption litigation, it is likely that different courts will reach different conclusions and ultimately the final word will come from the Supreme Court. New ERISA-related litigation will come with a high price tag for already strained state budgets and even a higher price tag for people who may lose benefits while waiting years for courts to determine if state laws are preempted.

The House bill before you today will increase access to mental health coverage for people covered by employers that choose to cover mental health benefits. The preemption language is clear and will preserve and strengthen Wisconsin's mental health mandate as well as many mental health and parity laws across the nation. The "floor" created by H.R. 1424 protects consumers by ensuring states can enforce current laws that are stronger than the proposed federal standards.

Thank you again for this opportunity to testify today.

ENDNOTES

[1] New Freedom Commission on Mental Health, Achieving the Promise: Transforming Mental Health Care in America. Final Report. DHHS Pub. No. SMA-03-3832. Rockville, MD: 2003.

[2] In part, this is because of adverse selection problems.

[3] Mila Kofman, Georgetown University Health Policy Institute, "California's mental health parity law is a standard that applies generally to health insurance coverage. Unlike a specific law applicable to individual or small group coverage, there is no guarantee that courts will uphold the law as it applies to individual and small group policies if challenged under ERISA and as a result, the legislative intent in the bill to save state individual and small group coverage from preemption may not be accomplished."

"Montana law requires coverage for severe mental illness and such coverage must be provided on parity with coverage for physical illness. The standard applies to individual and group coverage with no distinction between small group and large group coverage. The parity requirements differ from S. 558 and would be preempted, unless the exception in the bill is interpreted broadly."

In reference to Maryland "* * * requirements for individual coverage and large group coverage are in one section. Litigation may be necessary to determine if standards for individual coverage would continue. The mandate for large group coverage to include mental health benefits and provide coverage on parity with physical illness may also be litigated to determine if it is saved from S.558 preemption."

In reference to Nevada "* * * the mental health parity law for group coverage applies to groups of more than 25 employees. Similar to other states, although there is a mandate to cover mental health (severe mental illness), the standards for the mandate are 'parity type' standards. It may be up to the courts to determine if Nevada's law is saved under the new preemption standards."

[4] Randy Revelle, Chairman, Washington Coalition for Insurance Parity.

[5] Ibid

[6] Indiana Code §27-8-5-15.7

[7] Michigan Compiled Laws §500.3501
[8] Nevada Revised Statutes §689A.0455
[9] Oklahoma Statutes §36-6060.12

[Additional submission from Mr. Dilweg follows:]

INSURANCE DIVISION MEMORANDUM,
May 23, 2007.

Subject: S. 558 Federal Mental Health Parity

You asked me for an analysis of the S. 558, the Federal Mental Health Parity legislation. Below I outline the major issues identified and discuss the impact of S. 558 on the protections provided to Oregonians under SB 1.

The major issues identified include:

- Preemption of State parity laws
- Interpretation of the federal parity law—Who decides if a state's laws differ from the federal? Who has final interpretation authority of what the law means, what if the state interpretation differs from DOL or HHS?
- Enforcement—who enforces the parity requirement? Consumer protections?
- Cost increase opt-out—the cost opt-out is artificially low and allows companies to opt-out of the parity law, but not from a state's requirement to offer mental health coverage.

Preemption of Oregon's parity laws

Section 4(c) of the federal bill would preempt Oregon's Mental Health Parity Laws (SB 1) because those laws "differ" from the federal bill in regards to parity, negotiation and management, in- and out-of-network, and the cost opt-out provisions of the bill.

Effectively, S. 558 creates both a federal floor and ceiling that eliminates Oregon's ability to provide greater protection for consumers in specified areas:

- Oregon's law requires coverage of mental or nervous conditions and chemical dependency in all group health insurance.
- Oregon's law defines mental or nervous condition and chemical dependency.
- Oregon's law requires a single definition of "medical necessity" and "experimental or investigational" treatments. There is no such requirement in the federal law.
- Oregon's law allows for IRO review of denials based on medical necessity and experimental or investigational and requires the IRO to determine if the insurer uniformly applies those definitions to mental health and other medical conditions. There is no such requirement in the federal law.
- The federal law provides a cost opt-out that allows employers to waive coverage for one year if mental health costs increase more than 2% in the first year or 1% in subsequent years. There is no cost cap in Oregon law.
- Oregon's law defines "provider" and sets forth the requirements for providers to be eligible for reimbursement under the law. The federal law allows for the plans to negotiate separate reimbursement or provider payment rates and service delivery systems.

Interpretation of the federal parity law

There are similarities in the two bills:

- Parity—financial requirements for mental health can be no more restrictive than those for other medical conditions
- Management tools are allowed including utilization review, prior authorization, and use of network providers.
- Provides parity for "medically necessary" treatments.

However, while these requirements are similar, they do "differ." The preemption of "any" state law that "differs" from the federal law could come down to a matter of interpretation. Oregon's administrative rules set very specific guidelines for insurance companies for mental health coverage and for implementing SB 1. There is nothing in the federal bill that provides for states to "interpret" the federal statute—this brings up issues of how to enforce rate and form review, market regulation, and consumer protections. It is unclear who decides if the state law differs from the federal law and what a state's options are if the state disagrees with that decision.

Enforcement

The language in the federal law is very broad and much of the implementation of this bill will depend on the final regulations promulgated by DOL and HHS. Depending on how those regulations are worded, the differences in the Oregon law and

the final regulations could be substantial. There is no clarity in the federal bill as to the ability of states to interpret or enforce laws that "differ" from the federal law. This could be an issue in form reviews for large groups. If there has been an audit by DOL or HHS which finds the company in compliance, but our Rates and Forms sections believes the form does not meet the requires it is unclear if we could disapprove the form. The same issues could arise in market surveillance and in consumer protection. If our parity laws differ from the federal law how do we enforce violations of the law or assist consumers in disputes with companies?

Cost increase exemption

The opt-out because of cost increases is a serious concern as it would allow employers to opt-out of mental health parity for one year (although in Oregon they would still be required to offer mental health coverage) if the actual costs of mental health treatment was more than 2% greater than medical conditions in the first year or more than 1% in subsequent years. The one-year opt-out also raises the question of what, if any parity laws or coverage requirements would apply in states, such as Oregon, when mental health coverage is required.

Comparison of S. 588 and Oregon's SB 1

The following chart outlines the difference between S. 558 and SB 1.

S. 588 AND OREGON SENATE BILL 1

S. 558		SB 1	
		ORS 743.556	Requires all group health insurance policies issued in Oregon to included coverage for mental or nervous conditions and chemical dependency
Section 712A(a)(1) 2705A (a)(1)	Requires financial requirements for mental health benefits to be ''no more restrictive than'' those for all medical and surgical benefits	ORS 743.566(2) OAR 836-053-1405(1)	Expenses for treatment of mental health conditions must be provided ''at the same level as, and subject to limitations no more restrictive than'' those for treatment of other medical conditions
712A(a)(1)	Deductible, co-payments, coinsurance, out-of-pocket expenses may be ''no more restrictive than'' those for all medical and surgical benefits	743.566(2) OAR 836-053-1405(2)(a)	Reimbursement and cost-sharing, including deductible, co-payments, coinsurance, out-of-pocket expenses for mental health may be no greater than those for treatment of other medical conditions
		836-053-1405(2)(b)	Reimbursement and cost-sharing, including deductible, co-payments, coinsurance, out-of-pocket expenses for wellness and preventive services for mental health may be no greater than those for treatment of other medical conditions
		836-053-1405(2)(d)	Reimbursement and cost-sharing, including deductible, co-payments, coinsurance, out-of-pocket expenses for prescription drugs for mental health may be no greater than those for treatment of other medical conditions

S. 588 AND OREGON SENATE BILL 1—Continued

S. 558		SB 1	
712A(a)(2) 2705A (a)(2)	Treatment limits for mental health may be no more restrictive than those for all medical and surgical benefits—including frequency of treatment, number of visits, days of coverage, or scope or duration of treatment.	743.566(3) & (7) 836-053-1405(2)(c)	Treatment limits including annual or lifetime limits, limits on total payments, limits on duration of treatment, or financial requirements may be no less than those for other medical conditions.
712A(b) 2705A (b)	Benefits may be managed to provide ''medically necessary'' services. Management may include utilization review, authorization or management practices and contraction with and use of network providers.	743.566(3)	Treatment may be limited to treatment that is ''medically necessary'' as determined under the policy. Management methods include, selectively contracted provider panels, policy benefit differential designs, preadmission screening, prior authorization, case management, and utilization review.
		836-053-1405(3)	Group health insurance policy must contain a single definition of medical necessity and experimental or investigational. Allows for IRO review of denials of treatment based on experimental or investigation or medical necessity including whether the insurer's definition is uniformly applied to mental health and other medical conditions.
712A(c) 2705A (c)	Requires benefits for in- and out-of-network services to be the same for mental health and other medical benefits. Does not require out-of-network coverage of mental health if out-of-network coverage is not provided for medical.		
712A(c) 2705A (c)	Allows insures to negotiate separate reimbursement or provider payment rates and service delivery systems for different benefits.	743.566(5)	Defines providers who are eligible for reimbursement.
712A(d) 2705A (d)	Exempt small employers (2-50)		Does not exempt small employers
712A(e) 2705A (e)	Cost cap exemption of 2% year one and 1% subsequent years if the application of the law results in an increase for the plan year of the actual total costs of coverage with respect to medical benefits and mental health benefits. Allows exemption for one plan year.		No cost exemption
712A(g) 2705A (g)	Allows health insurance plan to define Mental Health Benefits	836-053-1405(1)	Mental or nervous conditions and chemical dependency are defined by rule. Excepts tobacco and food addictions from definition of chemical dependency.

S. 588 AND OREGON SENATE BILL 1—Continued

S. 558		SB 1	
Section 4	ERISA preemption—S. 558 supercedes any provision of State law that ''establishes, implements, or continues in effect any standard or requirement which differs'' from (a), (b), (c), or (e) Does not preempt state laws relating to individual or small employer plans.		
Section 5	Consumer protections: DOL and HHS must designate a ''group health plan ombudsman'' to serve as an initial point of contact to permit individuals to obtain information and to provided assistance with mental heath services under health insurance coverage.		Consumer Protections under Oregon Law: Group health insurance policy must contain a single definition of medical necessity and experimental or investigational for chemical dependency and mental condition and for all other medical conditions. Allows for IRO review of denials of mental health treatment based on experimental or investigation or medical necessity including whether the insurer's definition is uniformly applied to mental health and other medical conditions.
	HHU and DOL must conduct ''random audits'' of group health plans to ensure compliance with the Act.		Requires the Department to do a review of the rules within two years of the effective date to determine whether the requirements are being met. Requires insurers to have policy and procedures in place to ensure uniform application of the policy's definition of medical necessity to all conditions. Allows the Department to conduct ongoing market surveillance of insurers' policies and procedures for implementing SB 1. Requires insurer's to file policy forms for review by the Department to ensure compliance with the rules and statutes. The Department has a Consumer Protection section that deals with complaints from consumers, provides information about mental health services and benefits to consumers, and assists consumers in working through disputes with insurers.

MIKE KREIDLER
STATE INSURANCE COMMISSIONER

STATE OF WASHINGTON

OFFICE OF
INSURANCE COMMISSIONER

Phone: (360) 725-7000

June 6, 2007

The Honorable Maria Cantwell
United States Senate
717 Hart Senate Office Building
Washington, DC 20510

RE: Mental Health Parity Legislation, S. 558

Dear ~~Senator Cantwell~~ Maria:

I'm writing to you to express concerns that I have over S.558 and how this legislation would adversely impact Washington State health insurance consumers. At a minimum, I would strongly urge the Senate to adopt the pre-emption language currently found in HR 1424 in order to preserve Washington's more comprehensive mental health parity laws.

I support and commend the federal effort to broaden provisions for mental health insurance benefits, but would urge you to oppose provisions within this legislation that would preempt Washington's mental health parity legislation and possibly our mandated benefits for the treatment of chemical dependency.

Beginning in 2006, Washington State required health benefit plans marketed to groups of over 50 employees to include coverage for mental health services. Those mental health services must be at parity with medical and surgical services otherwise provided under the health benefit plans. If S.558 is passed by Congress, our statute requiring coverage of mental health services would be pre-empted for employers of more than 50 employees, allowing carriers to reduce or eliminate this coverage altogether. Such a weakening of our state's strong mental health parity law would be an unfortunate set-back for Washington consumers.

My second concern is with respect to the "cost exemption" provision within S.558. This section allows a health plan to opt out of providing mental health parity based on increases in the plan's total cost of coverage. If total plan costs increase by more than two percent after the first year, the employer would not be bound by the mental health parity requirements for the following year. Tracking these costs from plan to plan to this level of precision will be difficult, if not impossible, and may be subject to gaming by carriers or employers.

We have observed that "cost exemptions" for mental health treatment are very easy to manipulate and inflated cost estimates are often submitted to avoid providing mental health parity. This direct observation is based on health carrier and employer responses

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Consumer Assistance Only:
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Health Care Admin. 1-800-631-7788
Securities: 1-877-550-3907

May 22, 2007

Senator Patrick Leahy

433 Russell Senate Office Building

Washington, DC 20510

Re: Congressional Mental Health Parity Legislation

Dear Senator Leahy:

I am writing to express my concern with respect to pending federal mental health parity legislation.

As you know, since the 1997 enactment of Vermont's Mental Health Parity Law, Vermont has been a national leader in the development of public policy supporting access to adequate and appropriate treatment for Vermonters with mental health and substance abuse conditions. The law has been nationally recognized for the comprehensive breadth of its nondiscrimination provisions, and has assured Vermonters' access to critically important treatment. For example, under Vermont law:

- Insurers must provide coverage for treatment of mental health and substance abuse conditions.
- Insurers are not permitted to impose a greater financial burden for access to mental health and substance abuse care than for access to other kinds of health care.
- Vermont consumers are not restricted to lower annual coverage maximums for mental health treatment than are provided for in connection with physical health treatment.
- Vermonters with a broad range of mental health and substance abuse conditions are protected by the law.

I understand that there are at least two versions of federal mental health parity legislation pending in Congress. Both versions afford less protection to consumers than Vermont's Mental Health Parity Law. The House version treats coverage of mental health and substance abuse conditions as an "option", thereby perpetuating discriminatory treatment of some Vermonters for no rational purpose. Its higher-cost "optional" coverage will create barriers to access to quality care. The Senate version is very weak in its substantive protections, particularly with regard to substance abuse treatment. Most important, for purposes of this letter, the version of the federal legislation pending in the Senate contains a preemption provision which would take away the consumer protections existing in Vermont.

Because of the weak consumer protections in both versions, I urge you to oppose any version of the legislation which includes a provision preempting the stronger consumer protections contained in Vermont's Mental Health Parity Law.

Please let me know if you have any questions concerning the Douglas Administration's position on this matter, or if the Vermont Department of Banking, Insurance, Securities and Health Care Administration can be of assistance in your efforts in any way.

