ASSESSING MENTAL HEALTH PARITY: IMPLICATIONS FOR PATIENTS AND EMPLOYERS

HEARING

BEFORE THE

SUBCOMMITTEE ON EMPLOYER-EMPLOYEE RELATIONS

OF THE

COMMITTEE ON EDUCATION AND THE WORKFORCE

HOUSE OF REPRESENTATIVES

ONE HUNDRED SEVENTH CONGRESS

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HEARING ON ASSESSING MENTAL HEALTH PARITY:

IMPLICATIONS FOR PATIENTS AND EMPLOYERS

Wednesday, March 13, 2002

U.S. House of Representatives

Subcommittee on Employer-Employee Relations

Committee on Education and the Workforce

Washington, D.C.

The Subcommittee met, pursuant to notice, at 3:48 p.m., in Room 2175, Rayburn House Office Building, Hon. Sam Johnson, Chairman of the Subcommittee, presiding.

Present: Representatives Johnson, Roukema, Ballenger, McKeon, Tiberi, Andrews, Kildee, Rivers, and Tierney.

Staff present: Kristin Fitzgerald, Professional Staff Member; Dave Thomas, Legislative Assistant; Victoria Lipnic, Workforce Policy Counsel; Heather Valentine, Press Secretary; Patrick Lyden, Professional Staff Member; Allison Dembeck, Executive Assistant; Deborah L. Samantar, Committee Clerk/Intern Coordinator; Michele Varnhagen, Minority Labor Counsel/Coordinator; Camille Donald, Minority Counsel/Employer-Employee Relations; and, Dan Rawlins, Minority Staff Assistant/Labor.

Chairman Johnson. A quorum being present, the Subcommittee on Employer-Employee Relations will come to order. We're meeting today to hear testimony on assessing mental health parity and its implications for patients and employers.

Under Committee Rule 12(b), opening statements are limited to the Chairman and Ranking Member of the Subcommittee. Therefore, if other Members have statements, they will be included in the hearing record. With that, I ask unanimous consent for the hearing record to remain open for 14 days to allow members' statements and other extraneous material referenced during the hearing to be submitted in the official hearing record.

Hearing no objection, so ordered.

OPENING STATEMENT OF CHAIRMAN SAM JOHNSON, SUBCOMMITTEE ON EMPLOYER-EMPLOYEE RELATIONS, COMMITTEE ON EDUCATION AND THE WORKFORCE

Good afternoon. Let me extend a warm welcome to all of you, and especially you, Mr. Kennedy, welcome, and to my colleagues Mr. Andrews, Mr. Tiberi, and Mr. Ballenger.

Today's hearing will focus on mental health parity and how it will affect patients and employees. Specifically, the hearing is going to investigate current and proposed laws to provide mental health care to patients.

As you know, in 1996, the Congress enacted the Mental Health Parity Act. This Act prevented employers from establishing annual or lifetime mental health care coverage limits unless the limits also applied to medical and surgical benefits. However, the law did not require employers to provide mental health care coverage but simply imposed new requirements if they were offered.

When the law expired at the end of 2001, the Senate passed legislation significantly expanding mental health parity requirements. The Senate legislation would require that both mental health and medical and surgical coverage have identical financial requirements and treatment limitations. In English, that means that when you visit the doctor, you'll have the same co-pay and number of allowable visits, no matter what the cost.

Employers and others expressed concerns about the Senate legislation. Employers are already dealing with yearly average premium increases of 15 percent or more, and they're worried that they may have to drop coverage altogether because of parity requirements, and increased costs due to several new legislative proposals, including the Patients' Bill of Rights. Because of concerns such as these, and because no House committee had fully examined the impact, Congress opted for a simple one-year reauthorization in the 1996 law.

Today, we will look at this issue in detail. We want to hear the concerns of mental health advocates about access to mental health services, and in addition, we want employers and care managers to explain how requirements would impact the care they provide today. We also have a state law expert who will shed some light on how the states are balancing the concerns of advocates and employers. After thoroughly examining mental health parity in today's hearing, the Subcommittee may look at specific proposals that would strike the appropriate balance between the

concerns of advocates and employers.

I look forward to working with my colleagues on both sides of the aisle, as we examine the issue.

WRITTEN OPENING STATEMENT OF CHAIRMAN SAM JOHNSON, SUBCOMMITTEE ON EMPLOYER-EMPLOYEE RELATIONS, COMMITTEE ON EDUCATION AND THE WORKFORCE – SEE APPENDIX A

Chairman Johnson. Right now, I'd like to welcome all our witnesses. We look forward to your testimony and the guidance it will offer us as we address the issue of mental health parity.

Mr. Andrews, do you have a statement?

Mr. Andrews. I do. Thank you, Mr. Chairman.

OPENING STATEMENT OF RANKING MEMBER ROBERT ANDREWS, SUBCOMMITTEE ON EMPLOYER-EMPLOYEE RELATIONS, COMMITTEE ON EDUCATION AND THE WORKFORCE

I first want to thank you for having this hearing, which I think is an important step along the way toward addressing this problem, and I want to commend and congratulate my colleagues, Mrs. Roukema and Mr. Kennedy, for taking a leadership role in this. This is more than just a matter of legislative priority. It's a matter of personal commitment for both of you. I know that, and I appreciate it very much.

I would be remiss if I didn't add a personal note for Mrs. Roukema, that we are all optimistic and hopeful for her complete good health in years to come, and admire her persistence, which is entirely characteristic of her career here in the Congress, and we know that she will be an important voice in this country for many years to come.

I strongly support mental health parity, but I think those of us who advocate the need for it need to come up with a more descriptive term to talk about what we're talking about. One of the ways that I understand mental health parity is that the lack of it is the barrier between recognizing problems and solving them.

Three years ago this spring we had probably the worst outbreak of violence in an American school in our country's history, Columbine High School in Colorado. I don't know what all the facts are of that record, but it's pretty obvious to me as a layperson that two deeply troubled young men perpetrated a rage of violence against dozens of their classmates and peers and teachers. I've often wondered what would have happened if a guidance counselor who was particularly sensitive to

these issues had detected a forewarning of this behavior in the two young men who created such pain at Columbine.

The answer is probably nothing would have happened, because here's what the facts would have unfolded: The guidance counselor may well have said, “I see a pattern here of difficulty for this family.” Let's say the counselor had called the parents in and described that pattern of difficulty to the parents, and the parents had been duly alarmed and duly concerned, and decided to seek help for their sons.

I don't know the particulars of their families' insurance policies, but I know they were two very affluent families that had achieved quite a bit in their lives. But I'll bet you this. I'll bet the blue-chip health insurance coverage that the parents of those two young men had did not have many mental health benefits.

If the thought would be that the two young men should see a therapist, substance abuse counselor, other kind of professional, there wouldn't have been the resources to do that. There no doubt would not have been the publicly subsidized resources in the country or city in which they lived, and they make too much money to qualify for Medicaid if they live in a state that covers mental health services under Medicaid. So what probably would have happened is nothing, unless the parents did the extraordinary, and often unattainable thing, of reaching into their own pockets to pay for the care.

One of the best antidotes to the outbreak of violence in America is better mental health services for people, and one of the best ways to provide mental health services for people is to expand the scope and reach of private insurance to make sure that it does so. The Chairman is correct that there does need to be a balance struck between the very legitimate needs of premium payers, usually employers, and the needs of families who need these kinds of services.

It's my sense that by failing to strike that balance in the past, that we've imposed a much greater cost on the health care system and a much greater cost on the insurance system, because I can't think of many mental health problems that don't usually manifest themselves into a serious physical health problem at some point along the way: a violent altercation for a person who is bipolar, a failure of an organ or health system for a person who is manic-depressive, certainly many physical problems associated with substance abuse.

So I think that it's imperative that we strike that balance, and I'm enthusiastically looking forward to the legislation that Mrs. Roukema and Mr. Kennedy are supporting so that we can work on that as a basis, and go forward.

I thank the Chairman and look forward to the testimony.

Chairman Johnson. Thank you, Mr. Andrews. I appreciate your comments. I'm glad to welcome our colleagues here.

Our first witness is the gentlelady from New Jersey, Congresswoman Marge Roukema. Mrs. Roukema is a sponsor of H.R. 162, called the Mental Health and Substance Abuse Parity

Amendments of 2001. Our second witness is the gentleman from Rhode Island, Congressman Patrick Kennedy. I'd like to thank both of you for testifying before us today, and would remind you both that we have a five-minute rule here.

Congresswoman Roukema, you may begin.

Mr. Kennedy. I just want to point out, in response to Mr. Andrews' statement, that I don't want it to be thought that there is more violence among the mentally ill than there is among the general population. I just want to state that for the record, because I do think people have many myths and stereotypes about the mentally ill, and I think it's important to clear up that perception at the outset before we get into the testimony. I'd like to thankfully turn to my good friend and colleague, Marge Roukema.

Chairman Johnson. Thank you.

Mr. Roukema, thank you.

STATEMENT OF CONGRESSWOMAN MARGE ROUKEMA, SUBCOMMITTEE ON EMPLOYER-EMPLOYEE RELATIONS, COMMITTEE ON EDUCATION AND THE WORKFORCE

I thank you. Chairman Johnson, I apologize for not hearing your opening statement. I know what a fine leader you are on this Subcommittee and what an open mind that you have, and the fact that you, along with Representative Andrews, my colleague from New Jersey, are developing an agenda for this Subcommittee and the Full Committee. I certainly want to say that I'm very proud to be a Member of this Subcommittee, and to be working with you.

As you know, and I think as you referenced, I have been a part of the House working group on mental illness, and for nearly a decade I have been advocating attention to House mental health parity bills. I have done what I could, maybe not enough yet. We're going to keep pressing forward, to not only bring the direction of this House to the parity issue, but also to help policymakers understand and eliminate whatever lack of understanding they have about how we deal with psychiatric illnesses.

In my opinion, the way I like to explain today's hearing it that it is really about discrimination. For too long, we in the Congress have allowed the health plans to openly and legally discriminate against patients by making them pay more out-of-pockets costs for their health care and allowing fewer visits to treating mental health clinicians, and arbitrarily limiting hospital stays, and in some cases, denying it altogether.

I say without reservation that I believe the Members of Congress would be outraged if health insurers were restricting diabetics so that they could not see their endocrinologists without enormous costs or cancer patients so that they could not see their oncologists on regular visits that were medically necessary. But it's acceptable for health plans to openly discriminate against

patients with mental illness. How can we in Congress stand by and let that continue to happen?

I am here to dispel, if I can, any remaining uninformed or biased opinions regarding mental illness, and I want to point out, aside from my own opinions, some objective data that we have on this subject. According to the landmark 1999 Report of the Surgeon General, mental illness affects a substantial number of Americans every year. Roughly 20 percent of the U.S. population is affected by mental disorders in any given year, 22 percent of our children have mental illnesses with at least some mild functional impairment, and 50 million adults suffer from mental illness. The nation's elderly are particularly at risk. I won't go into all the statistics there, but we will include them in the record.

The good news is that mental illness can be treated more effectively than at any other time in our history. Properly diagnosed, and with timely treatment interventions, patients, including Americans who are working on the job every day, can recover and resume healthy and productive lives. The National Institute of Mental Health, for example, has shown that the success rate of treatment for disorders such as schizophrenia, depression, and panic disorders surpass the success rates for treatment of other medical conditions, even heart disease.

As the Surgeon General's Report notes, and I will quote: “Everyday language tends to encourage a misperception that mental health or mental illness is unrelated to physical health or physical illness.” I continue to quote: “In fact, the two are inseparable.” The argument over cost and the effectiveness of treatment falsifies the essential truth. Mind and body are inseparable and it is time that we started treating them as such for insurance purposes.

I appreciate and understand, as a strong business advocate in this Congress, that businesses have some concerns about the potential cost of national parity legislation. Certainly, we in Congress should not ignore those concerns, but this reality is that the lack of parity and the lack of access to effective treatment for mental illness costs American business far more today than parity law ever will.

The Surgeon General estimates that the direct business cost of lack of parity and lack of access to timely treatment is at least $70 billion per year, mostly in the form of absenteeism and lost productivity and increased use of sick leave and use of medical services in the absence of access to psychiatric care. The New York Times reported just in January of last year that, “The Chevron Corporation found that it saved $7 for every dollar it spent on an employee assistance program offering mental health resources . . . and research at Johns Hopkins University found that insurance plans with the highest financial barriers to mental health treatment experienced a greater number of disability claims related to mental illness.” There are other articles that I won't go into in popular magazine literature, that talk about the investment and workers' mental health and how it pays off for businesses.

Some 34 states have enacted some form of state parity law, although there is considerable variation in the scope of coverage of state laws, and because state laws do not cover ERISA plans, more than 128 million Americans are exempted from state parity requirements. The ERISA statute makes it possible for employers to voluntarily provide health care for their employees. For the past 27 years, ERISA has provided uniform federal standards. **I want to stress this: For the past 27**

years, ERISA has provided uniform federal standards for all employer-provided health, pension, and welfare plans. To ensure that Americans with ERISA health plans receive parity in mental health illness coverage, Congress enacted the Mental Health Parity Act of 1996.

I want to make the point, that we should follow the lead of our wonderful colleagues in the Senate, Senator Pete Domenici, a Republican, and Senator Paul Wellstone, a Democrat, and continue to deal with mental health parity needs.

I have more information here, which I will submit for the record, but I do want to state that there is a lot of misinformation and distortion. We are not mandating as our opponents have said, what businesses should cover, but we are suggesting fairness and parity on this issue.

Mr. Chairman, I conclude by saying that I certainly look forward to working with you both on the Committee and in the Full House so that we can get this bill passed this year. Mr. Kennedy and I are going to be introducing the Domenici-Wellstone bill in the next week or so.

WRITTEN STATEMENT OF CONGRESSWOMAN MARGE ROUKEMA, SUBCOMMITTEE ON EMPLOYER-EMPLOYEE RELATIONS, COMMITTEE ON EDUCATION AND THE WORKFORCE – SEE APPENDIX B

Chairman Johnson. Thank you, Mrs. Roukema. Both of you are privileged to submit your extra remarks for the record.

Mr. Kennedy, you may begin.

STATEMENT OF CONGRESSMAN PATRICK KENNEDY, 1ST DISTRICT OF RHODE ISLAND, U.S. HOUSE OF REPRESENTATIVES, WASHINGTON, D.C.