Yours truly,

Paulette J. Thabault

Paulette J. Thabault
Commissioner

cc Govenor James Douglas
Rep. Anne Donahue
Ken Libertoff, Vt. Assen. for Mental Health
David Fassler, M.D., Council of Mental Health & Substance Abuse Professionals
Sandra Howell, Pres., Vt. Psychological Assen.
Robert Pierattini, M.D., President, Vt. Psychiatric Assen.
Rep. Ann Pugh, Chair, House Human Services
Rep. Steve Maier, Chair, House Health Care
Sen. Doug Racine, Chair, Senate Health & Welfare
Health Care Reform Commission

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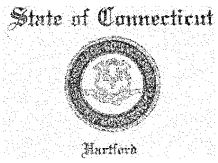


June 22, 2007

The Honorable Christopher Dodd
United States Senate
448 Russell Senate Office Building
Washington, D.C. 20510

Re: Senate Bill No 558
Mental Health Parity

Dear Senator Dodd:

I appreciate the fact that Tamar Magaryk from your office has been consulting with the Connecticut Insurance Department on the above bill relating to mental health parity. I would like to provide my comments at this critical time.

Senate Bill 558 does not require plans to offer mental health benefits at all, but rather only requires that, if a plan chooses to provide mental health benefits, along with health benefits, it do so on a parity basis.

Connecticut has strong insurance laws requiring coverage of mental and nervous conditions, and coverage of those conditions on a parity basis, under individual and group health insurance policies. I am concerned over any federal bill, which, if enacted, would erode or eliminate Connecticut's protections.

The Connecticut Insurance Department has had concerns over the past months on the Senate Bill 558. Some, but not all, of these concerns have been addressed, as the Senate bill continues to be revised.

Our primary concern under the latest draft wording is the preemption wording. Under the preemption wording, federal law (ERISA) will preempt certain state laws which differ from federal requirements. As an important example, there is a provision in the bill which provides that, if group insured plans can show a specified increase in cost due to adding mental health parity, such plans do not need to provide mental health parity

The Honorable Christopher Dodd
United States Senate
Page 2

for the following year. Combined with the preemption provision, this means that Connecticut insured plans demonstrating such cost increases will no longer have to meet the Connecticut mental health benefits. I am concerned that many insured plans will indeed be able to demonstrate the cost increase, and therefore will no longer provide mental health benefits, resulting in a loss of needed benefits for Connecticut consumers.

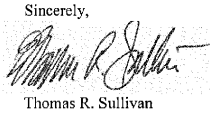
Furthermore, although SB 558 has been amended various times over the months to eliminate problem aspects (such as earlier wording, which would have preempted state utilization review laws), the latest wording is not totally clear on some of these important points. Accordingly, the Department has concerns that if the Senate version is ultimately enacted, there may be litigation challenging the accepted interpretation on these issues.

In view of these concerns, and in particular, the preemption issue, the Connecticut Insurance Department does not support SB 558.

Instead, if preemption language is to be included in the bill, the Connecticut Insurance Department supports the type of language contained in the House version of the bill (HR 1424), which provides that federal law (ERISA) shall not preempt any state law which provides greater consumer protections. The Connecticut Insurance Department is in agreement with the National Association of Insurance Commissioners (NAIC) which wrote to Senators Kennedy and Enzi on May 2, 2007. The NAIC requested that, if the Senate decides to include preemption language in the bill, the NAIC prefers the language in the House bill. Again, the overriding concern of the Connecticut Insurance Department, and other state Insurance Departments, is that federal law not reduce or eliminate mental health protections provided to consumers under state insurance laws.

I appreciate the opportunity for the Connecticut Insurance Department to offer its comments on this important legislation.

Sincerely,



Thomas R. Sullivan
Commissioner

cc: The Honorable M. Jodi Rell, Governor
Julie Williams, Director Washington Office of the Governor
Kevin Lembo, Office of the Health Advocate

Chairman ANDREWS. Well, thank you, Commissioner.

And we thank all the witnesses for giving us an excellent basis for our discussion as a committee.

I would ask unanimous consent that two letters dealing with the issue of the scope of preemption in the Senate bill be entered into the record. The first is from Mila Kofman, associate research professor at Georgetown University, and the other is a letter from Gregory Heller.

Without objection, they will be entered into the record.

[The letters follow:]

GEORGETOWN UNIVERSITY

Health Policy Institute

VIA E-MAIL

June 15, 2007

The Honorable Nancy Pelosi
235 Cannon HOB
Washington, DC 20515

Dear Speaker Pelosi:

This is a response to your request for an analysis of the preemption provisions in the Mental Health Parity Act of 2007 (S. 558 as amended 6/13/07 draft) and the potential impact on consumers in California and in other states.

As a way of background, researchers at the Health Policy Institute conduct a range of studies. My specific focus is studying the private health insurance market including federal and state regulation and preemption issues. Currently I am the co-editor of the Journal of Insurance Regulation and serve (as one of six non-regulator members) on the Consumer Board of Trustees of the National Association of Insurance Commissioners. Before joining the faculty at Georgetown University, I was a federal regulator at the U.S. Department of Labor, where I worked on issues affecting ERISA health plans including implementation of federal health care reforms like the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Mental Health Parity Act of 1996 (MHPA), the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA), and the Women's Health and Cancer Rights Act of 1998 (WHCRA).

The new preemption standards in S. 558 would expand ERISA preemption, create a federal ceiling on consumer protections, and preempt stronger state-based standards. The preemption would not necessarily result in new benefits for workers and families because there is no requirement to cover mental health benefits and there are opportunities to get out of federal requirements.

Significantly, S. 558 would be a departure from the principles of federal health coverage reforms first established over a decade ago in HIPAA (also called "Kennedy/Kassebaum") and evidenced in subsequent reforms including existing federal parity requirements, NMHPA, and WHCRA.

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Since 1996, a key principle for Congress has been to incrementally reform private health coverage by establishing a federal floor of protections for workers and their families. Through a federal standard that is a floor, not a ceiling, Congress has recognized that state policymakers may determine that to protect patients and people in state-regulated plans, a stronger set of standards are necessary than those provided in federal law.

Additionally, as discussed at a recent hearing before the U.S. House of Representatives Committee on Education and Labor, HELP Subcommittee, existing federal preemption under ERISA has been a major challenge to comprehensive state-based health care reforms seeking to address the uninsured problem in the United States. Some Members of the Committee were looking for ideas on how to remove the ERISA preemption obstacle.[1] By expanding ERISA's preemption, S. 558 would add an additional hurdle and would make it more difficult for states to implement effective and comprehensive state-based health coverage reforms to address the health care crisis in the nation.

The following summarizes requirements under S. 558 and then discusses the potential adverse effect the legislation would have on people in California and in other states.

Summary

S. 558 would not require employers or insurers to provide benefits for mental health conditions but would establish standards for those that choose to provide such coverage. When applicable, S. 558 would generally prohibit group health plans and their insurers from having more restrictive coverage of benefits for mental health. This includes restrictions on number of visits, frequency of treatment, and days of coverage; and higher out-of-pocket expenses like deductibles, co-payments, coinsurance, and annual and lifetime coverage limits (§712A(a)).

The standards only would apply to health coverage benefits provided by employers with more than 50 employees and would not apply to small businesses (2-50) or individual health insurance policies. What is included as a "mental health benefit" would be determined by an ERISA-covered group health plan (§712A(f)), which means that there is no requirement to cover services related to recognized mental health conditions in the International Classification of Diseases or in the Diagnostic and Statistical Manual of Mental Disorders.[2]

The new standards would not apply if a plan's cost in the first year goes up by 2% and 1% in subsequent plan years (§712A(e)). Plans would be required to provide a notice to covered workers 60 days after a loss of mental health parity benefits (§712A(e)(5)). Although health plans would be required to notify the federal government when choosing to be exempt, the federal government would be required to maintain that information on a "confidential basis" and thus specific information about their employer would not be available to covered workers and families (§712A(e)(6)(C)).[3]

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[1] Maryland's "Fair-Share" law was found to be preempted by ERISA. There are efforts to challenge recent health care reforms in Massachusetts based on ERISA. For additional information see Kofman, M., Testimony, Health Care Reform: Recommendations to Improve Coordination of Federal and State Initiatives, before the U.S. House of Representatives Committee on Education and Labor, Subcommittee on Health, Employment, Labor and Pensions, May 22, 2007 available at http://edlabor.house.gov/hearings/help052207.shtml

[2] Note that the amendment to the Public Health Service Act would establish a different standard for state and local governmental group health plans and their insurers (§ 2705A(f)).

[3] This means that workers and their families would find out that their health benefits have been cut two months after the fact; some would likely incur significant out of pocket financial responsibility for services and treatment

Preemption

S. 558 includes several provisions related to preemption. The bill would preempt state law when the state standard "differs" from the federal standards in the bill (Bill sec. 4(a) amending ERISA by adding (c) to §731 of ERISA). This general preemption standard would preempt state mental health parity laws that are more consumer protective than the federal law. While the bill also has exceptions to this general preemption, these are ambiguous and would invite ERISA litigation challenges.

One exception is in section 731(c)(2)(A) and (B), which seeks to clarify that portions of state law not preempted will continue to apply and that individual and small group coverage standards are not preempted. Section 731(c)(2)(B) states in part: "Nothing in this subsection shall be construed to preempt State insurance laws *relating to* the individual insurance market or to small employers…." (emphasis added)

The second exception is in section 731(c)(2)(C), which states in part:

> Consistent with subsections (a), (c), and (e) of Section 712A, nothing in section 712(A) shall be construed to require a group health plan (or coverage offered in connection with such a plan) to provide the following: (i) Any mental health benefits, *except that State insurance laws applicable to health insurance coverage that require coverage of specific items, benefits, or services (including for specific mental health conditions) are specifically not preempted* by this subsection or such section 712A. (emphasis added)

These exceptions to the general preemption provision provide an improvement over an earlier version of S.558, which would have broadly preempted many state-based consumer protections. However, the current language falls short of ensuring that existing individual and small group laws as well as benefit mandates in the states are saved from the new preemption language that would be added to ERISA.

I believe that states will face ERISA litigation challenges to laws S. 558 seeks to save from preemption. For example, some states have one mental health coverage standard that applies to policies sold in the large group, small group, and individual health insurance markets. When the requirement is included separately in the insurance codes applicable to individual, small group, and large group markets, S. 558 would not adversely impact the state standard for individual and small group coverage. However, when there is one standard that applies to all markets, such standard could be challenged, and depending on a number of factors including how the phrase "relating to" in section 731(c)(2)(B) is interpreted, if found preempted, people with individual coverage and small group coverage would lose existing rights.[4]

Another example of how S. 558 falls short of meeting its goal of not preempting state coverage laws for "specific items, benefits, or services" is the ambiguity in what this includes. In other words, a state law to provide "specific items, benefits, or services" appears to be saved from

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received during that period not realizing that their covered benefits had changed. (Note that this is a general standard under ERISA to provide notice after a change in benefits occurs.)

[4] Federal courts considering preemption challenges would do so in the context of a long history of ERISA preemption cases, which are not always consistent with general principles of preemption.

preemption under section 731(c)(2)(C)(i). However, it is not clear what type of state law would qualify as requiring "specific items, benefits, or services."

It is also not clear if a qualified law coupled with "parity requirements" – requiring alcohol abuse treatment "under the same terms and conditions" for diagnosis and treatment of physical illness[5] -- would also be saved under the exception in 731(c)(2)(C)(i) or be preempted under the general preemption in section 731(c)(1). This would have to be addressed through courts.

Examples of state laws that may be challenged using the new ERISA preemption in S. 558

California's mental health parity law is a standard that applies generally to health insurance coverage (see Insurance Code § 10144.5 Severe mental illnesses; serious emotional disturbances of children applicable to insurers; Health and Safety Code § 1374.72. Severe mental illnesses; serious emotional disturbances of children applicable to managed care plans). Unlike a specific law applicable to individual or small group coverage, there is no guarantee that courts will uphold the law as it applies to individual and small group policies if challenged under ERISA and as result, the legislative intent in section 731(c)(2)(A) and (B) to save state individual and small group coverage from preemption may not be accomplished.

Furthermore, the legislature has labeled this standard a "parity" law.[6] Because it is a law that appears to require "specific items, benefits, or services," it may be within the exception in §731(c)(2)(C)(i). However, the parity label and parity-type standards in California's law raise questions of how broad the exception is (and if interpreted very broadly, the exception would eviscerate the rule). Thus, courts interpreting how broad the exception is may do so in light of the intent of S.558 and its general preemption, which is to have *one* national parity standard and not allow state standards that differ. California's policymakers could attempt to enact a new law but, in addition to general considerations related to enactment of legislation, the law would have to be carefully crafted to avoid the new preemption provision (the meaning and scope of which is likely to be litigated in federal courts).

I have also looked at mental health laws in Montana, Connecticut, Maryland, and Nevada. All four states would have preemption issues. In these and other states, mental health mandate laws are general and would raise the same litigation questions as the California law. Furthermore, the laws require coverage for mental health but are coupled with "parity" standards, which raises likely preemption challenges under S. 558 whether such laws are saved from broad preemption.

- Montana law requires coverage for severe mental illness and such coverage must be provided on parity with coverage for physical illness. The standard applies to individual and group coverage with no distinction between small group and large group coverage. The parity requirements differ from S. 558 and would be preempted, unless the exception in §731(c)(2)(C)(i) is interpreted broadly. Also, on its face, there is no distinction between large group, small group, and individual coverage. Depending on how §731(c)(2)(A) and (B) are interpreted (in the context of current ERISA preemption cases), consumers with individual and small group coverage would lose existing protections if the law is found to be preempted. (See section 33-22-701 et al of the Montana Statutes).

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[5] This language is in section 15-508 of the Maryland Insurance Code. However, other states have similar language or include other standards that appear to provide for parity in benefits.

[6] See Legislative Findings in Health and Safety Code § 1342.7. 2000 Main Volume Section 1 of Stats.1999, c. 534.

- Connecticut's mental health coverage requirement has elements of "parity" and so may have to be litigated to determine which, if any, requirements would survive preemption. Also Connecticut's mental health law applicable to group coverage does not distinguish small group from large group coverage. This means that if preempted, then covering mental health in policies sold to small businesses would no longer be required. (See §38a-514 Connecticut insurance laws).

- In Maryland, requirements for individual coverage and large group coverage are in one section (see §19-703.1 for HMOs and §15-802 for insurers and nonprofit health service plans). Litigation may be necessary to determine if standards for individual coverage would continue. The mandate for large group coverage to include mental health benefits and provide coverage on parity with physical illness may also be litigated to determine if it is saved from S. 558 general preemption. Consumers with individual coverage may lose rights, in addition to a loss of strong protections for people in large group coverage if the law is found to be a "parity" law that differs from S. 558 and as such preempted.