Thank you, Mr. Chairman and Ranking Member Andrews. I appreciate the opportunity to address you and Committee Members, along with my good friend and colleague, Congresswoman Marge Roukema, who really is a great champion of mental health parity in this country, and with whom I'm very honored to share co-sponsorship of this legislation.

There would be too much for me to say in this short time. I do want to join Mrs. Roukema in submitting our statements and additional information that's important for you as a Committee to digest. But I think that I want to get to the central point that Mrs. Roukema began with in her testimony, and that is this is a simple issue of patent discrimination. It's a simple issue of discrimination.

The fact of the matter is if it were cancer or diabetes or asthma or anything else, none of us would be even considering this hearing in the context of whether we're going to balance the cost. I might add that we have plenty of statistics that show that the increase in premiums is negligible.

When you actually add the productivity benefit that this can bring to workers that have been covered by mental health parity plans, you'll see why businesses, including the Wall Street Journal, have reported so favorably about why this is a good thing to do.

But leave that aside. We ought to have a discussion about health insurance and health insurance costs, because that is a big issue in this country. I certainly am very cognizant of the difficulty that small businesses in my state have in paying premiums, and the difficulty individuals have paying premiums and families being covered. We have nearly 50 million Americans who are uninsured.

That is a problem, but that is not what you're asked to decide. That's not the issue before us, because if it were an issue of cost, then, you know what? Let's just cut chemotherapy, because that's very costly. Let's just cut diabetes treatment, because you know what? I don't have diabetes, so why do I want to support someone else who has diabetes? Let's cut the cost of treating asthma, because you know what? It's climbing every day, and there's an epidemic of asthma out there, so you know what? I think it's best if we don't cover asthma, because you know what? More and more people are going to need that coverage, and it's going to be more costly. So you know what? Let's not cover it.

Do you know how foolish all of that sounds? Well, just as foolish as us not covering mental health, because this is a physical illness. We have the Surgeon General. We have the NIH. We have Nobel laureates. I mean the science on this is just without question.

But what continues to pervade in this discussion are myths and stereotypes. Those unfortunately are what's keeping us from moving forward the way we need to move forward, because the experience tells a different story than those who would frighten us into holding fast to our deep-seated prejudices and stereotypes about the mentally ill.

So I submit to you as a Committee that you have the opportunity to do what is the most American thing in this country, and that is break down the barriers to opportunity for over 54 million Americans who suffer from some form of mental illness and who are really imprisoned. They cannot fulfill their God-given potential as human beings because of a barrier that's erected against them because they suffer from a disease that is discriminated against under insurance practices.

So I look forward to answering the questions of the Committee. I know there are a great number of folks who have been fighting in the trenches far longer than I have, who have a lot to contribute to today's testimony.

But I would just want you to consider this as a civil rights issue like every other civil rights issue. I can recall talking to a friend of mine not too long ago about Dr. King's speech from a Birmingham jail, and how at that time his letter was very simple. Some like to caution patience, “Now is not the time.” I would say that this is always what we're hearing in regard to our efforts to enact parity legislation in this country, and those who counsel delay are really those who are protecting the injustice of our current system.

I would hope you would join me in seeing the light and recognizing that we are living in the year 2002 and that we had better come to grips with the realities of modern science in terms of understanding mental illness.

Thank you very much, Mr. Chairman.

WRITTEN STATEMENT OF CONGRESSMAN PATRICK KENNEDY, 1ST DISTRICT OF RHODE ISLAND, U.S. HOUSE OF REPRESENTATIVES, WASHINGTON, D.C. – SEE APPENDIX C

Chairman Johnson. Thank you, sir.

I thank both of you, the gentlelady from New Jersey and the gentleman from Rhode Island, for testifying before us today. Your expertise in this area is much appreciated, and you may certainly put the rest of your remarks and any other materials you desire into the record.

Mr. Andrews. If I may, we don't have any questions on our side for the panel, but Ms. Rivers, who has a very important interest in this subject, did want to know if she could have five minutes, and with your consent, I would ask for that.

STATEMENT OF CONGRESSWOMAN LYNN RIVERS, COMMITTEE ON EDUCATION AND THE WORKFORCE

Thank you very much. In the early 1980s, I was diagnosed with serious mental illness, manic-depressive disease, which is an illness characterized by huge mood swings, ranging from high productivity to profound depression. During those times of depression, I would sleep up to 22 hours a day, finding it too difficult to take care of my very small children who needed me at the time, and to do even very simple daily activities, to even take a shower or comb my hair.

The day of my diagnosis was the best day of my life, and it was the best day of my life because this thing that had taken over my life was finally shown to be real, not a figment of my imagination. I was not bad. I was not lazy. I was not engaged in self-defeating behavior. I was sick. That began what, for me, was a 10-year odyssey to wellness. Every morning and every night, I get up and I take my handful of pills. The pills work because I have a real illness, an illness that is physically based, and so physical treatment works for me.

During the time that I went through this 10 years of treatment, my family was not covered for mental illness, save for a couple of visits to my doctor. But for the most part, we paid the cost of my medical care out of our income, and it consumed 50 percent of our take-home income, as a young family.

Families all over this country are doing that, because of this discriminatory law. The fact that we allow this discrimination to persist is a shame upon our nation, because it's very purely and simply about money. But every time we talk about the cost of providing parity, we somehow never get to thinking about the cost of not providing it. I would like to compare two people for you whose life journey takes them to the Capitol of the United States of America. I'm one of them.

You just heard my story, and through my treatment, I was able to go to the University of Michigan and graduate with honor and distinction, to go to law school, to serve on my local school board, my state legislature, and come here to Washington, D.C. to cast votes on behalf of my community. One journey ended happily.

The other journey was that of Rusty Westin, a non-medicated schizophrenic. His parents had tried for years to get him treatment through the system in their state, and were unsuccessful. Finally, they became so frightened of him they threw him out. He got in a car. He drove to Washington. He entered the Capitol, non-medicated, delusional, and armed and he killed two police officers and shot several tourists.

That, my friends, is the cost of not having parity. That is the cost of not giving people treatment. If we want to continue to play games and dance around this topic and call it anything but what it is, we are fooling no one. It's about money, it's about discrimination, and it's about treating everybody fairly, and it's about time we did it.

Thank you.

Chairman Johnson. Thank you, Ms. Rivers.

Our colleagues have no further comments, and we appreciate your testimony. Thank you for being with us this afternoon. We appreciate that.

Will the second panel please come forward and take their seats?

Our first witness on the second panel will be Mrs. Kay Nystul. She is a Behavioral Health Nurse and a Case Management Coordinator for Wausau Benefits. The second witness will be Mr. Lee Dixon. Mr. Dixon is Group Director of the Health Policy Tracking Service for the National Conference of State Legislatures. Our third witness will be Dr. Henry Harbin. He is Chairman of the Board at Magellan Health Services, Inc., and is testifying on behalf of the American Managed Behavioral Healthcare Association. Our fourth and final witness is Ms. Jane Greenman. She is Vice President and Deputy General Counsel of Human Resources, Labor and Benefits for Honeywell International. Mr. Greenman is testifying on behalf of the ERISA Industry Committee.

I would like to remind Members that we will be asking questions of the witnesses after their testimony. In addition, Committee Rule 2 imposes a five-minute limit on all questions, and if you would try to adhere to our five-minute rule in your testimony, we would appreciate it. I think you understand the lights. They go green, yellow, and red.