- In Nevada, the mental health parity law for group coverage applies to groups of more than 25 employees. Similar to other states, although there is a mandate to cover mental health (severe mental illness), the standards for the mandate are "parity-type" standards. Again it may be up to the courts to determine if Nevada's law is saved under the new preemption standards. If preempted in its entirety, the requirements would not apply to large groups and would no longer apply to coverage sold to employers with 26 to 50 employees even though S. 588 strives to save such laws. (See section 689B.0359, Title 57. Insurance, Nevada Statutes)

In summary, because of the ambiguities in the exceptions to broad preemption in S. 558 and a history of extensive litigation to determine the extent of ERISA preemption, courts may be looking at the scope of the new preemption for many years, with potentially conflicting outcomes. If state laws are found to be preempted, then consumers would lose existing rights.

Finally, establishing a federal ceiling on consumer protection is a considerable departure from a decade of federal health care reforms that established a minimum national standard and allowed for more protective state-based rights. This coupled with no actual requirement to cover mental health benefits could result in a significant loss of existing coverage benefits that people with mental health-related illness current rely on as a way to access and finance necessary medical care.

I hope you find this preliminary analysis useful. If you have any questions, please contact me at 202-784-4580.

Very truly yours,
Mila Kofman, J.D.
Associate Research Professor

Cc: Senator Reid

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June 28, 2007

by fax
Deborah Beck
President
Drug & Alcohol Service Providers
Organization of Pennsylvania
3820 Club Drive
Harrisburg, PA 17110

RE: Senate Bill 558

Dear Ms. Beck:

You have asked me to comment on the analysis of S. 558 submitted by Professor Sara Rosenbaum of George Washington University. In particular, you have asked me to consider, and comment upon, Professor Rosenbaum's conclusion that S. 558, as currently drafted, protects Pennsylvania's Act 106 and other, similar addiction treatment laws found in other states. Unfortunately, I disagree with Professor Rosenbaum's conclusion that the current language of S. 558 protects Pennsylvania's Act 106.

Before explaining why I believe Professor Rosenbaum's interpretation of S. 558 is incorrect, I should note at the outset that I am thrilled to see Professor Rosenbaum's support of the general goals at issue: (a) enacting a meaningful federal law that effectively addresses insurance discrimination against mental illness and addiction, while simultaneously (b) protecting state addiction treatment laws such as Act 106 (and of course other similar laws). Unfortunately, S. 558 as currently drafted falls far short of the second goal.

Senate Bill 558 sets forth, in section 712A(b)(2), a crystal-clear new federal permission slip for managed care. Under that provision, a group health plan "shall not be prohibited from . . . managing the provision of mental health benefits". As a general proposition, under legal principles known as conflict preemption and field preemption, if a federal statute explicitly says that a person can do something (like manage a benefit for medical necessity), and a state statute says that the company cannot, it is the federal law that controls. If a federal statute says you can drive on the left-hand side of the road, you can drive on the left-hand side of the road.

Thus, under the plain language of Section 712A(b), state laws that currently prohibit or control health insurance interference with addiction treatment would be eliminated. It is certainly possible to write a bill that carves out a space for such state medical management laws, but S. 558 does not do so. Quite to the contrary, after its initial grant of new federal authority to managed care, S. 558 does not talk about state medical management provisions at all, and therefore fails to protect such state laws.

Professor Rosenbaum devotes considerable attention to the "special preemption rule" set forth in S. 558, at section 4. While I disagree with Professor Rosenbaum on the interpretation of this section, it is important to note at the outset that careful parsing of the language of S. 558's preemption provision only answers questions of *express* preemption, and not questions of conflict preemption and field preemption. Express preemption is obviously an important inquiry, but is by no means the only one: essentially by definition, principles of conflict preemption and field preemption apply even where there is no language in a statute explicitly addressing a particular preemption question.

Insurers will argue that Section 712A(b)'s ban on state-law medical management prohibitions is clearly and irreconcilably in conflict with Pennsylvania's Act 106. Insurers will doubtless add that this was clearly the intent of Congress, a position that will almost certainly find support in a legislative record that will be filled with paeans to national uniformity.

Professor Rosenbaum argues that the "special preemption section" singles out other parts of the statute for explicit preemption, and that the failure to include medical management laws in that list of preempted laws means that state medical management laws are not preempted and are protected. I find no comfort in this argument. Insurers will doubtless argue that the drafters of the bill knew how to preserve some state laws, and indeed clearly did so in Section 4(c)(2)(C), in a list of preserved state laws that rather pointedly does *not* include state laws that regulate or prohibit medical management.

Professor Rosenbaum also claims solace in ERISA's insurance savings clause, which – as a general matter – saves from preemption state laws regulating insurance. Unfortunately, however, S. 558 does not contain any language that invokes or refers to ERISA's savings clause. If enacted in its current form, the "special preemption rules" would be placed within ERISA Section 731, in a way that would allow insurers to argue that the insurance savings clause does not apply.

The "special preemption rule" of S. 558 would amend ERISA Section 731 of ERISA by adding a new subsection (c), which will be a "Special Rule in Case of Mental Health Parity Requirements". This "Special Rule" will be preceded by the current Subsection (a), which sets forth a general rule of construction governing the continued applicability of state laws. That law provides:

(1) In general

> Subject to paragraph (2) and except as provided in subsection (b) of this section, this part shall not be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group health insurers except to the extent that such standard or requirement prevents the application of a requirement of this part.
>
> (2) Continued preemption with respect to group health plans
>
> Nothing in this part shall be construed to affect or modify the provisions of section 1144 of this title with respect to group health plans.

Thus, the "special preemption rule" of S. 558 – ***which does not mention medical management at all*** – is preceded by a "general rule" that defines what is preempted and what is saved. The general rule would apply. Under this general rule, laws "solely relating to health insurance issuers" are singled out for protection (that is, are saved from preemption) and other laws are not. The problem here is that behavioral health benefits are frequently not provided by health insurance issuers, but rather by carve-out companies that, in Pennsylvania anyway, frequently take the position that they are not subject to the jurisdiction of the Insurance Commissioner because they are not health insurance issuers. Therefore, Pennsylvania's Act 106 does not "***solely*** relat[e] to health insurance issuers," and therefore – under this general rule – Pennsylvania's Act 106 is among the class of rules that Congress has decided to eliminate, under the text of ERISA Section 731 as it would appear after enactment of S. 558. It bears repeating that the touchstone for statutory interpretation here is Section 731 as it would appear after enactment, not S. 558 as moved forward in the Senate. I believe that Professor Rosenbaum's failure to place S. 558 within this statutory context is a critical oversight.

While it could certainly be argued that ERISA's general savings clause applies by virtue of subsection 731(a)(2), which says "nothing in this part shall be construed to affect or modify . . . section 1144 of this title with respect to group health plans," how this argument would fare with respect to carve-out contractors is anyone's guess.

Furthermore, I am extremely troubled by Professor Rosenbaum's assumption that "managing the provision of mental health benefits" (found in subsection 712A(b)) is completely separate from "financial requirements" and "treatment limitations" applicable to such mental health benefits (subsection 712A(a)). Even if S. 558 clearly saved state medical management laws, S. 558 indisputably and intentionally preempts state "financial requirements" and "treatment limitation" laws. It is easy to imagine insurance-industry arguments that any number of managed care tools are "financial requirements" and "treatment limitations" and not "managing the provision of mental health benefits". Consider, for example, a treatment facility-insurer contract that required medical necessity review as a precondition not of treatment, but of reimbursement. The patient might never know about this economic coercion (indeed typically would not, as most such contracts are

Deborah Beck
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confidential). Is this a "financial requirement" or "managing the provision of mental health benefits"?

These terms may have settled meanings within the advocacy and health policy communities. If so, why aren't these definitions in S. 558? As matters now stand, however, it appears that Professor Rosenbaum's analysis is based on assumptions regarding conventional meanings that would not necessarily be shared by insurers or courts.

Finally, I would like to make a point about a fundamental equivocation in Professor Rosenbaum's analysis. This equivocation sheds some important light on the current shortcomings of S. 558. Professor Rosenbaum repeatedly asserts that S. 558 will in fact save or protect more "stringent" state insurance laws, but also argues, at page 8 of her letter, that if the bill actually said this – if the statute explicitly preserved "more stringent" state laws – this would generate considerable legal confusion. In other words, Professor Rosenbaum is arguing "you can't write a statute that saves 'more stringent' state laws, but that's o.k., because the statute saves more stringent state laws." Professor Rosenbaum cannot have it both ways: the "more stringent" standard either works, or it doesn't. If the standard is robust enough and clear enough to establish the distinction that we are all seeking to draw, then the statute should include the standard. If the standard is not robust enough to do so, then it cannot be offered as a meaningful guiding principle that describes or defines S. 558's scope and preemptive effect.

To me, the fact that informed and well-intentioned advocates with significant institutional resources behind them cannot point to a clear standard within the language of S. 558 proves beyond any doubt that this law does not, in its current form, provide adequate protection to Pennsylvania's Act 106 or to similar laws in other states.

Very truly yours,

GREGORY B. HELLER

GBH/ld

Chairman ANDREWS. Again, I would like to thank each of the witnesses for very edifying testimony.

And, Mr. Trautwein, I wanted to come to you for a moment. You had said that one of the effective cost control strategies for insurers and employers who offer a mental health benefit is medical management.

When you say medical management, what do you mean?

Mr. TRAUTWEIN. This is the process of making sure the appropriate care is directed to the individual. So it is a question of matching the care to the person.

Chairman ANDREWS. So, for example, an insurer would determine whether the level of care—whether a psychiatrist would be

appropriate or a therapist or some other form of care provider, is that correct?

Mr. TRAUTWEIN. It is basically a check not only on utilization, but you want to make sure that the care is effective, that it is helping the particular individual.

Chairman ANDREWS. Right. And in your testimony on page two, you say that you are troubled by the lack of specific protection for medical management of benefits in the bill before us.

Where in the bill that is before the committee is there any language that would prohibit the kind of medical management that you are making reference to?

Mr. TRAUTWEIN. That is precisely what troubles us. The previous House and Senate bills had specific provisions.

In fact, former members, in the past, very much emphasized the protections for medical management as a means of keeping the cost, overall cost, of the bills down.

So this lack of specific provision——

Chairman ANDREWS. Yes, I understand that there is not a specific provision saying that insurers can do this, but where is there language that says they can't?

Mr. TRAUTWEIN. The answer is there is no line, but the lack of a positive protection leads us to believe that there could be inroads on our ability to do that.

Chairman ANDREWS. So if I understand your argument, it is that in the matter of an insurance contract that is governed by ERISA, if a specific practice isn't authorized by the statute, the insurer can't do it? Is that your position?

Mr. TRAUTWEIN. I think our primary concern is at the state level, that the states might——

Chairman ANDREWS. Well, of course, we are talking about this bill, though, what in this bill.

So is it your position that if ERISA as amended would not specifically authorize an insurer or an employer to do something, they can't do it? Is that your position?

Mr. TRAUTWEIN. No, sir.

Chairman ANDREWS. Well, why would we be concerned, then, about this bill?

It seems to me that the bill's silence about the availability of medical management techniques for insurers and employers means they could utilize them, doesn't it?

Mr. TRAUTWEIN. I think to an extent it does, but we would feel better and more secure if we had that provision in there.

Chairman ANDREWS. Mr. Melek, in your testimony, you talked about medical management provisions, and I want to make sure I understand this correctly.

In your conservative estimate, meaning, I guess, in this case that medical management tools either couldn't be used or weren't used as aggressively as they could be, it is your conclusion, isn't it, that the average increase is 0.6 percent in outlays? Is that correct?

Mr. MELEK. That is correct. If there is no response to increase utilization management or the employers didn't take additional action to reduce their cost——

Chairman ANDREWS. Could you tell us again what your conclusion was if under your so-called increased U.M. scenario, which I

take it means more profound use of the tools that Mr. Trautwein just talked about—what was your cost increase projection if that happened?

Mr. MELEK. Well, it is as close to zero as you can get. It is three cents per member per month.

Chairman ANDREWS. Three cents per member per month.

And let me also ask you—I think I understood that you said that your calculations were gross cost calculations, meaning that you did not take into your analysis reductions in absenteeism, increases in productivity, decreases in physical and surgical health outlays, is that correct?

Mr. MELEK. That is correct.

Chairman ANDREWS. So it is plausible, isn't it, that if one were to take those into consideration that you could make a strong argument that the payer, the insurer or the employer, actually has a net benefit from implementation of mental health parity, is that not correct?

Mr. MELEK. That is correct.

Chairman ANDREWS. Mrs. Carter, has that been your experience? You mentioned Mr. Johnson from CNN and others. Has that been your experience over the years, that employers who have voluntarily adopted parity programs have seen a business benefit?

Mrs. CARTER. I don't understand what he is talking about, because we in the mental health community have been watching companies for years who have had parity insurance for their employees.

And what we have seen happen is that over the first few years insurance might go up just a very little bit, but over 3 years or 4 years or 5 years, the total cost of health care for the company comes down, because people who go for physical health—I don't like to make a distinction, because I don't think there should be a distinction.

But people who go for physical health who are depressed or suffer from some mental illnesses and don't realize it keep going to the doctor and going to the doctor, and health costs are more than when they receive mental health care.

Then they don't go to their physical health doctors.

Chairman ANDREWS. So, Mrs. Carter, it is——

Mrs. CARTER. So over a period of time in all the ones that we have studied the health care costs, overall health care costs came down.

Chairman ANDREWS. This, Mrs. Carter, would be the person who gets treatment for clinical depression and therefore doesn't suffer significant weight loss and a stroke or a heart or attack or something that comes with that, then, right? That is what we are really talking about——

Mrs. CARTER. Yes.

Chairman ANDREWS [continuing]. Somebody who has that kind of—thank you.

Mrs. CARTER. And people who are depressed don't feel good. They don't know what is the matter. They have stomach aches and all kinds of aches and pains and just keep going to the doctor for care.

Chairman ANDREWS. Very well.

I understand that our friend and colleague Mr. Ramstad has arrived.

Is that right, Jim? Are you here? Jim, please come forward.

And with Mr. Kline's consent, I am going to recognize Mr. Ramstad for a statement at this time and then go to Mr. Kline for questions, if that is okay.

Okay. Without objection, there is a seat for you, Jim at the end of the table there. We are glad to see you arrived safely. We welcome you and thank you for the great work you have done on this issue.

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

Mr. RAMSTAD. Thank you, Mr. Chairman, Mr. Kline and distinguished committee members, friends all. Thank you very much for your indulgence and for allowing me to testify out of order today.

What is normally a 2-hour flight from Minneapolis turned into a 5-hour ordeal by way of Dulles, so thank you very, very much.

As some of you know, on July 31st, 1981, I woke up from my last alcoholic blackout under arrest for a variety of offenses in Sioux Falls, South Dakota, the city jail.

I am alive and sober today only because of the access I had to treatment, along with the grace of God and the support and fellowship of other recovering people over the last 25 years, 11 months.

But too many people don't have the access to treatment that Patrick Kennedy and I had. I believe it is a national disgrace that 270,000 Americans last year were denied addiction treatment, according to SAMHSA.

I think it is a national tragedy that 150,000 of our fellow Americans died last year as a direct result of chemical addition. Thirty-four thousand Americans committed suicide as a direct result of their untreated depression.