Ms. Nystul, you may begin your testimony.

STATEMENT OF KAY NYSTUL, BEHAVIORAL HEALTH NURSE AND CASE MANAGEMENT COORDINATOR, WAUSAU BENEFITS, WAUSAU, WI

Thank you, Chairman Johnson, for allowing me to speak on the issue of mental health coverage. I'm a registered nurse with over 20 years of experience in the field of mental health and feel very strongly about doing the right thing for patients who need mental health treatment.

I'm also a certified case manager, and today work for Wausau Benefits as a behavioral health nurse. As a case manager, I work closely with patients and their treatment providers to promote optimum quality of health, as well as help them utilize the resources available to them. One of those primary resources is their health plan. Therefore, public policy that encourages health plan sponsors to continue offering mental health coverage for those who truly need it is vital.

There are limits to health plan funds, and choices have to be made. Mandates that prescribe how plan sponsors must provide for mental health coverage create an incentive for employers not to offer the coverage. I know this is the opposite of what Congress is trying to achieve.

In my role as a nurse case manager, my number one job is to be an advocate for the patient. People who need mental health treatment need support, and enough information about their illness to be able to make informed decisions.

When a third-party payer is involved, experience suggests that money is sometimes spent differently than it would be spent if it were coming out of a family budget. When sharing health care costs with their employer, patients tend to be more selective about the level and kind of treatment sought. It's critical that plans be able to continue using behavioral health management techniques and criteria so that mental health dollars can wisely be spent.

I think the answer is complex as to what is needed; yet the desired outcome is simple. Federal mandated coverage for all conditions listed in the DSM-IV is not the right prescription for effective allocation and delivery of mental health benefits. A clear distinction, however, does need to be drawn between what is considered a serious mental illness and other conditions that are listed in the DSM-IV.

Conditions in which there is a biochemical imbalance, such as major depression, and/or bipolar disorder are treatable and are precisely the kind of conditions for which health plans earmark their mental health dollars. On the other hand, treatments for other conditions listed in the DSM, for which there is no chemical imbalance, have few, if any, objective criteria to determine when treatment is necessary or when it has succeeded.

I like to refer to people with these conditions as the “unhappy well.” They may choose to seek treatment, and it certainly is their right to do so. However, treatment is not likely to impact or improve their particular situation. In these cases, a significant amount of dollars can be spent, and

to what end?

Conditions such as occupational problems, spiritual and religious problems, relationship problems, do not stem from chemical imbalance, but rather from life choices and stressors that we all face every day. Federal mandates requiring coverage for these conditions could force plans to use limited plan dollars unwisely. The tragedy will occur when individuals who use all the available benefit dollars for these low-impact conditions, actually do develop serious mental health disorders and need that benefit.

When benefit resources dry up, other available resources need to be accessed, such as people's own savings. Sometimes when that's the issue conditions go untreated. Leaving serious mental conditions untreated, as we all know, is not in anyone's best interest.

In summary, I know and believe that case management works, and that mandating parity treatment for every condition listed in the DSM-IV is not the answer. It will make my job as a case manager almost impossible. Federal mental health policy must be crafted in such a way that people who truly need mental health services and treatment get it, and that funding is not put at risk.

When people suffering from serious mental illness receive the care they need when they need it, everybody wins. The patient gets better, their employer has their employee back, and families have their loved ones back.

Thank you very much.

WRITTEN STATEMENT OF KAY NYSTUL, BEHAVIORAL HEALTH NURSE AND CASE MANAGEMENT COORDINATOR, WAUSAU BENEFITS, WAUSAU, WI
SEE APPENDIX D

Chairman Johnson. Thank you very much. I appreciate your testimony.

Mr. Dixon, you may begin your testimony now.

STATEMENT OF LEE DIXON, GROUP DIRECTOR, HEALTH POLICY TRACKING SERVICE, THE NATIONAL CONFERENCE OF STATE LEGISLATURES, WASHINGTON, D.C.

Thank you, Mr. Chairman. My name is Lee Dixon. I'm Director of the Health Policy Tracking Service at the National Conference of State Legislatures. The Conference is a bi-partisan organization the serves the legislators, the staffs of the legislators, the commonwealths, territories, and the District of Columbia. It's a pleasure to be here today on behalf of NCSL during this historic hearing on mental health parity. This afternoon, I will describe the standard NCSL uses to define

parity and briefly discuss the current status of parity legislation in the state legislatures.

I'm submitting two documents for the record. One is a chronology of the enactment of state parity laws over the past eight years and the second is a table on the current state of statutes on parity, mandated benefits, and mandated offerings in the state legislatures.

Currently, 23 states have laws that require parity benefits for the treatment of mental illnesses. Among these states, there is a variation with regard to the extent of coverage for mental illness and alcoholism and other drug addiction. Some states require health insurers and managed care entities to reimburse for the treatment of all diagnoses of mental illness, while others limit the reimbursement to treatment for what are called the biologically based mental illnesses. Other states have enacted parity laws for mental illnesses and substance abuse. The map in my testimony displays the 23 states that we show as having parity statutes.

I think the important thing here is to look at the definitions that we use. Under the current state insurance laws, disability or health care service plans may not discriminate based on race, color, religion, national origin, ancestry, or sexual orientation. Parity, as it relates to mental illness and chemical dependency, further prohibits insurers or health care service plans from discriminating between coverage offered for mental illnesses, biologically based mental illnesses, chemical dependency, and other physical disorders and diseases. In short, parity requires insurers to provide the same level of benefits for mental illnesses, biologically based mental illness, or chemical dependency, as for other illnesses.

The typical parity provision found in state legislation amends the current insurance laws for that state by adding a new section. The amendment usually adds the language that “Insurers shall provide benefits for the treatment of mental illness, biologically based illnesses, and/or alcoholism and drug addiction under the same terms and conditions as provided for other illnesses and diseases.” The typical provision also provides definitions or related terms, including health insurer, serious mental illness, mental illness, and medical coverage. All policies issued are renewed after the date are to be in accordance with this statute, and then the benefits include lifetime and annual limits, co-payments, deductibles, visit limits, or in-patients. All of these are referenced in the definitions section.

State parity laws, as I think we've heard today, may contain several variables that affect the level of coverage required under the law. Some parity laws, such as in Arkansas, provide broad coverage for mental illnesses listed in the diagnostic and statistical manual of the American Psychiatric Association. Other state parity laws limit coverage to a specific list of biologically based, sometimes referred to as serious mental illnesses.

“Biologically based brain diseases” is a term used in the debate for parity and includes, but is not limited to, the following diagnoses: schizophrenia, schizo-affective disorder, delusional disorder, bipolar affective disorders, major depression, panic disorder, paranoia, autism, and obsessive-compulsive disorders. At the state level, deciding whether parity should apply to all mental illnesses or only to serious mental illnesses that are considered related to the biological functioning of the brain has created some debate on occasion.

Many other types of laws can mandate coverage for the treatment of mental illness and substance abuse. Many states require that some minimum level of coverage be provided for mental illness, biologically based mental illness, substance abuse, or the combination thereof. The National Conference of State Legislatures does not consider these laws to be full parity, because they allow discrepancies in the level of benefits being provided between mental illnesses and physical illnesses. These discrepancies can be in the form of different outpatient and inpatient limits, co-payments, deductibles, and annual lifetime limits.

The one other thing I would, in summation, just talk about is the fact that NCSL defines this legislation as mandated benefits. The other type of legislation out there is a mandated offering, where the insurer is required to offer, but there may be discrepancies within the plans and the products that an insurer provides.

I would be glad to answer any questions.

WRITTEN STATEMENT, WITH ATTACHMENTS, OF LEE DIXON, GROUP DIRECTOR, HEALTH POLICY TRACKING SERVICE, NATIONAL CONFERENCE OF STATE LEGISLATURES, WASHINGTON, D.C. – SEE APPENDIX E

Chairman Johnson. Thank you for your testimony.

Dr. Harbin, you may begin your testimony.

STATEMENT OF HENRY HARBIN, M.D., CHAIRMAN OF THE BOARD, MAGELLAN HEALTH SERVICES, INC., COLUMBIA, MD, ALSO TESTIFYING ON BEHALF OF THE AMERICAN MANAGED BEHAVIORAL HEALTHCARE ASSOCIATION

Thank you, Mr. Chairman. I'm Henry Harbin, Chairman of the Board of Magellan Health Services, and I appreciate having the opportunity to speak to you today about the importance of and the need for a comprehensive mental health parity bill. Today, I am representing my own company, Magellan Health Services, as well as the American Managed Behavioral Healthcare Association, or AMBHA.

AMBHA is an association of the nation's leading managed mental care companies, of which Magellan is one. We are collectively responsible for managing mental health and substance abuse benefits for over 110 million individuals in America. In addition, AMBHA is a member of the Coalition for Fairness in Mental Illness Coverage, and that includes a number of members, and I will list them: The National Alliance for the Mentally Ill, the National Mental Health Association, the American Hospital Association, the American Medical Association, the American Psychiatric

Association, the American Psychological Association, the Federation of American Hospitals, and the National Association of Psychiatric Health Systems.

We are all united in our support for a comprehensive mental health parity bill, and these organizations represent not only a managed care company such as ours, but also many providers, consumers, and citizens. Let me speak a little bit about Magellan.

We are the largest of the managed mental health care companies, so you understand my experience base today. We manage about 70 million Americans for their mental health and substance abuse benefits. We subcontract with many employers, Fortune 500 companies, as well as health plans such as Blue Cross plans, commercial carriers like Aetna, and so on.

I'm here today to support this parity bill, a comprehensive bill, and I would like to make three main points. First, comprehensive parity legislation addresses a significant public health issue that has far-reaching social and economic consequences for this country. Second, I believe that now is the right time to address this issue. Thirdly, mental health parity has been shown to be cost-effective. Let me say a couple of comments about each one of these.

As was already referenced in the Surgeon General's Report, almost 20 percent of the U.S. population, one in five, is affected by a mental disorder. Additional data from the World Health Organization shows that mental illness was the second leading cause of disability and premature deaths worldwide, second only to heart disease, and outstripping the disease burden caused by cancer.

Mental illness costs society billions of dollars in health care, medical expenditures, lost wages, absenteeism, and lower productivity, to say nothing of the intangible costs of otherwise preventable human suffering. This issue is further exacerbated by the stigma associated with seeking help for these problems, as well as the financial disincentives created by limited mental health benefits. As a psychiatrist, I have seen firsthand the detrimental effect that financial and other barriers can cause on an individual's ability to access care.

By offering comprehensive mental health benefits, we send the message that mental health is a disease, just like diabetes, heart disease, or cancer, and it's already been pointed out there is ample evidence that the treatments for many common but serious mental disorders surpasses those for many common medical problems. We believe that comprehensive benefits will facilitate early access to treatment, which will lessen burden and suffering and lower the costs across the board.

In addition, many studies have shown that early, effective treatment of mental illness leads to lower morbidity, lower medical costs generally, lower disability costs, and less absenteeism in the workplace. In a recent article in the Wall Street Journal they quote an experience with Bank One employees where they found that their employees lost a total of 10,000 workdays over a two-year period due to depressive illness alone, more than 10 times the workdays lost to either high blood pressure or diabetes.

The second point I'd like to make is that this is now the time to pass this. The scientific evidence is here. It has shown that there are cost-effective, effective treatments for these illnesses.

As you've already heard from Mr. Dixon, legislators in 34 states have recognized the importance of this issue and have passed some form of mental health parity, but a significant percentage of individuals with health insurance are covered under plans governed not by the states, but you ERISA.

The Mental Health Parity Act of 1996 passed by Congress was an important step in addressing the problem of discrimination in health benefit coverage, but access to mental health services remains limited. Inequity is still allowed and exists in the areas of treatment limitations and financial requirements. Passing mental health parity legislation in a more comprehensive form will eliminate such inequitable treatment access without mandating that coverage be offered.

Finally, I would like to share some of the cost data that our company and others have gathered here with the impact of parity. In our experience at Magellan, the implementation of parity legislation results in only a very modest increase in the total health care premium. At Magellan, we have yet to see an increase of greater than 1 percent of the total health care premium as a result of state parity legislation. Our experience is in the range of .2 to .8 percent. I would also like to point to the study presented by the Office of Personnel Management on the federal employees' program that implemented full parity for all federal employees January 1, 2001. Their estimate of cost increase was about 1.3 percent, and that did include substance abuse.

My final comments are to say that we would like to support a comprehensive bill that would include all DSM-IV diagnoses, and we think this is the time to do it in order to affect this discriminatory situation. I know we'll have time for questions, and I'm available to answer them.

Thank you.

WRITTEN STATEMENT OF HENRY HARBIN, M.D., CHAIRMAN OF THE BOARD, MAGELLAN HEALTH SERVICES, INC., COLUMBIA, MD, ALSO TESTIFYING ON BEHALF OF THE AMERICAN MANAGED BEHAVIORAL HEALTHCARE ASSOCIATION SEE APPENDIX F

Chairman Johnson. Thank you, sir.

Ms. Greenman, you may begin your testimony.

STATEMENT OF JANE GREENMAN, VICE PRESIDENT AND DEPUTY GENERAL COUNSEL, HUMAN RESOURCES AND COMMUNICATIONS, HONEYWELL INTERNATIONAL, MORRISTOWN, NJ, TESTIFYING ON BEHALF OF THE ERISA INDUSTRY COMMITTEE

Mr. Chairman, Members of the Subcommittee, good afternoon, and thank you for the opportunity to speak with you today. There are several key points in my written statement on behalf of the ERISA Industry Committee, also known to you as ERIC that I would like to highlight.

First of all, employers have a strong interest in providing voluntary employment-based health care coverage to employees and their families. Employers' health care coverage arrangements are tailored to the specific resources and needs of each employer and its workforce. Voluntary employee benefit plans have tailored needed health, retirement, and other benefits to tens of millions of employees and their families.

We are concerned that mandating broad mental health parity will do more harm than good in seeking to assure adequate access to appropriate care for people who suffer from mental illness. The relevant cost analysis, which studies of the cost of parity do not adequately address, is how increased cost will be distributed among employers and employees

Under our existing, voluntary, private health benefit system, employers offer differing levels of mental health care coverage. The impact a broad parity mandate will have on employers and their employees cannot be determined based on average national cost. In fact, the cost of such mandates will vary dramatically from one employer to another, depending on a wide range of factors: location, workforce composition, available mental health service provider networks, and current levels of employer coverage.