And I know there are some people on this committee concerned about cost. Let's look at the cost. It is a national crisis that untreated addiction and mental illness cost our economy over $550 billion last year. That is according to respected actuarial firms that have done those studies.

And of course, the costs that can't be measured—I am sure you have heard today from witness after witness—that can't be measured in dollars and cents. The human suffering, the broken families, the shattered dreams, the ruined careers, the destroyed lives, and on and on and on.

It is time to end the discrimination against people suffering the ravages of chemical addiction and mental illness. It is time to end the higher co-payments, the deductibles, the out-of-pocket limitations, costs that are higher than people who undergo treatment for other diseases pay.

These are discriminatory barriers to treatment that don't exist for other diseases. And if you accept the premise of the American Medical Association, 1956, that mental illness is a disease, that addiction is a disease, then you can't justify this discrimination vis-a-vis other diseases, this discrimination in treatment.

And that is why we have worked so hard on the Paul Wellstone Mental Health and Addiction Equity Act, so many of us.

I am sure Patrick Kennedy, our colleague from Rhode Island, explained the 14 field hearings that we had across this land—people desperate for greater access to treatment, people suffering the ravages of these diseases, people who want the discrimination ended.

And speaking of cost, we had at these field hearings CEO after CEO who have either on their own, as self-insured, or through their health plans already provided treatment equity for their employees.

CEO after CEO after CEO testified they are saving dollars. They are saving hundreds of thousands of dollars, small-, medium-and large-size companies.

We had six insurance plan CEOs testify in support of this legislation. Why? Because they have seen all the empirical data in the world that shows parity doesn't cost, it saves dollars.

So I urge this respected committee, friends all, all of you, that you mark up this important lifesaving bill.

With me, this isn't just another public policy issue. This truly is a matter of life and death, because I have seen my two uncles die from untreated alcoholism.

I have seen others suffer immeasurably from their mental illness and chemical addiction. I have seen families torn apart by the ravages of their child's addiction.

And we can address this problem as a nation by passing this bill. It won't raise premiums. This is according to Milliman & Robertson, again addressing my friends' concerns about cost.

Milliman & Robertson, the highly respected actuarial firm, who doesn't have a political axe to grind, said in their study that for the price of a cheap cup of coffee per month, 16 million people on health plans can receive treatment for their mental illness or chemical addiction.

Again, I will be glad to furnish the actuarial studies to anybody who argues that this is going to be a costly mandate. First of all, it is neither. It is not a mandate, and it is going to save literally billions of dollars.

Let me conclude, Mr. Chairman—and again, you have been very generous, and I appreciate the chance to testify here today.

Let me conclude by saying as strongly as I can, it is time to end the discrimination against people who need treatment for their mental illness and addiction. Thank you, Mr. Chairman and members of the committee.

[The statement of Mr. Ramstad follows:]

Prepared Statement of Hon. Jim Ramstad, a Representative in Congress From the State of Minnesota

Chairman Andrews, Ranking Member Kline, distinguished committee members and friends all, thank you for holding this important hearing.

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

But too many people don't have access to treatment. It's a national disgrace that 270,000 Americans were denied addiction treatment last year. It's a national tragedy that last year alone, 150,000 of our fellow Americans died from chemical addiction and 34,000 Americans committed suicide from depression. And it's a national crisis that untreated addiction and mental illness cost our economy over $550 billion last year.

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

It's time to end the discrimination against people suffering the ravages of mental illness and chemical addiction. It's time to end the higher copayments, deductibles, out-of-pocket costs, and limited treatment stays—discriminatory barriers to treatment that don't exist for other diseases. According to the GAO, 90 percent of plans impose financial limitations and treatment restrictions on mental health and addiction care that are not imposed on other illnesses. It's time to treat mental illness and chemical addiction under the same rules as other medical illnesses.

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

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

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

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

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

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

Chairman ANDREWS. Well, Mr. Ramstad, thank you for being here and being with us, and we celebrate your continuing personal victory as well as your commitment to this cause very, very much.

Mr. RAMSTAD. By the way, Mr. Chairman, one addendum. I would just like to add that we appreciate also the support of the president of the United States, who endorsed parity legislation in 2002 in a speech in Albuquerque, New Mexico when he was with the Senate chief sponsor, Senator Domenici.

We are anxious to get the bill down to him to sign.

Chairman ANDREWS. As we said, we believe we have a lot of bipartisan support for this legislation.

I am going to turn now to my friend from Minnesota, Mr. Kline, for his questions.

Mr. KLINE. Thank you, Mr. Chairman.

And welcome, Jim. I will congratulate myself again for having chosen to come back last night. [Laughter.]

I don't know what moved me, but—so I know what that means when a 2-hour flight turns into a multi-hour ordeal. Glad to see you, and glad you made it and glad you are safe.

A couple of comments and questions. I think many of us are eager to move forward with some parity legislation.

And part of what we are talking about today and trying to learn about are the differences between the Senate bill co-sponsored by Senator Kennedy and Senator Domenici and the bill that the president was talking about—what is in that bill versus what is in the House bill that is sponsored by our colleagues Mr. Ramstad and Mr. Kennedy.

And by the way, I of course always appreciate the passion, Jim, that you bring to this and our colleague Patrick as well. And so I

have got some questions, probably not for you, Jim, but for some of the other members of our panel.

And by the way, Mr. Chairman, I would like unanimous consent to submit this letter for the record from——

Chairman ANDREWS. Without objection.

[The letter follows:]

THE GEORGE WASHINGTON UNIVERSITY,
June 27, 2007.

Hon. PETE V. DOMENICI; Hon. EDWARD M. KENNEDY; Hon. MICHAEL B. ENZI;
U.S. Senate, Washington, DC.

DEAR SENATORS DOMENICI, KENNEDY AND ENZI: This letter is written in response to your request for an analysis of the preemption provisions of S. 558, the Mental Health Parity Act of 2007. The views expressed herein are my own and not those of the George Washington University.

Based on my review, I conclude that the preemption provisions contained in the Act save comprehensive state laws that regulate the mental health benefit design of insurance products sold in the employer-sponsored group health plan market. I further conclude that the Act's preemption provisions are wholly consistent with current ERISA preemption doctrine, which treats states as full partners in the regulation of insured plans. Given the broad policy imperatives underlying this legislation, I believe that its enactment would cure one of the most serious unaddressed issues in civil rights policy for persons with disabilities, while preserving the ultimate power of the states to determine the reach of these federal protections in the case of ERISA plans that purchase state-regulated health insurance.

I am a professor of health law and policy at the George Washington University School of Public Health and Health Services, where I also serve as the founding Chair of the Department of Health Policy. My 30-plus year legal career has focused on matters related to health care access, quality, and equality in the case of low income, minority, medically underserved, and vulnerable populations, including persons with or at risk for both physical and mental disabilities. Because of the unique interaction between the American legal system and the U.S. health care system, my health law knowledge and experience span federal and state law, with a particular emphasis on laws that finance health care and that regulate health care financial arrangements.

I have written extensively on health insurance, employee health benefits, and ERISA. The textbook that I co-authored with Professors Rand Rosenblatt and David Frankford, Law and the American Health Care System (Foundation Press, 1997, 2001), was the first health law textbook to give extensive treatment to ERISA as a central aspect of U.S. health law and policy. Over the course of my career, I have provided technical assistance, to Members of Congress from both parties on matters related to the legal implications of federal legislative proposals. In this capacity, I have, on several occasions, raised concerns regarding the preemptive effects of pending federal legislative measures, particularly when such measures threatened to harm underlying state law remedies for injured persons.

After careful analysis, I have concluded that far from diminishing protections for individuals, S. 558 advances long overdue national policy while at the same time, preserving states' power to adopt more comprehensive regulatory standards for health insurance products sold to ERISA-governed group health plans.

My conclusion is based on the fact that the legislation's special preemption provisions give clear and consistent direction to the courts regarding how to approach questions of preemption. In my view, S. 558 delineates its reach with care; a straightforward textual reading shows that the legislation honors ERISA's central preemption assumption: state laws regulating insurance should remain undisturbed unless they clearly conflict with a federal standard. I also believe that the legislative text clearly reflects Congress' underlying intent to remedy longstanding discrimination against persons with mental illness, while continuing to permit states to define the full parameters of these important federal safeguards through the application of more rigorous standards to insured products.

The need for a national policy on mental health parity is a longstanding and pressing one. I can think of few examples—not simply in the case of employer sponsored plans but also with respect to health care financing generally—in which the legal protections and safeguards established under state law have been weaker. Indeed, the United States Supreme Court's decision in Olmstead v L.C.[1] stands as a testament to the pervasive problems that individuals with mental illness encounter in attempting to secure equal access to appropriate treatment.

S. 558 will ensure parity for millions of Americans who are currently unprotected by state laws

If enacted, S. 558 will provide much needed relief in the case of ERISA-governed employer-sponsored plans. For two reasons, the imperative for federal intervention is overwhelming: first, states cannot reach self-funded health plans; second, millions of persons live in states whose mental health parity protections are weak to non-existent.

S. 558 offers a careful legislative structure that includes a special preemption clause, whose provisions save more stringent state insurance laws. This structure parallels more than two decades of United States Supreme Court decisions, which have interpreted the preemptive reach of ERISA §514 (the original federal ERISA preemption statute) as nonetheless saving state insurance laws in the case of insured products.[2]

Furthermore, modern ERISA jurisprudence has extended the reach of the term "state laws that regulate insurance" under §514 to reach not only benefit and coverage design, but also network structure and the power to make final determinations regarding the meaning of insurance contract clauses.[3]

In determining whether the Mental Health Parity Act represents a departure from this general and longstanding rule, the starting point for any ERISA preemption analysis would be the United States Supreme Court's seminal decision in New York State Conference of Blue Cross and Blue Shield Plans v Travelers Insurance Co.[4] In Travelers, a unanimous Court reminded lawmakers that "pre-emption claims turn on Congressional intent" and that the courts do their work "on the assumption that the historic police powers of the States were not to be superseded by [a] federal act unless that was the clear and manifest purpose of Congress."[5] The regulation of health insurance, as recognized by the ERISA preemption statute itself, represents such an area of "historic" state power to regulate conduct.

The Mental Health Parity Act's preemption clause has three key components. First, the "special" preemption section (Section 4) provides that the legislation preempts a state "parity standard or requirement" that "differs from" the provisions of subsections (a), (c) or (e) of Section 712A of ERISA or Section 2705A. Second, this preemption clause is limited by certain clarifications, i.e., special rules of construction that, without exception, specifically save state laws regulating benefits, services, the treatment of certain conditions, and networks. Finally, the legislation clarifies that states remain free to regulate, without regard to federal standards, the individual and small group markets. Taken together, these provisions can be read as placing national minimum standards under medium and large group plans, while permitting states to both strengthen these standards in the areas of benefits, coverage, conditions to be treated and networks, and to regulate the individual and small group markets. In short, the "Special Preemption Rule" found in §4 is a clear signal to the courts that where mental health parity is concerned, their preemption analysis is to follow this carefully delineated approach.

In my view, concerns that S. 558 lacks clear directives on "ceilings" or "floors" are misplaced. It is the structure of §4 that is critical, and this special preemption rule, taken together with other aspects of the bill and its history, protect the key aspects of more stringent state laws, including those that cover the small group market, mandate coverage of mental health benefits and regulate the management of benefits and networks. At the same time, S. 558's robust parity requirement, which contains none of the exceptions, limitations and exclusions frequently found in state parity laws, will supersede weaker state parity statutes. Thus, while commonly described as a "ceiling," in practice S. 558 functions like a "floor" because of its saving clause. In sum, S. 558 sets out a special analytic protocol when considering preemption in a mental health parity context, and its approach quite clearly favors the retention of the more stringent features of state mental health parity laws.

1. The special preemption rule in S. 558 preserves state powers to regulate the individual and small group markets.

The arguments that have been advanced regarding the preemptive impact of S. 558 on the small group and individual markets fail to take into account the limited scope of S. 558's basic preemption language. As noted above, only subsections (a), (c) and (e) of Section 712A of ERISA and Section 2705A of the PHSA are given preemptive effect. None of these subsections contain any language exempting the small group or individual market. S. 558's small group exemption is contained in subsection (d). However, this subsection has no preemptive effect. Simply put, state laws covering the small group or individual markets (whether they cover such markets exclusively or as part of a broader statute applicable to all markets) do not "differ from" any of the provisions of S. 558 that have preemptive effect, and therefore, such laws cannot be preempted.

In addition, even if S. 558's basic preemption provision were not so clearly limited, the bill's special preemption rule explicitly preserves state laws regulating the individual and small group markets in recognition of the fact that S. 558 reaches employer groups of 50 or more. The measure states as follows:

Rule of construction relating to certain state laws—Nothing in this subsection shall be construed to preempt State insurance laws relating to the individual market or to small employers (as * * * defined [under the bill]). ERISA §731(c) (2)(B) as added.

In my view, this clarification clearly protects state laws applicable to the small group or individual market, without regard to whether the law specifically references such markets or applies more broadly to all insurance policies. The term "relating to" in the clarification section is the same phrase used in ERISA's basic preemption provision, and will be interpreted in accordance with longstanding ERISA preemption case law.[5a] The courts have consistently held that state laws mandating the coverage of particular benefits "relate to" group health plans, whether or not these laws expressly reference such plans or sweep more broadly.[6]

Furthermore, the special preemption section provides an overarching "clarification" instruction to the courts, which, underscoring Congressional intent, cautions the courts not to read its preemptive provisions broadly:

In general—to the extent that any provision of State law is preempted under this subsection, any remaining provision of such state law shall remain in effect and shall not be preempted. ERISA 731(c)(2)(A) as added.

Thus, even if the basic preemption provision of S. 558 preempted state laws covering the small group or individual markets, which it clearly does not, the clarification language would certainly protect any such laws without regard to the manner in which they were structured.

2. S. 558 explicitly saves state laws that define what constitutes mental health benefits in connection with health insurance coverage offered under an employer-sponsored plan.

As a matter of federal law, the Act defines the term "mental health benefits" as what is specified under a group health plan or a health insurance issuer offering coverage in connection with a group plan. At the same time, the text makes clear that states can go farther. Specifically, S. 558 provides that mental health benefits mean:

[B]enefits with respect to mental health services (including substance use disorder treatment) as defined under the terms of the group plan or coverage, and when applicable, as may be defined under state law * * * applicable to health insurance coverage offered in connection with a group health plan. §2705A(f) as added [emphasis added]

The intent of §2705A is clear: federal law allows plans and issuers to define mental health benefits unless such a definition is contained in a state law governing health insurance products sold to employer groups. S. 558 thus preserves state power to define the reach of mental health parity in the case of insured products. Indeed, because states are given unconditional power over the central definition of the Act, they effectively have the power to delineate the parameters of mental health coverage design in the case of insured products, not only with respect to the provision of any mental health services but also with respect to the amount, duration, and scope of mental health services that must be furnished.