In the current economic environment, employers can ill-afford to increase spending on health care coverage. Therefore, the cost of parity will primarily take the form of increased employee cost-sharing, reductions in other health care and retirement benefit coverage, and/or the elimination of mental health coverage entirely.

Mandating broad parity would restrict employers' benefit design options at the worst possible time. Currently confronted with 15 to 25 percent annual cost increases, employers are already being forced to make tough decisions about levels of employee cost-sharing and reducing coverage. Enacting a broad parity mandate further limits employers' available options, making those decisions even tougher, and increasing the likelihood that some employers will simply cease offering mental health coverage.

While employees and dependents who now have comprehensive mental health coverage might experience modest improvements to such coverage as a result of a broad parity mandate, employees and dependents with less mental health coverage would be at high risk of losing it entirely should a broad parity mandate be enacted. In short, policymakers should not enact a mandate that primarily helps employees and dependents that already have comprehensive coverage, but potentially hurts employees and dependents with the least coverage.

As employers struggle with health care costs, any mental health parity mandates would seriously impair employers' bargaining leverage with mental health providers. Mandating broad parity forces employers to make major concessions to health care providers without getting any concessions as to cost or levels of coverage from such providers. All of these and other concerns raised in my written statement will become even more acute if expanded ERISA liability is enacted. Litigation expenses are already rising and class action lawsuits are multiplying.

In the face of added liability exposure, many employers will retreat from offering mental health coverage, since it is not in their business interest to enter into arrangements that are likely to result in expensive litigation. In conclusion, ERIC's fundamental concern is that mandating a broad mental health parity requirement creates potentially serious problems and may, indeed, harm at least as many people as it helps.

Employers of all sizes have limited resources to spend on employee benefits. Within their varying budgets they allocate resources among pension, health, vision, dental, mental health, disability, life insurance, and other employee benefits, according to available resources and according to what employees tell us that they want. Congress should not override these resource allocation decisions by mandating broad mental health parity, because the result is more likely to be reduced health coverage than it is increased health coverage.

Thank you very much.

WRITTEN STATEMENT OF JANE GREENMAN, VICE PRESIDENT AND DEPUTY GENERAL COUNSEL, HUMAN RESOURCES AND COMMUNICATIONS, HONEYWELL INTERNATIONAL, MORRISTOWN, NJ, TESTIFYING ON BEHALF OF THE ERISA INDUSTRY COMMITTEE – SEE APPENDIX G

Chairman Johnson. Thank you, ma'am.

I'd like to ask you a question, if I might, Ms. Greenman. You testified that many employers are concerned about their employees' mental health and offer generous mental health benefits. If they're already offering health benefits, why are employers opposed to expanding the parity requirement?

Ms. Greenman. I think the key issue for employers that already offer generous benefits is the limitation on design flexibility. Many employers will address mental health issues for their employees, including the kind of productivity concerns that have been mentioned today, by a variety of strategies.

For example, there are employee assistance programs. There are disability management programs that are designed to, if necessary, on a gradual basis get employees who are absent, who are ill, back to work, regardless of the cause of their illness. Sometimes they need to get back to work over a period of time, or phase-in, sometimes it can be done, but it's a managed disability

program.

Imposing a mental health parity requirement would essentially eliminate the flexibility that employers now have to structure programs that are designed for the kinds of conditions and the kinds of concerns that are represented by mental health conditions. Very often these may differ somewhat from the kinds of concerns that arise in other types of physical illnesses.

Chairman Johnson. Well, are you also trying to say that it depends on the business the company is in? Should the business determine to some extent the kind of coverage they're looking at?

Ms. Greenman. Well, it certainly depends on the resources of the business involved.

Chairman Johnson. Thank you.

Mr. Dixon, your chart reflects that more than half the states have required mental health parity only for serious mental illness. Could you tell us more about how laws like this, such as the Texas law, are structured, and are they doing the job?

Mr. Dixon. Mr. Chairman, you're correct. Of the 23 states that have enacted parity legislation, the vast majority of them do have it for the biologically based mental illnesses. We have not conducted any studies as to how those laws and how the insurance market is working within any of those states, though we have not seen any legislation to repeal the parity laws in Texas or in any of those states, also.

Chairman Johnson. Thank you, sir.

Mr. Andrews, do you care to question?

Mr. Andrews. I do. I want to thank the entire panel for excellent, thought-provoking testimony. We appreciate everyone's contribution.

Ms. Greenman, welcome back. I know that you testified very ably on earlier issues, and I wanted to begin with you and ask you a couple of questions. You make the assertion that employers will likely abandon some mental health coverage if there is a federal mandate. In particular those that offer fairly minimal plans will just offer nothing.

Mr. Dixon tells us that there are 24 states that have adopted some health care mental health parity law. Since these statutes cover non-ERISA plans by definition, it is more likely they cover smaller employers, those that are least able to bear this burden. Do you have any evidence of abandonment of mental health coverage by employers in those 23 states?

Ms. Greenman. I don't have specific evidence. I do know, however, that the state legislation that is somewhat liberally referred to as mental health parity legislation really is not the same as the legislation that's being considered in this regard.

Mr. Andrews. But do you have any data or any research that would show an abandonment of mental health coverage by employers in those 23 states?

Ms. Greenman. What I'm suggesting is that the legislation in those states would not be comparable to the legislation that's being considered here.

Mr. Andrews. Whatever it is, ERISA imposes some obligation on employers. It may not be an obligation as dramatic as this one. Do you have any evidence that shows abandonment of coverage?

Ms. Greenman. I don't have data one way or the other.

Mr. Andrews. You make an assertion that costs will explode as a result of this mandate, and that they'll go up considerably for employers. But Dr. Harbin tells us that Magellan has not seen an increase in premiums of greater than 1 percent, they haven't seen that yet, they've seen a typical range of .2 to .8 percent; and the CBO has done an analysis of the Senate bill and they estimate an increase in premiums for group health plans by an average of .9 percent.

Do you have studies or data that would contradict either of those conclusions?

Ms. Greenman. Yes, I do. There was a study done in '96 when the initial mental health parity legislation was enacted. The Health Policy Economics Group of Price Waterhouse sponsored it. Their estimates were that there would be a total compounded cost increase of mental health benefits that would range from 60 to 190 percent of the cost of the benefits, and that the premium increase would be as high as 10 percent.

Mr. Andrews. Okay. My understanding is, though, that five years later Price Waterhouse looked at the bill that was before the Senate, and in a report called “An Actuarial Analysis of S. 543” done in July-August 2001, they indicated an increase in premiums of 1 percent, which is about the same as the CBO did.

So do you have anything more recent than 1996 that would contradict these findings?

Ms. Greenman. The latest data that I have, although I can't cite the authority for you at this point, is that the estimates range somewhere between 8.7 to 11.4 percent. If you wish, we can get back to you with a specific date.

Mr. Andrews. Sure. I'm sure the Chairman would welcome the record to be supplemented with that.

Let me conclude by saying that the last statement that you make in your written statement is that employers make decisions as to what to cover according to their business needs and employee preferences, which is obviously the case.

We have this voluntary system. Is there any evidence that under this voluntary system mental health benefits are increasing for employees? Are there more things being covered for more

people, is it going the other way, or is it standing still? What do you have on that?

Ms. Greenman. I don't have comprehensive data that cuts across the employer population. I know that our benefits at Honeywell have increased.

Mr. Andrews. Let me say the reason I raised that question is that your statement frames the issue before us. My assumption is that benefits are not increasing under this voluntary system. As a matter of fact, they're probably eroding.

Chairman Johnson. Can I interrupt you?

Mr. Andrews. Sure.

Chairman Johnson. Maybe Mr. Dixon can answer that question. Can you?

Mr. Andrews. If anyone on the panel can, I'd be eager to hear their answer.

Dr. Harbin. I think I could add that in-as-much-as our group manages mental benefits for the majority of people that are under a managed care program, we've not seen much evidence there's any increasing in benefits.

There are employers who, over time, have added some additional things like employee assistance programs, which are primarily geared for people with less severe problems. I mean, they're helpful, and they're very important, but they're not really aimed at people with more serious problems. We've seen some evidence of people reducing their benefits.

Our experience in talking with a number of insurers and employers with the passage of the 1996 parity bill is that many of them told us that the way they handled that was just to further limit sessions and benefits or increase co-pays. It was legal, and it was allowed, but I don't have a comprehensive study. That's our anecdotal experience.

Mr. Andrews. Before I conclude, the questions the Committee really has to deal with are these:

The first question is whether you believe we should encourage the expansion of mental health benefits. If you believe that we shouldn't, then that's a credible position. It's one with which I disagree, but it's a credible position. If you believe that we should encourage the expansion of mental health benefits, then it frames the question as to how we do it, and there are three options, I suppose.

We could permit the present voluntary system to go on as it is. We could try to create a set of incentives or subsidies that would add to the present system. Or, we could follow the strategy that's in the bill before us.

I frankly support the third of those options, but I'm not foreclosed to the other possibilities. But I think you can't say that you're for expansion of mental health benefits and not come to terms

with following one of those three options.

Ms. Greenman. I would add, Mr. Andrews, that we obviously are prepared to work with you to try and find some kind of acceptable solution to this problem, but do want to recognize that cost implications and design flexibility are really very important to the voluntary employer health system.

Mr. Andrews. They are important, which is why I would eagerly await any data you have to back up the assertions that you make.

Chairman Johnson. Mrs. Roukema, do you care to question?

Mrs. Roukema. Yes, I do.

I'm not quite sure what we've just heard. Dr. Harbin, I'm not quite sure what your reaction was, what your response was. It is my understanding from your testimony, that you were totally supportive of mental health parity. Is that not correct?

Dr. Harbin. Absolutely.

Mrs. Roukema. Well, then I misunderstood your response to the previous question.

Dr. Harbin. I think I was answering a question about have benefits expanded under the current voluntary system. I was saying we don't see evidence that they have. And I would add, in terms of the three choices outlined, we support the last.

Mrs. Roukema. I wanted to get that, again, on the record, because I wasn't quite sure of what you had said.

Ms. Greenman, and also Ms. Nystul, I believe that parity is the answer to the need here. But Ms. Greenman, it has been noted that some 34 states, I believe the current number is 34 states not 23, have enacted legislation and have implemented parity at the state level.

Now, Ms. Greenman, I just want you to know that every documented scientific as well as statistical body of evidence has shown that it's working in these states. The states have not demonstrated either that the costs have gone through the roof or that people are backing away from it and that's contradictory to everything that you implied in your statement.

The point is that the contradictions at the state level that you have laid out as the worst possible case have not happened at the state level. Both the cost factors as well as the coverage have been implemented, and more and more states are adopting it. So it's working at the state level.

Ms. Greenman. If I may make an observation. The state legislation, the state so-called parity legislation, really isn't parity in the pure sense of the word, because most of those statutes are limited to requiring coverage for biological-type mental illnesses.

Mrs. Roukema. That is not my understanding of it, and I think that's contradictory to the data.

Dr. Harbin. Could I speak to that?

Mrs. Roukema. Yes, Dr. Harbin.

Dr. Harbin. The data that we presented that found a .2 to .8 percent increase included states with a comprehensive parity bill, such as Maryland, for instance, which passed a bill similar to either H.R.162 or 543. We saw the costs go up less than 1 percent; so we feel that there are several states where the data is applicable.

Mrs. Roukema. It is my understanding that most of those states have comprehensive coverage.

Dr. Harbin. Off the top of my head I don't know how many. There's quite a range of what illnesses they covered.

But I'd like to further add, there was a study done by SAMSA, I believe in '99 that did look at the impact of passage of a serious mental illness bill and what it represented, as opposed to all DSM-IV. And their estimate was in the 90 percent range of the cost; the 80 to 90 percent range of the cost would be represented by the severely mentally ill diagnoses by themselves, which I think says two things.

One of the concerns raised by my colleague from Wausau is that some of the more less-severe illnesses, still important in our mind for coverage, don't represent a big part of the cost burden; and two, that these serious mental illness state parity bills are applicable in trying to estimate the costs of parity, if it's a managed benefit.

Ms. Greenman. I would like to make the observation if I may, that the Maryland legislation, while it is very broad, still permits, for example, a sliding scale co-payment system, whereas the legislation that's currently under consideration would not permit any differential.

And the kind of legislation that is that broad could even make the mental health carve out kinds of programs unworkable. This is because the very premises on which they're based, that you have a managed care system within your health program for mental health conditions, if they could not have any differentiation in the structure of coverage, they would not be workable.

Mrs. Roukema. Well, in the first place, I don't think the way you have described the result of it is exactly correct. But let me just say that we are talking about 128 million Americans or more, under ERISA plans, that are not covered.

So these are real world cases. We're not talking in the abstract. We're talking about real people with real problems and real cost factors. I haven't looked at those Wall Street Journal articles but I certainly shall. I believe that all the objective data that I have seen indicates that there are saving factors here in terms of the other kinds of limitations that mental illness causes in terms of productivity, et cetera.

In conclusion I just want to say that I think the statistics are in favor of expanding the coverage.

Chairman Johnson. Mr. Dixon, do you care to comment? You haven't made any comments, and you're the state expert, theoretically. Is she right on the number of states?

Mr. Dixon. The discrepancy between 34 and 23 rests, with regards to the definition of mandated offerings, on the fact that some states have passed parity legislation much like 543, which would require an insurer, if they offer the mental health benefit, to offer it with parity. But that does not require all insurers to provide parity, and from that standpoint, we do not score that state as a parity state. That's the discrepancy.

Mrs. Roukema. I see the distinction there, but you are correct, and that refutes the way I would like to have refuted the whole idea that this is a mandate, making everyone know there is a lot of discretion here.

We are not requiring everybody. But I'm glad you made that point.

Mr. Dixon. Mr. Chairman, to get back to the question about the states, what we have seen with regard to state legislation over the past three years is that the legislation that is being introduced and being enacted is to expand the mental health benefit. In fact, in three or four of the states where they had only biologically based mental health benefits previously, they are expanding it to all mental illnesses, and even to alcohol and other drug addictions.

Chairman Johnson. Thank you very much, sir. I appreciate your testimony.

Ms. Rivers?

Ms. Rivers. Thank you.