3. The special preemption rule in S. 558 saves state regulatory standards mandating coverage of mental health benefits or requiring out-of-network coverage, thereby empowering states to effectively define the reach of parity in the case of insured products.

Rather than closing off state protections where parity's scope is concerned, S. 558 in fact preserves state laws that define the remedial reach of the Act's provisions in the case of the insured market. The Act's special preemption rule contains explicit "Clarifications" whose express purpose—as a textual matter—is to limit the preemptive effects of the Act. In this regard, the Act contains an additional rule of construction where benefit and coverage design and out-of-network provider coverage are concerned:

Rule of construction relating to mental health and out-of-network coverage * * * [N]othing in section 712A [relating to parity] shall be construed to require a group health plan (or coverage offered in connection with such a plan) to provide the following

(i) any mental health benefits, except that state insurance laws applicable to health insurance coverage that require coverage of specific, items, benefits, or services (including for specific mental health conditions) are specifically not preempted by this subsection or such section 712A [emphasis added]

(ii) Out-of-network coverage for either medical and surgical benefits or mental health benefits, except that state insurance laws applicable to health insurance coverage relating to the provision of out-of-network mental health coverage are specifically not preempted by this subsection or such section 712A ERISA. §712(c)(2) as added by S. 558 [emphasis added]

This express rule of construction clarifies that, consistent with general principles of ERISA preemption under ERISA §514, state benefit mandates applicable to the design and administration of insured products sold to employer-sponsored plans, including state laws that regulate provider structure and design and laws that govern the interpretation of insurance contracts are not preempted.[7]

The Mental Health Parity Act thus leaves states free to delineate the terms of insurance products sold to employer-sponsored group health plans, including the items, benefits and services that together constitute the coverage design to which the federal parity law applies. (The phrase "items benefits and services" is a common tern of art used in both public and private health insurance law; it is used to refer to benefit classes, covered procedures within classes, the amount, duration, and scope of benefits, limitations and exclusions, and key definitional terms such as "medical necessity.")

State benefit mandates should be protected from preemption whether they are "freestanding mandates" (e.g., a requirement to cover a minimum number of visits per year) or mandates embedded in mental health parity laws (i.e., a law requiring insurers to cover mental health benefits and to do so at parity with other benefits). Contrary to what some have argued, I do not believe there is any conflict between the "Clarifications" language regarding benefit mandates and the basic parity standard contained in S. 558. Although S. 558's parity provision does not, by itself, mandate coverage of mental health benefits, the "Clarifications" language makes it clear that if a state parity law does mandate such coverage, that aspect of the state law is not preempted.

It is also worth emphasizing that the often-highlighted distinction between "conditional parity laws" (which do not mandate the coverage of mental health benefits) and "mandated parity laws" (which do impose such a mandate) is largely irrelevant in practice. Evidence from the Kaiser Family Foundation's annual review of employer-sponsored benefits suggests that there is no appreciable market for health plans that cover no mental health benefits whatsoever, especially in the large group market that is subject to S. 558. This evidence suggests that only about 2% of all insured individuals have no mental health coverage at all, even in states that have conditional parity laws. Thus, even when insurers are legally permitted to exclude all mental health benefits, it does not appear that they have the ability to do so as a practical matter. As a result, I consider "conditional parity laws" such as S. 558 and "mandated" parity laws" to be distinctions without true differences,

In sum, as a matter of federal law, the Mental Health Parity Act's special preemption provision, in combination with the Act's PHS Act amendments, clarify the following Congressional intent: (1) that as a general matter, state laws regulating insurance products sold in the employer group market will be saved unless specifically preempted under the Act; (2) that state laws delineating a minimum mental health benefit design in the group health insurance coverage market (including a minimum mental health benefit and the minimum range of conditions to which absolute parity must apply) should be saved; (3) that state laws that delineate the range of services, items, benefits and procedures to which parity applies are saved; and (4) that state network parity requirements are saved.

4. State laws regulating the manner in which mental health and other benefits are managed would not be preempted by S. 558.

As explained above, only subsections (a), (c) and (e) of Section 712A of ERISA and 2705A of the PHSA are given preemptive effect. The provision of S. 558 authorizing health plans to manage benefits through the application of medical necessity reviews or otherwise is contained in subsection (b). Moreover, there is nothing in subsections (a), (c) or (e) that refers to or is inconsistent with State benefit management laws. Accordingly, even if the very general language in subsection (b) were somehow construed as inconsistent with such state laws, the laws would not be preempted by S. 558. For example, I do not see any basis for preemption of Pennsylvania's law restricting health plan medical necessity reviews of substance abuse services provided during an initial treatment period or the quality standards set forth in Vermont's Rule 10.

There is a compelling policy imperative for the approach taken by S. 558, and a "HIPAA" approach to preemption is no less susceptible to extensive litigation to clarify the terms of the law.

S. 558 addresses mental health parity, a matter of fundamental importance to the health of the American people. Many observers—including prior Presidential Ad-

ministrations and numerous legal observers including my colleagues Rand Rosenblatt, Sylvia Law, David Frankford, and myself in our textbook Law and the American Health Care System—assumed that parity was addressed by Titles I and III of the Americans with Disabilities Act in combination with the health insurance safe harbor. Unfortunately that has turned not to be the case; indeed, the United States Supreme Court has given at least implicit approval to lower court decisions that effectively interpreted questions of health insurance design as beyond the reach of the ADA, thereby permitting public and private health insurers and employer-sponsored group plans to continue blatant discrimination.[8]

The reforms contained in S. 558 represent an important step toward rectifying the injustice of discrimination against persons with mental illness. Furthermore, the legislation takes this step while carefully balancing the need for a national floor with discretion on the part of states to provide a more comprehensive framework in the case of insured plans.

The law should be read as encouraging an expanded state intervention, not only because it is a remedial statute, but also because of the broad problem of mental health parity across health care all categories of state-regulated health care financing arrangements. To be sure, states such as Vermont, have made remarkable strides in developing a parity policy. At the same time, the decade-long record in the case of S. 558 underscores the seriousness of the problem and the absence of state protections across the board. Comprehensive state parity laws are wanting not only with respect to insurance products sold to employee health benefit plans but also with respect to Medicaid coverage for adults,[9] coverage for children under separately administered SCHIP plans,[10] insurance sold in the individual market, and public employee health benefit plans (as Vermont's law illustrates,[11] state employee plans may be excluded as a matter of state law in the absence of a statute that explicitly extend parity to public employee plans).

There are some who argue that what is needed in order to clarify state powers and reduce the risk of litigation is a "HIPAA approach" to preemption that would save "more stringent" state laws. Apart from the fact that it is not possible in my view to draft state law protections any stronger than the special preemption statute contained in S. 558, the notion that a HIPAA standard somehow will avoid legal confusion is misplaced. In a federal legal system, preemption disputes probably are inevitable, regardless of whether the dispute arises in the case of a Commerce Clause or Spending Clause statute. Indeed, along with several colleagues I recently published an analysis of the more than 500 HIPAA preemption cases decided since the final Privacy Rule was promulgated.[12] To say that the HIPAA preemption framework has generated legal disputes regarding which state laws are preempted and which are saved because they are more "stringent" frankly is the understatement of the century.

Regardless of whether a federal statute purports to establish a "ceiling" or a "floor" (both nice catch-phrases but without any legal meaning), the critical issue in resolving preemption disputes is the clarity of the text and the evidence of underlying Congressional legislative intent. In this regard, S. 558 could hardly provide a clearer or more consistent roadmap that balances the need for national standards with the ability on the part of states to expand upon those standards. The drafters have gone to great lengths in my view to provide clarity regarding the power of states to regulate the group health plan insurance market. It is my hope that this critical national debate over parity ultimately will spark a comprehensive vision of parity at all levels of government and with respect to all forms of health care financing.

Please do not hesitate to contact me if I can be of further assistance.

Sincerely,

SARA ROSENBAUM, J.D.,
Harold and Jane Hirsh Professor of Health Law and Policy and Chair, Department of Health and Human Services, Centers for Medicare and Medicaid Services.

ENDNOTES

[1] 527 U.S. 581 (1999)

[2] Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724 (1985)

[3] Ky. Ass'n of Health Plans, Inc. v Miller 538 U.S. 329 (2003); Rush Prudential HMO v Moran 536 U.S. 355 (2002)

[4] 514 U.S. 645 (1995)

[5] 514 U.S. 655

[5a] United States v. Ness, 466 F.3d 79, 81 n. 1 (2d Cir. 2006) ("We follow the general rule that the use of identical language in different provisions of a statute is a strong indication that they are to be given the same interpretation, absent clear evidence that Congress intended otherwise.")

[6] See, e.g., Shaw v. Delta Air Lines, 463 U.S. 85, 96-97 (1983); Aloha Airlines, Inc. v. Ahue, 12 F.3d 1498, 1504-05 (9th Cir. 1993); Standard Oil Co. of Cal. v. Agsalud, 633 F.2d 760 (9th Cir. 1980).

[7] In the wake of Rush Prudential HMO v Moran and Kentucky Association of Health Plans v Miller, it is difficult to think of any state insurance regulation that would not be saved, other than state laws that are found to create additional remedies. See Aetna Health Inc. v Davila 542 U.S. 200 (2004)

[8] See e.g., Doe v Mutual of Omaha 179 F. 3d 2d 557(7th Cir., 1999), cert. den. 528 U.S. 1106 (2000). Doe involved HIV, the other health condition that triggers rampant discrimination in insurance design. During the oral argument in the case, Mutual of Omaha stipulated that "it has not shown and cannot show that its AIDS Caps are or ever have been consistent with sound actuarial principles, actual or reasonably anticipated experience, bona fide risk classification, or state law." Id., 179 F.3d. 562. Unyielding industry resistance to evidence showing the potential for fair and efficient management of mental conditions underscores how equally apt this stipulation would be in the context of mental health coverage.

[9] See.e.g. Rodriguez v Miller 212 F. 3d 211 (2d Cir., 1999) (No ADA violation when a state Medicaid program imposes restrictions on personal care services for persons with mental illness that do not exist in the case of beneficiaries with physical conditions).

[10] Rosenbaum, S., Markus, A., and Sonosky, C. Public Health Insurance Design for Children: The Evolution from Medicaid to SCHIP. The Journal of Health and Biomedical Law. March 2005.

[11] See memorandum from Herbert W. Olson to Paulette Thabault regarding S. 558 (June 16, 2007)

[12] Rosenbaum, S., Borzi, P., Burke, T., and Nath, Sonia W. Does HIPAA Preemption Pose a Legal Barrier to Health Information Transparency and Interoperability? BNA's Health Care Policy Report. Vol. 15, No. 11, 3/19/2007.

Mr. KLINE [continuing]. George Washington University.

Medical management has been an issue discussed back and forth here, and the chairman correctly asked, "Well, if it is not explicitly excluded, can't we assume that it is there?"

And I guess I would ask the question what would be the harm in making sure that the language is put in there to explicitly allow it.

Can you address that, Mr. Trautwein, and why that would make you feel better and what the concerns are?

Mr. TRAUTWEIN. Well, again, in the administration of benefits, there is always a tug-of-war about who can do what when and where, and not only the tug-of-war in preemption between what the federal government can do, what the states can do, but in terms of regulation, what plans can do and what the restrictions are.

So I think we would be much more comfortable if that language was there, as it has been in past bills.

Mr. KLINE. Okay. Thank you.

And I think, in fact, when we were talking about the 0.6 percent, 0.3 percent, 0.2 percent, at least initially, I think, Mr. Melek, didn't you make an assumption that there was medical management, and then you looked at different levels if you didn't have it? Is that correct?

Mr. MELEK. Yes. In our baseline scenario, we had 0.6 percent increase. That had an underlying——

Mr. KLINE. I don't mean to interrupt—an underlying assumption that there was medical management at sort of current levels.

Mr. MELEK. That is right, compared to what is currently commonly in place in managed care plans.

Mr. KLINE. Okay. And so, in order to sort of solidify your analysis, it would be clearer and easier for you if we had explicit language allowing medical management, is that correct?

Mr. MELEK. I think that is correct, although, de facto, in health care today it is used.

Mr. KLINE. Okay. Thank you very much.

Now, we were in a discussion earlier talking about the House bill, and I think, Jon, you brought it up in your testimony about new remedies that might be available and the litigation.

Can you expand on that, what those costs might be and what those remedies might be, what the impact would be?

Mr. BREYFOGLE. Right. And before I do, on the medical management point, there are a couple of provisions in the House bill that I do think warrant the clarification we are asking for.

First of all, the House bill imposes a broad requirement that there be no differences in treatment limitations, and treatment limitations is fairly broadly defined.

So if you had different U.R. tools that were being applied to medical benefits versus mental health benefits, you might see somebody arguing that there was non-parity in that regard. So there is the issue there.

The other provision in the House bill is actually the one that is the remedies provision, which basically says, to paraphrase the medical management point, nothing in the federal law should be construed to preempt any state law that provides greater methods, provides greater consumer protections methods, methods of access to benefits, et cetera.

So I don't know what methods of access to benefits means, but if a state law were to regulate U.R., that is a method or imposition on accessing benefits, arguably. So I think there is some unclarity there that relates to medical management.

Mr. KLINE. So explicit language authorizing——

Mr. BREYFOGLE. There are a couple of provisions——

Mr. KLINE [continuing]. Would fix that?

Mr. BREYFOGLE [continuing]. That I do think—and that provision might be read to just apply to insured plans, but it might be read more broadly.

And the treatment limits rule clearly applies to self-insured and insured plans.

The second point on medical management is the law does not preempt state insurance laws as to insured plans, so there are states that do bar medical management for mental health and limit it.

So already, there is a built-in preservation of anti-medical management laws in the insured market in the House bill.

We didn't get everything we wanted in the Senate bill, which has essentially the same framework. But those are the reasons why we want the clarity in this bill.

As to the remedies point that you asked, basically there—ERISA provides the exclusive set of rules for litigating claims under ERISA plans. It is in federal court. It has certain remedies.

State laws that provide punitive damages, compensatory damages are completely preempted. That is all very settled.

There is a special rule that is being added just for mental health benefits provisions that saves state remedies. I mean, remedies is a pretty precise term legally speaking.

And so I think if you have a dispute over whether a parity law is being followed, and you are in an insured plan, you have a darn good argument under the House bill that you can sue for whatever

state law remedies are available, punitive damages, compensatory damages, et cetera.

Mr. KLINE. Okay. Thank you.

And I thank the chairman for letting me go past the time. I yield back.

Chairman ANDREWS. Thank you very much, Mr. Kline.

Mr. Kildee is recognized for 5 minutes.

Mr. KILDEE. Thank you, Mr. Chairman.

First of all, I thank all of you.

Mrs. Carter, I arrived in Washington with you and your husband in 1976. You were very kind, by the way, you and your husband, to my children, who were 4, 5 and 6 at that time. They used to play in the tree house with Amy in the backyard of the White House.

As a matter of fact, my 4-year-old left for Baghdad last night again.

And it is good to have you here, and thank you for all you have done in this field. Let me ask you this.

We know of the inequality between mental and physical health treatment, and there is still some amongst us who have either a medieval or superstitious attitude toward mental health, and that attitude has changed a great deal in the 30 years that I have been in Congress.

But that lack of understanding is found among people in government and people in business. Is that lack of understanding greater in business or greater in government?

Or have attitudes changed and it is now more of a false concern for cost for mental health?

Mrs. CARTER. Well, first, congratulations on being able to stay in Washington.

Mr. KILDEE. Thank you. [Laughter.]

Mrs. CARTER. I think attitudes are changing a little bit. I think for the first time since I have been involved the stigma is beginning to lift. We still have a long way to go, but I think it is beginning to lift.

I think that Katrina and soldiers coming home, National Guardspeople coming home, have helped people to see that mental illnesses are real and that people need help.

The stigma goes back to when—actually, before I first started, of course, for generations, but when I first started, people were being moved out of the big central hospitals into communities with no services available.

And nobody knew how to treat mental illnesses. There was no knowledge about the brain. And that has all changed. And so many people still have that same attitude about mental illnesses that was prevalent back when I first began.

But today, mental illnesses can be diagnosed and treated and the overwhelmingly majority can lead normal lives, living at home, going to school, working.

And so to me, it is just a tragedy that we don't help people. We relegate them to a lower standard because of their illness. I hope government is changing, because I really want to have this parity bill passed.

And I do think, from what I have seen over the years, businesses are beginning to come around. I don't think it is just because Tom Johnson is in Atlanta, Tom Johnson and these other CEOs.

But so many businesses are beginning to see that if they provide parity they have a happy, healthier workplace, and the productivity goes up. And so I think some businesses, not all of them by a long shot—so many are not—but I think it is beginning to happen.

I think there is a new awareness of the necessity to help people with mental illness.

Mr. KILDEE. And you have indicated that this concern for cost is really a false concern for cost.

Mrs. CARTER. Well, the first argument is it is going to break the bank. But we have evidence from all the studies that that doesn't happen, that the cost is very minimal.

And as I said before, over a period of time overall health costs for a company actually come down. And I think the main reason is because people go to primary care doctors.

And when mental health services are available to them through insurance and they access the professional mental health person and get treatment, then they have so many fewer trips to doctors, to the primary care doctor.

Some primary care doctors understand and recognize mental illnesses, but they are very few.

Mr. KILDEE. Thank you very much, Mrs. Carter.

Chairman ANDREWS. The gentleman yields back his time.

It is a pleasure to turn to our Dr. Boustany for 5 minutes.

Mr. BOUSTANY. Thank you, Mr. Chairman. I would like to thank you for holding this hearing.

And I want to thank all the witnesses for your very excellent testimony.

To Ms. Smith, I want to say I have a lot of empathy for your situation, and I applaud your courage for being here today.

My daughter, who is 22 years old, would not be alive today if we didn't go the extra mile as a family to seek out care for her depression several states away because I could not find adequate care in my hometown.

And I have practiced medicine in my home town for 15 years as a cardiovascular surgeon and had pretty good access to just about any health care in a town of 120,000.

So the parity issue—it goes way beyond just simply, you know, the insurance fix that we are looking at in this bill or even the Senate bill.

And I think Jim is nodding his head. He recognizes that, you know, as well, that just doing this is only going to be a real scratch on the surface of the problem, because there are so many other things that affect access to health care. Some have been alluded to today.

I worry that this whole thing is going to degenerate into the usual fight over the ERISA preemption, and, you know, it would be a shame if we don't get anything all the way through the legislative process and onto the president's desk if that were to be the block again.

And I have a quick question. I guess I will start with Mr. Trautwein.

Do the self-insured groups typically have better mental health coverage than other insured groups?

Mr. TRAUTWEIN. I think particularly larger employers were first as the ethic changed from treatment to prevention and management of chronic conditions. I think the better coverage followed that ethic.

Mr. BOUSTANY. Because I worry that if we dismantle the ERISA preemption and take down what a good plan's—then, you know, we are actually doing more damage in the long run, and that is—I guess that is a concern I have.

I know the Senate has worked very hard to strike that balance, looking at the reality of how do you get everybody together to move something forward.

And I guess that is one concern I have about moving this House bill forward, and hopefully we can continue to have serious dialogue as we go forward on it.

Mr. Dilweg, when you were testifying, you mentioned if the Senate bill is enacted, consumers would lose existing state-based coverage guarantees.

But under the bill, wouldn't the states regulating insurance remain undisturbed unless they clearly violate a federal standard?

Mr. DILWEG. I think how we look at the Senate bill is—I mean, obviously, it deals with the ERISA side, and in Wisconsin about 40 percent of my population is under self-insured plans, so we welcome this issue coming to those self-insured plans.

But I also see that we would need to implement new legislation. We have a legislative intent on a very low mandate that has been there for 30 years of $7,000 capped on just an overall cost not specific to benefits.

So it would be beholden to our legislature to enact parity. And for the past 30 years, we have been unable to enact parity. So then I would look at about a third of my population potentially losing their current $7,000 coverage.

And this is also reflected by the state of California as well. Although they have full parity, not a lower coverage than we do, they share our concerns as well on this.

Mr. BOUSTANY. Isn't it true that some states have weaker requirements, clearly? And you know, I guess if we were to enact the Senate bill, it might have a positive impact in some 25 states with weaker existing requirements.

Mr. DILWEG. Well, I also worry that it is easier for employer groups to move state by state and knock down parity laws. So you could have really an all-or-nothing situation in some of these areas. And that is a concern of mine, a concern in Wisconsin.

So you know, the House bill may not be as convenient as the Senate bill, but I am concerned about my consumers, and I am not alone in that, in sharing that.

Mr. BOUSTANY. Mr. Breyfogle, would you like to comment on that?

Mr. BREYFOGLE. Yes. There is a specific provision in the Senate bill that basically says if a state law has a parity component and a mandate component, that the Senate bill only preempts the parity component, leaving the mandate component in place.

You know, what that would do in the Wisconsin case is basically raise the bar, eliminate the $7,000 limit that is permissible in Wisconsin and raise the bar and allow full parity on benefits and some existence of the mandate.

There is a sort of tricky legal question which is because of that, then a state court might look at if this provision is severed, is the rest of the Wisconsin law preempted.

I think the answer is probably not, but the important point is it is the same legal issue even under the House bill, because the House bill says that it would preempt any state law that preempts the application of the new federal standard.

So the problem in Wisconsin is under the House bill, because the parity rule in Wisconsin—there is no parity, so you would have a situation where the $7,000 limit is preempted even under the House bill.

It would be jacked up so you had full parity, and you would still have state courts struggling with the question of given that, would the state of Wisconsin legislature have adopted the original mandate plus parity. So the House bill creates the exact same legal issue for Wisconsin.

And any state that has coupled parity with mandates where the parity rule is not a full one or a complete one has that same issue. So it is really a specious comparison——

Chairman ANDREWS. I am going to just permit Mr. Dilweg to respond. Then we are going to go to Ms. McCarthy.

Mr. BREYFOGLE. Sure, sure.

Mr. DILWEG. Thank you, Mr. Chairman.

I think, you know, you are getting into the detail of preemption here, but I think what I see from my perspective is a lot of experts disagreeing on preemption in the Senate with the Senate bill and a lot of attorneys much wiser than me getting into that.

But I recognize when attorneys disagree that I am going to be in court for about 5 years to 10 years. I look at what is in the House bill and I see the HIPAA model moving forward, and there is pros and cons to that. But that is a working model, and so that is——

Chairman ANDREWS. Yes. We certainly don't want to do anything that would disrupt the ERISA preemption litigation industry. [Laughter.]

Mr. BREYFOGLE. Thank you very much.

Chairman ANDREWS. The bar that has grown up around interpreting ERISA preemption is a very valued part of our committee.

I would go to Ms. McCarthy for 5 minutes.

Mrs. MCCARTHY. Thank you, Mr. Chairman, and thank you for holding this hearing.

And my colleague, Mr. Ramstad, I remember being on the floor at 2 in the morning several years ago when we actually thought we were going to bring the bill up and get it passed.

Unfortunately, here we are many, many years later. I thank you for certainly carrying this through, because it is an important issue.

You know, I think that the majority of us know someone that has gone through mental illness. I can speak for someone in my family who I have watched over 30 years struggle, and I will say that it

is only in the last couple of years that, finally—bipolar, but finally coming up to a medication that actually works for him.

It is a great time right now for what we have seen in the advancement of medications to help people. And it is like night and day. You know, my brother, who I loved through all those years, to see him happy is probably the most rewarding thing.

You talk about medical management, and you know, I have a concern with that, mainly because my office—and I can't speak for other offices—when we see a lot of these health plans that have medical management, there is a constant fight because they are denied, denied, denied, to the point of where our office has to get involved to get the treatment.

And I am not talking about mental illness. I am talking about any kind of health care. So I could see this coming down into our office on trying to fight for people for the care that they should have.

You know, when I hear about CEOs, we know that CEOs want to have mental parity, many because they train a lot of their employees, and it costs them a couple hundred thousand dollars, and yet when they fight to have—whether it is depression or anything else, they are having a hard time, even though they are paying the insurance companies to have that treatment.

It gets down to be a hassle because the patient or the employee is not going to fight constantly to get the treatment that they need, because they will give up on it. And I have seen this too often.

So hopefully, you know, we are going to go down the road and get a bill out that will be good for everybody.

But I guess the question that I wanted to ask—and I will throw this out—on September 11th, we had a national tragedy. Katrina, we had a national tragedy.

And certainly, with 9/11 I am still dealing with—when I say I—the children now. They are all going through post-traumatic syndrome. You can see it through the therapy that they have been getting. We have run out of money.

Those groups that came together to take care of the families and now the children—there is no money for them to take care of them. Most of them don't have the kind of insurance where they can get the treatment that they need.

So I am probably leaning more toward the Ramstad bill, only because people will have the access that is there.

But I guess my question is do you think that the mental health parity regulation would have helped the nation and my constituents recover from this disaster more quickly?

And what do you view as the benefit for having this legislation in place in the event of future national tragedies and disasters like those that we witnessed on 9/11?

Mr. Wellstone, if you have an answer for that, I would love to hear your input.

Mr. WELLSTONE. Yes. Would you be able to repeat that for me again? I am sorry.

Mrs. MCCARTHY. Talk about 9/11. I mean——

Mr. WELLSTONE. Yes. No, I have got your question. I think if we had had a mental health parity bill, it would have helped, abso-

lutely, because people would have been able to access much more treatment.

So the answer is yes, I think it would have.

Mrs. MCCARTHY. Because I dealt with the—certainly, we had a very large impact in Nassau County where I live. But I think the nation as a whole, you know, suffered a great deal of anxiety and depression.

Mr. WELLSTONE. I think you are absolutely right, I mean, and I think it is just the right thing to do. I think it is the right thing to do, to allow everybody to have access to decent treatment and care that is going to help them.

And then when we hear these costs—I mean, it seems like it is very, very iffy if there is even costs at all.

And then when you start to look at the, you know, lost productivity, lost days at work and all that stuff, it sounds to me that we could not only provide fairness to everybody but also save money.

Mrs. MCCARTHY. Well, my background was a nurse before I came here, and I have to say it has been a very tough argument over these years that preventative care or continuous chronic care for anything actually saves money in the end.

But hopefully one day we will win all those battles.

Chairman ANDREWS. Thank you. The gentlelady yields back her time.

We go to Mr. Loebsack for 5 minutes.

Mr. LOEBSACK. Thank you, Mr. Chairman.

I want to thank you, Mr. Ramstad, as I did Patrick Kennedy for coming in. I am a new member here and getting to know folks, and only recently I learned of your involvement in this, so I want to thank you very much.

I mentioned already that my mother suffered from mental illness when I was growing up, and I dare say that—or at least I would guess that maybe everybody in this room has been touched by mental illness in one form or another, and if not mental illness, then some kind of addiction.

So I just think this is such an important hearing that we are having today, and I didn't plan to come back this early, but I did intentionally so I could be a part of this.

So I appreciate the testimony from everyone. I want to make one comment.

Mrs. Carter, you know, I have thought about these issues a lot in the past, in part from a personal standpoint, but I never really made the connection between lack of insurance parity and stigma.

I mean, I have grown up. I am 54 years old. I have thought about the stigma aspect a lot as I have grown up, but I never thought about it in terms of lack of insurance parity. Can you just comment a little bit more on that, that connection?

Mrs. CARTER. I really believe that when insurance covers an illness that it makes it all right to have. I really believe that. I have seen that with other illnesses, not mental illnesses, but cancer, for instance.

I remember when nobody spoke about cancer and nobody would mention the word. And the stigma was terrible. And when you—are you familiar with Kay Jameson?

Mr. LOEBSACK. No, I am not.

Mrs. CARTER. She says that when you find a cure for a disease, the stigma goes away. Well, there is cancer treatment now, but there is—and there may be a cure for some of them, but not for all.

And I think we are approaching that with mental health. We have so much better treatment today, and I think that if insurance covers it—for instance, in some of the companies that we have been watching for years, when mental health coverage was available through the insurance, through the company, it took a while for people to access it.

The stigma was still there. But then after a while, one would go, and then another one would go, and then pretty soon it just became the thing to do, to access this coverage.

And so I think parity will not only help people who suffer because they cannot pay for help, but it will also lift the stigma.

Mr. LOEBSACK. Thank you.

Also, I guess when I listen to folks who are concerned about the cost of coverage from an employer standpoint, I get very frustrated, obviously. I understand the concerns, the costs and all the rest.

But it also sort of makes me think about just sort of the 47 million Americans who are without health insurance, period, let alone extending it for mental health issues.

And I have one question for Ms. Smith, because I am not sure you have been asked a question yet, but I am a new member of Congress, and so when I come to hearings or prior to the hearings, I have a very steep learning curve on so many issues.

And I can only imagine what is going through your mind as you are listening to all this today. But I do want to ask you, what are your impressions of what you have heard today?

Because you have a wonderful compelling story that you told us, but what do you think about this debate today?

Ms. SMITH. I think that we are right at the dawn of a new age in terms of mental health. And I really agree with Mrs. Carter that I believe that the stigma is lifting and that the treatments are much, much improved over years in the past, where they were actually barbaric in some cases.

And this particular hearing today really fills me with hope, because, like so many people have said, it is the right thing to do. And to hear that over and over again from all these people is really thrilling.

Mr. LOEBSACK. Thank you.

Thanks to all of you.

And thank you, Mr. Chairman.

Chairman ANDREWS. Thank you.

Mrs. CARTER. Could I say one other thing?

Mr. LOEBSACK. Yes, please.

Mrs. CARTER. I didn't mean we are approaching the time when stigma is gone.

Mr. LOEBSACK. I understand.

Mrs. CARTER. I mean we are approaching the time when we have good treatments and know a lot more about the brain and how to deal with mental illnesses.

Mr. LOEBSACK. Thanks for all your efforts.

Chairman ANDREWS. Before we go to Mr. Hare, Mrs. Carter, it is my understanding that your later flight has been canceled and you need to depart by 5 o'clock.

If you need to leave now, that is fine, but we have one more questioner with Mr. Hare, so we will be finished at about 4:55. It is entirely up to you.

Mrs. CARTER. I think if I leave by—I have to leave by 5:00, they tell me.

Chairman ANDREWS. Very well.

Mr. Hare, you are on for 5 minutes.

Mr. HARE. I promise you, Mrs. Carter, I will go fast. I know what it is like. I had a 5-hour flight, too, from Illinois back.

And I want to thank you all for coming.

I, too, like my friend Dave Loebsack, am a new member, but just as a personal aside, if I could, Mr. Wellstone, I had the honor of meeting your dad twice.

And I have to tell you that from my perspective, I have never met a better public servant than your father. He was a tremendous man. And you know, I thank you for picking up that torch and moving it.

It seems to me that if we are talking about this debate today—and Ms. Smith said she was glad to hear this—and I apologize for being late on the testimony, Mr. Wellstone.

But one thing you said that was incredibly compelling to me is that every 16 minutes a child or adult takes their life because of depression and the pain of depression and untreated and other mental illnesses associated with it. I think the clock is ticking pretty fast here.

And so I commend you, Mr. Chairman, for having the hearing. And I want you to know that from this freshman's perspective, H.R. 1424—we need to move this thing very, very quickly.

And I am honored, Mr. Ramstad, to be a co-sponsor of the bill, because I think it is incredibly important.

And so I just want to thank you all for that. I just had two quick questions.

And one for you, Mrs. Carter, and I know you have to leave. You know, from your perspective, could you go into a little bit of detail—if Congress doesn't act on this parity act in a meaningful period of time here, what, from your perspective—what it is going to have regarding mental health care treatment and why it is so necessary that we get this thing quickly and correctly?

Mrs. CARTER. I think it will be a tragedy if this bill is not passed now. We have had three reports—I named them before; the surgeon general's report, President Bush's New Freedom Commission report—and they all confirm that the mental health system in this country is in a shambles and that there is no way to repair it. We have to start over.

There is no way to start over and do anything now. I mean, it takes a long time. And there is great opportunity now to pass parity and get help for people who suffer.

People are suffering in our country, and I just get very distressed about it, because it seems like we don't provide help for them, and we don't even have a guilty conscience about it.

I am just so hopeful that parity is going to pass. It will mean so much to our country.

Mr. HARE. Well, I believe, Mrs. Carter, in my heart of hearts, it is going to pass.

You know, I want to thank you for everything you have done on this, and you know, one way or another, it is—I am a new kid on the block here, but you know, we will get her done. And I think it is incredibly important.

Mr. Breyfogle, you mentioned that the Senate mental health parity legislation is better than the House bill because it doesn't mandate coverage of all illnesses listed under the DSM-IV.

But in Mrs. Carter's experience working with behavioral diseases, she says that all mental illnesses are potentially devastating, so therefore covering all of them is critical, it seems to me.

And I guess, you know, we need to treat all illnesses defined in DSM-IV in order to eliminate the stigma—and we have heard about that—surrounding the mental illness which prevents people from seeking long-term treatment and costs more in the long run.

I was wondering if you could maybe just respond to that.

Mr. BREYFOGLE. I think the point isn't to pick out anything in the DSM-IV that we don't think should be covered or we don't think is appropriate.

I think from an employer's perspective being able to design the terms of your health plan is critical in terms of how you allocate a scarce set of resources to cover a group of people. And so it is a basic tenet.

There is no manual that is mandated for traditional inpatient medical benefits that is mandated under law that you have to cover every particular thing.

And it is sort of a critical point that employers have which is that they need the flexibility to design their health plans to target coverage in a way that they think is most effective for their particular workforce.

It is not that there is anything in the DSM-IV that employers would point to and say this is unworthy. Not every employer can afford the most expensive health plan. Some industries are much more competitive than others. Some employers are just struggling to have a health plan.

And so a mandate that requires really an unprecedented—and further than parity—for this as mental health—the statute is going to define everything that is covered, whereas for non-mental health, the statute is silent. That is really not parity, in our view.

Mr. HARE. Well, I think it—just to conclude, Mr. Chairman, I think it would be a wonderful day when we pass this legislation for people who have mental illness and their families, because it isn't just the person with the mental illness that is affected. The entire family is.

And if not now, you know, when? And if not us, you know, who?

So I yield back. Thank you, Mr. Chairman.

Chairman ANDREWS. I thank the gentleman for yielding.

I want to thank each of the witnesses for their efforts and their testimony today. I think you have given the committee an excellent record with which to work as we go forward.

Mr. Kline, did you have any concluding remarks?

I did want to say to Mrs. Carter again how very, very honored we are to have you with us.

And just as a personal aside, I grew up in a town called Bellmawr, New Jersey, and in 1976 when then Governor Carter was seeking the presidency, you came to our home town. I was not present. I was in college at the time.

But my father and mother went to see you. I think half the town did. And I will tell you that your picture is in the town hall. Your visit was regarded as one of the great moments in the history of our community.

And I think it shows you the esteem with which you are held across the country by people. We thank you very much for your participation here today. Thank you, Mrs. Carter.

And we thank the other witnesses.

And I would ask unanimous consent that letters from the attorney generals of Maryland, Washington and Connecticut and from the National Association of Insurance Commissioners be entered into the record.

Without objection.

[The letters follow:]

RICHARD BLUMENTHAL	KEVIN LEMBO
ATTORNEY GENERAL	HEALTHCARE ADVOCATE
State of Connecticut	**State of Connecticut**

June 25, 2007

Honorable Christopher J. Dodd
United States Senator
SR 448
Russell Senate Office Building
Washington, DC 20510-0702

Dear Senator Dodd:

We write to express our continued concerns with S. 558, the *Mental Health Parity Act*. While we strongly support the federal effort to expand critical mental health insurance benefits, we remain concerned that Connecticut's mental health parity laws which mandate the provision of a broad range of mental health services may be adversely affected by S. 558. A recent review of S. 558 and its impact on state mental health parity laws by the Georgetown University Health Policy Institute found that S. 558 may preempt Connecticut, California, Maryland, Nevada and other state laws, thereby reducing protections for people with mental illness in those states.

The recent mark-up of the bill fails to ensure that Connecticut's mental health parity law will not be preempted by a federal law that establishes lower standards of mental health insurance. For example, S. 558 does not mandate the provision of mental health services as Connecticut's law does. Further, S. 558 allows for the insurers to be exempt from the parity requirements if the cost of the mandate increases costs more than 2%. Connecticut's law does not allow for any cost exemptions. For there to be true mental health parity, mental health services must be provided without regard to artificial cost thresholds that would never be tolerated for physical health insurance policies.

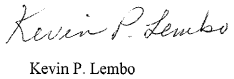
Traditionally, states have regulated insurance, and as in most other areas, states have been free to offer more protections than those offered under federal legislation. Therefore, we support federal mental health parity legislation that creates a floor, rather than a ceiling; protects our

strong state laws; is unambiguous; and, does not allow plans to escape the existing state mental health parity requirement.

We appreciate your consideration of our concerns and your recognition of the importance of meaningful mental health coverage for the people of Connecticut and the United States. Thank you for your continued attention to this critical matter.

Sincerely,

Richard Blumenthal
Attorney General



Kevin P. Lembo
State Healthcare Advocate

cc: CT MH Groups

DOUGLAS F. GANSLER
Attorney General

KATHERINE WINFREE
Chief Deputy Attorney General

JOHN B. HOWARD, JR.
Deputy Attorney General

STATE OF MARYLAND
OFFICE OF THE ATTORNEY GENERAL

TELECOPIER NO.
410-576-7036

WRITER'S DIRECT DIAL NO.
410-576-6311

July 5, 2007

The Honorable Benjamin L. Cardin
B40 Dirksen Senate Office Building
Washington, D.C. 20510-2002

Re: Senate Bill 558 - Mental Health Parity Act of 2007

Dear Senator Cardin:

I write to convey my concerns regarding the impact of S. 558, the Mental Health Parity Act of 2007 on Maryland law. I strongly support legislation that expands mental health benefits, including a federal mandate of full parity. I also applaud the efforts of the Senate to achieve that parity without stripping consumers of state law rights and protections. In response to a previous inquiry from Senator Mikulski's staff, my office pointed out the risk that, as originally introduced, S. 558 would preempt Maryland's mandated mental health benefit, including out-of-network mandates, and I was gratified to see that the June 13, 2007, Manager's Amendment does attempt to resolve those preemption concerns.

I nonetheless remain concerned that S. 558 may not achieve its laudable objectives and could actually hurt state consumers. First, questions have been raised as to whether the amendments clearly preclude preemption of all state insurance laws that govern mental health benefit requirements. I would urge caution with respect to the bill until consensus is reached on this critical element of the Manager's Amendment. I am working with my staff, with consumer representatives, the Maryland Insurance Administration and other state regulators and Attorneys General to analyze this language and will be happy to provide you with assistance in assuring that state laws relating to substantive mental health benefits are preserved.

Second, the bill continues to establish a federal ceiling for parity, as opposed to a federal floor. While the federal parity provisions appear to be, at this point, more generous than those currently afforded under Maryland's insurance laws, I urge reconsideration of this approach, both for the precedent it sets and for the limit that it establishes on future efforts by this State to

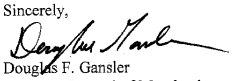
regulate its local health insurance market and to determine what is in the best interest of Maryland consumers.

Finally, the Manager's Amendment makes no change to the cost exemption contained in S. 558. The effect of a waiver under the cost exemption appears to be the elimination of all parity. The bill does not incorporate any express safety net, such as requiring an insurer to continue the parity provisions that existed prior to the application of the federal law, in the event a waiver is granted. Given that, the exemption is of great concern, particularly because the trigger appears low, it is uncertain how the cost of compliance to the plan will be calculated where the plan is fully insured, and there do not seem to be adequate regulatory safeguards in place to verify cost analyses.

As noted, I am reviewing the issues raised in the bill and I urge you withhold passage until any concerns the bill raises are addressed. My office is, of course, available to assist both you and the Senate Committee regarding these issues.

If you have any questions, please feel free to contact me directly.

Sincerely,



Douglas F. Gansler
Attorney General of Maryland

cc: Senate Committee on Health, Education, Labor and Pensions

DOUGLAS F. GANSLER
Attorney General

KATHERINE WINFREE
Chief Deputy Attorney General

JOHN B. HOWARD, JR.
Deputy Attorney General

STATE OF MARYLAND
OFFICE OF THE ATTORNEY GENERAL

TELECOPIER NO.
410-576-7036

WRITER'S DIRECT DIAL NO.
410-576-6311

July 5, 2007

The Honorable Barbara A. Mikulski
503 Hart Senate Office Building
Washington, D.C. 20510-2003

Re: Senate Bill 558 - Mental Health Parity Act of 2007

Dear Senator Mikulski:

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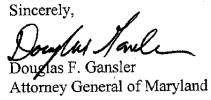

Douglas F. Gansler
Attorney General of Maryland

cc: Senate Committee on Health, Education, Labor and Pensions

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NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

May 2, 2007

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6th Floor
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10005-2906
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WORLD WIDE WEB
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The Honorable Edward M. Kennedy
Chairman
Health, Education, Labor & Pensions Committee
United States Senate
Washington, D.C. 20510

The Honorable Michael B. Enzi
Ranking Member
Health, Education, Labor & Pensions Committee
United States Senate
Washington, D.C. 20510

Dear Chairman Kennedy and Ranking Member Enzi:

As the United States Senate prepares to consider Mental Health Parity legislation, S. 558, which was passed by your Committee, we would like to express the objection of the nation's health insurance regulators to a specific provision in the bill.

Section 4(c) of the Committee-passed bill would supersede any state law that conflicts with the parity, negotiation and management, in- and out-of-network, or cost exemption provisions of the bill. Effectively, this creates both a floor and a ceiling that would eliminate the authority of states to provide greater protection for consumers in these specified areas. The members of the National Association of Insurance Commissioners (NAIC) find this limitation on the ability of state legislators and policymakers to do what they believe is right for their constituents both excessive and unnecessary.

Instead, should the Senate decide to include any preemption language in the bill, we would prefer the language in the Mental Health Parity bill currently being considered in the House of Representatives. As currently drafted, the House version, H.R. 1424, specifically states that nothing in the federal legislation "shall be construed to preempt any State law that provides greater consumer protections, benefits, methods of access to benefits, rights or remedies."

When S. 558 moves to the Senate floor, we urge you to preserve the authority of states to establish appropriate mental health protections for their residents. This would make S. 558 consistent with other federal laws, such as the Health Insurance Portability and Accountability Act (HIPAA), and make it better for consumers.

Thank you for your consideration in this important matter.

Sincerely,

Walter Bell	Sandy Praeger	Catherine J. Weatherford
Commissioner of Insurance	Commissioner of Insurance	Executive VP and CEO
State of Alabama	State of Kansas	
NAIC President	NAIC President-elect	

Chairman ANDREWS. As previously ordered, members will have 14 days to submit additional materials for the hearing record.

We thank each of the witnesses for doing a great job today.

And we declare the hearing closed.

[Additional submission from Mr. Andrews follows:]

Prepared Statement of Raymond F. Anton, M.D., President, the Research Society on Alcoholism

The Research Society on Alcoholism (RSA) welcomes the opportunity to submit this statement in support of the "The Paul Wellstone Mental Health and Addiction Equity Act of 2007," (H.R. 1424). 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 the National Institutes of Health (NIH) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) to stimulate critical and innovative re-

search initiatives in an effort to address the 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. The fruits of such research will not be fully realized, however, unless those who have alcohol-related conditions have access to the care and treatments which they need. For this reason, RSA respectfully urges the Education and Labor Committee to ensure that the Paul Wellstone Mental Health and Addiction Equity Act, introduced by Representatives Patrick Kennedy (D-MA) and Jim Ramstad (R-MN), is approved and travels an expeditious path to the House floor. The bill is a critical step in the prevention and treatment of alcoholism and the illnesses, injuries, and personal and economic loss associated with the abuse of alcohol.

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, their communities, and society as a whole. Untreated addiction costs America $400 billion annually and recent research indicates that alcoholism and alcohol abuse alone costs 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, 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 of physical and mental birth defects that last throughout the life of a child.

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, neurological and cardiovascular impairment as well as social and psychiatric problems.

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 that 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 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 pre-emptive 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 in 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 first Call to Action against underage drinking issued by the Surgeon General's Office on March 6, 2007.

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.

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 an 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.

Alcohol abuse and alcoholism are devastating problems of national importance. Fortunately, alcohol research has reached a critical maturity. RSA is committed to stimulating critical and innovative research initiatives to address the myriad of health problems that are directly attributable to heavy alcohol use, alcohol abuse, and alcoholism. RSA understands all too well the substantial costs which alcoholism and alcohol abuse impose on individuals and the health care system. We also know that mental health and addiction parity legislation is necessary to ensure that access to critical services is available to those who need it. We urge Congress to pass the Paul Wellstone Mental Health and Addiction Equity Act of 2007 as soon as possible.

[Additional submissions from Mr. Kline follow:]

June 14, 2007

The Honorable Edward M. Kennedy
The Honorable Michael B. Enzi
The Honorable Pete V. Domenici
United States Senate
Washington, DC 20510

Dear Chairman Kennedy and Senators Enzi and Domenici:

We write in joint and strong support of prompt Senate action on the manager's amendment to the bipartisan Mental Health Parity Act of 2007, S. 558. We support enactment of your balanced legislation into law this year.

Organizations representing consumers, family members, health professionals, and health care systems and administrators, business associations and insurance organizations negotiated in good faith with you and your staff over an extended period to produce this bill. We believe that it is a strong bill that will advance the interests of the greater mental health community while balancing the interests of employers who voluntarily sponsor benefit coverage. This bill also respects the role of the states in the regulation of insurance.

We urge its prompt adoption by the full Senate and will join you in opposing unacceptable or weakening amendments during the Senate debate and will remain committed to this bipartisan approach as this legislation moves forward. Thank you again for your joint leadership on this important issue.

Sincerely,

National Retail Federation
National Association of Wholesaler-Distributors
National Association of Health Underwriters
Society for Human Resource Management
National Association of Manufacturers
National Federation of Independent Business
Aetna
U.S. Chamber of Commerce
BlueCross BlueShield Association
CIGNA

American Hospital Association
American Psychiatric Association
American Psychological Association
Association for Behavioral Health and Wellness
Federation of American Hospitals
National Alliance on Mental Illness
National Association of Psychiatric Health Systems

U.S. Chamber of Commerce

July 10, 2007

The Honorable Rob Andrews
Chairman
Subcommittee on Health, Employment, Labor and Pensions
House Committee on Education and Labor
2175 Rayburn Office Building
Washington, D.C. 20515

Dear Chairman Andrews:

On behalf of the U.S. Chamber of Commerce, we would like to thank the Health, Employment, Labor and Pensions Subcommittee for holding the hearing on H.R. 1424, the *Paul Wellstone Mental Health and Addiction Equity Act of 2007*. The U.S. Chamber of Commerce is the world's largest business federation, representing more than 3 million businesses and its membership includes businesses and organizations of every size and in every sector of the economy.

Many of our member companies provide valuable healthcare benefits to their employees, and are committed to providing comprehensive benefits that are fair and equal. In doing so, they recognize the importance of providing mental health benefits. However, we do not believe that mandating benefits which may lead to the erosion of federal laws in the name of "fairness" accomplishes the goal that we all seek. Rather, such changes could have the ultimate effect of causing employers to stop offering health care coverage. Under the Employee Retirement Income Security Act (ERISA), employers voluntarily provide healthcare benefits to over 140 million workers.[1] We urge Congress to proceed cautiously in this area so as not to upset the voluntary system and the benefits it provides for millions of workers. With this in mind, the Chamber would like to highlight several concerns we have with H.R.1424 and its impact on the voluntary employer-provided system. On behalf of the Chamber and its membership, we respectfully request that this letter be included in the hearing record.

Introduction

The Chamber believes that changes to the voluntary system of employer-provided healthcare need to be carefully considered and analyzed for possible negative effects. Under the leadership of Senate Health, Education, Labor and Pensions ("HELP") Committee Chairman Edward Kennedy, HELP Committee ranking member Senator Mike Enzi and Senator Pete Domenici, the Chamber has been working with a number of interested parties from different perspectives to create a bi-partisan

[1] U.S. Census Bureau: Income, Poverty, and Health Insurance Coverage in the United States (2005).

bill that represents true compromise between all interested parties. We believe that the result of this effort – S. 558 – is a well-balanced and reasoned approach to mental health parity. Unfortunately, we do not see the same balanced approach in the House parity bill and would urge that several changes be made to the legislation as it is considered further by committees of jurisdiction in the House of Representatives.

Concerns

The House Parity Bill Creates a Benefits Mandate. Under the House parity bill, H.R. 1424, a plan that provides any mental health or substance-related disorder benefits must cover all conditions listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) manual which is used by mental health care professionals to identify and categorize all disorders. The American Psychiatric Association (APA) developed the DSM-IV manual "to facilitate communication among mental health professionals" and "provide convenient shorthand when communicating about patients."[2] This manual was not developed with the purpose of being a diagnostic guide for reimbursement of healthcare benefits. As such, this provision goes beyond parity and creates a mandatory benefit requirement for any plan that wants to provide mental health benefits.

Employers use a great deal of experience and logic to create plans that offer physical and mental healthcare treatment to their employees. Employers take into consideration the needs of their workers, the costs of treatment, and expected results. However, the House bill would force employers to treat all conditions in the DSM-IV, including some that an employer may find arbitrary or unrelated to its workforce. Under H.R. 1424, employers would no longer have discretion over benefit coverage decisions which will undoubtedly drive up costs and may force some employers to discontinue health coverage.

In contrast, the Senate's proposed parity bill, S. 558, maintains employer discretion with respect to benefit coverage decisions by allowing employers to designate which mental health facilities and conditions are bona fide and which should not be covered under their plan. Moreover, the Senate bill will meet Representative Kennedy's goal of ensuring equality in benefit coverage without imposing strict mandates that result in overwhelming costs to employers. If the House bill is adopted, employers will be forced to contribute more resources to an already overpriced health care system which will ultimately compromise the ability of employers to provide health insurance to their employees.

Medical Management Practices Must be Protected. As Congress considers passage of a Mental Health Parity bill, it is essential to protect the ability for health plans to manage coverage for substance-related disorders and mental health conditions. There is significant work being done to agree upon evidence-based measures of quality health care that will create a more transparent and accountable health care system. Over the past several years, clinical specialty groups have worked diligently to determine the appropriate level of care and expected outcomes for patients for a wide range of conditions. Health care providers are now moving away from the "trust" system of coverage and are now requiring transparency so that customers will know the precise cost of care and be able to better make informed decisions about treatment. Through this system of improved

[2] http://www.psych.org/research/dor/dsm/dsm_faqs/faq81301.cfm

transparency and accountability, we will unquestionably put health care reform in the right direction. Unlike the Senate bill or previous mental parity bills considered by Congress, the House bill (H.R. 1424) does not offer specific protection for the use of medical management tools.

Therefore, these efforts should be encouraged through the inclusion of protections for medical management practices that allow plans to appropriately manage coverage for mental health conditions and substance-related disorders. Without protections in place, there is a risk that state or federal laws may undercut or diminish these efforts. Furthermore, it is essential to safeguard these advances so employers are able to provide quality health care coverage to workers while also maintaining cost-effective plans.

The House Bill Mandates Out-of-Network Coverage. If a health plan provides coverage for most medical emergency services, in-patient and out-patient services on an out-of-network basis, the House bill mandates out-of-network coverage for mental health and substance-related disorders as well.[3] The provision creates a new mandate and impedes upon the states' authority to regulate fully-insured health plans. Although ERISA preempts most state interference with benefit plans, it specifically excludes the area of insurance.[4] This new mandate not only interferes with the federal rules but also impedes upon an area that Congress specifically left to the states to determine. The Senate bill requires parity between out-of-network medical and surgical benefits and out-of-network mental health benefits but it does not mandate that the employer provide all mental health benefits on an in-network basis.[5] The Chamber believes that this approach is fair and reasonable. Moreover, this provision fulfills the objective of expanding mental health parity standard without imposing the harsh mandates of the House bill.

The House Bill Gives States Overly-Broad Authority. The House bill (H.R. 1424) authorizes states to provide "greater consumer protections, benefits, methods of access to benefits, rights or remedies" than those in the legislation.[6] Such broad language gives states the ability to develop parity laws for fully-insured health plans that are "greater" than those in the House bill and could differ significantly from federal standards under ERISA. As such, this provision could provide states with the authority to enact consumer protections that exceed the applicable federal standards. Such a scenario would allow states to adopt their own enforcement and remedy schemes. As mentioned above, ERISA contains an established compromise between state and federal jurisdictions. Removing this compromise will upset the intended uniformity that the creators of ERISA intended.[7]

Do Not Erode ERISA Preemption. It is of utmost importance to the U.S. Chamber and its members that ERISA preemption be protected in any mental health parity bill passed by Congress. When ERISA was enacted in 1974, the preemption provisions were supported by both labor and the business community, who argued for uniform federal protection rather than being subject to the

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[3] H.R. 1424, 110th Cong. § 2(d) (2007)
[4] ERISA § 514(b)(2).
[5] S. 558 § 2(a).
[6] H.R. 1424 § 2(h).

[7] In Shaw v. Delta Air Lines, 463 U.S. 85 (U.S. 1983), the Court quoted Senator Williams as stating that one goal of ERISA was to avoid "conflicting or inconsistent state and local regulation of employee benefit plans" *citing* 120 Cong. Rec. 29933 (1974).

various laws of each state. Section 514 of ERISA preempts all state laws that "relate to any employee benefit plan," with certain exceptions. Throughout the years, the Supreme Court has reinforced the preemption provision by holding that ERISA prohibits both state laws that *directly* regulate employer-sponsored health plans, such as mandating that employers offer health insurance, and some laws that only *indirectly* affect plans, such as regulating the provider networks ERISA plans may use.[8]

In addition to the specific instances mentioned above, we must state our opposition to any consideration of provisions that may lead to the erosion of ERISA preemption. Without this protection, employers could face a myriad of state and local law requirements that would make the maintenance of a health plan an untenable burden. ERISA's uniformity for employer-sponsored coverage is based on sound public policy and is vital to their ability to offer voluntary health coverage to their employees.

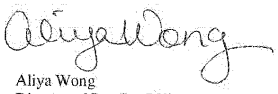
Conclusion

Again, we appreciate the work done by the Chairman and his colleagues on this very important issue. We have several concerns about the House bill and urge the House Education and Labor Committee, as well as the other committees of jurisdiction to address these issues. We look forward to continuing to work with the Chairman and other members of House in bringing forth mental health parity legislation that equalizes the treatment of mental health benefits without jeopardizing the voluntary-nature and uniformity of the current employer-provided system.

Thank you for your consideration of our concerns.

Sincerely,

Randel K. Johnson
Vice President
Labor, Immigration & Employee Benefits



Aliya Wong
Director of Pension Policy
Labor, Immigration & Employee Benefits

[8] The Supreme Court has interpreted the preemption clause very broadly to carry out the congressional objective of national uniformity in rules for employee benefits programs. The Court has held that ERISA preempts state laws that either refer explicitly to ERISA plans (i.e., all plans offered by private-sector employers) Mackey v. Lanier Collection Agency, 486 U.S. 834 (1988); District of Columbia v. Greater Washington Board of Trade, 506 U.S. 125 (1992) or have a substantial financial or administrative impact on them. Shaw v. Delta Air Lines, 463 U.S. 85 (1983); Metropolitan Life In. Co. v. Massachusetts, 471 U.S. 724 (1985); Aiessi v. Raybestos-Manhattan, Inc. 451 U.S. 504 (1981).

[Prepared statement of the American Occupational Therapy Association, submitted by Mr. Wu, follows:]

Prepared Statement of the American Occupational Therapy Association (AOTA)

The American Occupational Therapy Association (AOTA) submits this statement for the record of the July 10, 2007 hearing. We appreciate the opportunity to provide this information regarding the relationship of occupational therapy services to mental health and substance abuse treatment and highlighting the unique contributions of occupation based interventions. AOTA fully supports passage of H.R.1424, The Paul Wellstone Mental Health and Addiction Equity Act of 2007 and joins several hundred national advocacy organizations and a majority of House members in urging rapid passage of the bill.

Occupational Therapy for People with Mental Illness and Substance Abuse Disorders

Occupational therapy is concerned with an individual's ability to do everyday activities, or occupations, so that they can participate fully at home, work, and in the community. Occupational therapy practitioners use purposeful activities as therapy to help individuals with functional impairments, regardless of the cause, to maximize performance and independence. The profession has been guided by a holistic approach with an emphasis on psychosocial factors that impact human function. Occupational therapy brings a rehabilitation perspective to mental health and substance abuse treatment in keeping with increased emphasis on recovery and functionality.

The expertise of occupational therapy in the assessment and treatment of function and functional impairment across the lifespan argues for occupational therapy practitioners' full inclusion in mental health and substance abuse systems of care. Inclusion would ensure that their unique educational preparation and experience can be utilized for the benefit of people with mental illness and substance abuse conditions. According to the Institute of Medicine's Quality Chasm report, Improving the Quality of Health Care and Substance Abuse Conditions (November 2005), integration and collaboration among mental health practitioners is crucial to improving the mental health system. AOTA believes that inter-disciplinary teams maximize the level of expertise and experience available to a patient with mental illness. The federal New Freedom Initiative also calls upon the nation's mental health system to deliver higher quality, integrated services that contribute to more successful outcomes for people with mental illness. Occupational therapy is an essential part of the mental health assessment, treatment planning, and intervention process that will improve and restore function and independence for people affected by mental illness. There is also a distinct activity-based role for occupational therapy in both the acute treatment and recovery models of substance abuse treatment.

Occupational therapy practitioners work with people throughout the lifespan and in all types of settings where mental health services, substance abuse treatment and psychiatric rehabilitation are provided. Through the use of real life activities as therapy, occupational therapy practitioners improve functional capacity and quality of life for people with mental illness and substance abuse in the areas of employment, education, community living and home and personal care. As well as providing care in home and community based settings, in roles such as case mangers, occupational therapists continue to work in traditional mental health settings such as hospitals, state mental health institutions and partial hospitalization programs. Occupational therapy is covered by Medicare as a mental health service, especially in the partial hospitalization program. It is also recognized in many state mental health programs.

AOTA believes that occupational therapy is an underutilized service for people with mental health and substance abuse disorders that can meet and address independent living and recovery needs. This limited access affects both substance abuse and mental health systems of care and the limitation is often due to a lack of understanding about how occupational therapy can help or because of perceptions that therapists only address impairments of function caused by physical illness or injury. Occupational therapy can be invaluable in helping individuals maximize performance and develop or maintain skills for independent living and recovery consistent with a rehabilitation model of care. Recognizing the potential of occupational therapy to address functional impairment for people with mental illness and addictive disorders is essential to moving toward a recovery model for mental illness and substance abuse treatment that takes into account the importance of community integration and independence.

AOTA is committed to working collaboratively with other mental health and substance abuse providers and consumer advocacy organizations to improve the integration and coordination of services to meet the needs of patients suffering from these conditions. Occupational therapy's unique perspective and focus on activities of meaning can deliver positive outcomes for patients in regard to both community integration and recovery. Fully utilizing the expertise and knowledge of occupational therapists to minimize functional impairment caused by behavioral and substance abuse disorders and to maximize independence is an essential part of developing more integrated and effective systems of care.

Again, we thank you for the opportunity to comment on the role of occupational therapy in improving mental health and substance abuse services and to express our support for mental health and substance abuse parity. We look forward to continue working with the Committee to improve treatment and outcomes for people with those conditions.

[Whereupon, at 4:59 p.m., the subcommittee was adjourned.]

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