Ms. Greenman, you were talking about mental illness being excluded, but not for many of the reasons that people are asserting. One of the things I would like to know is what other illnesses do the members of The ERISA Industry Committee routinely exclude from coverage, and why; illnesses or conditions that are not a part of their coverage, other than mental illnesses?

Ms. Greenman. I'd like to correct a misunderstanding, because I did not state that most companies exclude mental illnesses. What I posited was that small and mid-size employers, if forced to ratchet up the cost, might eliminate some mental illnesses.

Ms. Rivers. Actually I'm going to ask you about that too, but first I want to know what other illnesses or conditions, do your members exclude from coverage under their insurance policies, and why?

Ms. Greenman. The ERISA Industry Committee represents large employers, and typically those employers, including my own, do not exclude any significant condition that would include mental

illness.

Ms. Rivers. You also said that there was the potential of abandoning mental illness coverage under these bills if costs rose too much. What other illnesses have your members dropped because costs have risen too high?

Ms. Greenman. As I said, I think that the larger companies tend to provide comprehensive benefits.

Ms. Rivers. So that would be none, to both of my questions? You don't know of any other illnesses that your membership excludes and you don't know of any other illnesses that have been dropped because the costs have gone too high; is that correct?

Ms. Greenman. That's correct, but it doesn't really go to the issue of managing costs.

Ms. Rivers. The other issue that you raised is that you want to provide what employees want. But given the intense stigma that is associated with mental illness in this country, and I'm certainly aware of it firsthand, is it reasonable to expect that employees in the workforce are going to come to the human resource person, or if they work on a factory floor, like my ex-husband did, to his union rep and say: "My wife has manic-depressive disease." "My son is a schizophrenic." "My daughter has panic attacks, and we need coverage for that"? How likely is it that those individuals are going to come forward in the workplace and share that information in the hopes of getting better coverage?

Ms. Greenman. Particularly for the employers that ERIC represents, that scenario would not happen, because, for example with an employee assistance program there is an arrangement completely separate from the supervisor or from an HR manager where an employee who has a mental health problem himself or herself, or for whom a family member has a mental health problem, can call without having any disclosure whatsoever to their supervisor or their HR manager.

Ms. Rivers. Is that to get help or is that to get coverage? I'm talking about the idea that employees would have to lobby for coverage.

I mean, the argument that certainly gets put forward in Michigan is that the big three auto manufacturers say that they're going to give the employees what they want. But there is a reticence on the part of employees to come forward in the workplace with very private information on illnesses that still have tremendous stigma attached to them. So I'm trying to understand how the big company can determine what the need is.

Ms. Greenman. Virtually every year, sometimes more often, with respect to particular issues we will have global employee surveys, at some significant cost and effort, that will solicit employees' views on a wide range of issues, including their benefits coverage, and that would be without attribution. Employees do not have to disclose their identities.

Ms. Rivers. My last question is why, whether it's actually happening to the employers that you represent, do you distinguish between mental illness and any other kind of illness in your arguments? I can understand distinguishing between certain kinds of illnesses and elective treatment. If I want to have cosmetic surgery, a tubal ligation, or choose contraception I could, but why do you make a distinction between one kind of illness versus another?

Ms. Greenman. That's where, as I mentioned to Mr. Andrews, I think there may be some room for creative discussion about covering all conditions that are listed in the DSM, given that there is significant elasticity of usage.

Ms. Rivers. Could you show me where it says that in the bill? I imagine it mentions case management and not covering everything under DSM-IV.

Chairman Johnson. Ms. Rivers, we're going to have to call it off. We've got to go vote. But I would like to add that all Members may submit questions for the record, and other testimony.

Make a final comment, if you wish.

Mr. Andrews. Very quickly, with unanimous consent, I have some statements for the record from groups with an interest in this issue, and I would ask they be submitted for the record.

Chairman Johnson. Is there any objection? Without objection, so ordered.

I wish to thank the witnesses for your valuable time and testimony, and thank you for waiting for us during our votes. I thank the Members for their participation. If there's no further business, the Subcommittee stands adjourned. Thank you all.

Whereupon, at 5:04 p.m., the Subcommittee was adjourned.

APPENDIX A - WRITTEN OPENING STATEMENT OF CHAIRMAN SAM JOHNSON, SUBCOMMITTEE ON EMPLOYER-EMPLOYEE RELATIONS, COMMITTEE ON EDUCATION AND THE WORKFORCE

Opening Statement of Chairman Sam Johnson

Employer-Employee Relations Subcommittee

March 13, 2002

GOOD AFTERNOON. LET ME EXTEND A WARM WELCOME TO ALL OF YOU, TO THE RANKING MEMBER, MR. ANDREWS, AND TO MY OTHER COLLEAGUES.

TODAY'S HEARING WILL FOCUS ON MENTAL HEALTH PARITY AND HOW IT WILL AFFECT PATIENTS AND EMPLOYERS. SPECIFICALLY THE HEARING WILL INVESTIGATE CURRENT AND PROPOSED LAWS TO PROVIDE MENTAL HEALTH CARE TO PATIENTS.

AS YOU KNOW, IN 1996 CONGRESS ENACTED THE MENTAL HEALTH PARITY ACT.

THIS ACT PREVENTED EMPLOYERS FROM ESTABLISHING ANNUAL OR LIFETIME MENTAL HEALTH CARE COVERAGE LIMITS UNLESS THE LIMITS ALSO APPLIED TO MEDICAL AND SURGICAL BENEFITS.

HOWEVER, THE LAW DID NOT REQUIRE EMPLOYERS TO PROVIDE MENTAL HEALTH COVERAGE. IT SIMPLY IMPOSED NEW REQUIREMENTS IF IT WAS OFFERED.

WHEN THE LAW EXPIRED AT THE END OF 2001, THE SENATE PASSED LEGISLATION SIGNIFICANTLY EXPANDING MENTAL HEALTH PARITY REQUIREMENTS.

THE SENATE LEGISLATION WOULD REQUIRE THAT BOTH MENTAL HEALTH AND MEDICAL AND SURGICAL COVERAGE HAVE IDENTICAL FINANCIAL REQUIREMENTS AND TREATMENT LIMITATIONS.

IN ENGLISH, THAT MEANS THAT WHEN YOU VISIT THE DOCTOR, YOU'LL HAVE

THE SAME COPAY AND NUMBER OF ALLOWABLE VISITS, NO MATTER WHAT THE CAUSE.

EMPLOYERS AND OTHERS EXPRESSED CONCERNS ABOUT THE SENATE LEGISLATION.

EMPLOYERS ARE ALREADY DEALING WITH YEARLY AVERAGE PREMIUM INCREASES OF FIFTEEN PERCENT OR MORE.

EMPLOYERS ARE WORRIED THAT THEY MAY HAVE TO DROP COVERAGE ALL TOGETHER BECAUSE OF SENATE PARITY REQUIREMENTS, INCREASED COSTS DUE SEVERAL NEW LEGISLATIVE PROPOSALS, INCLUDING THE PATIENTS BILL OF RIGHTS.

BECAUSE OF CONCERNS SUCH AS THESE, AND BECAUSE NO HOUSE COMMITTEE HAD FULLY EXAMINED THE IMPACT OF AN EXPANDED PARITY LAW, CONGRESS OPTED FOR A SIMPLE ONE YEAR REAUTHORIZATION OF THE 1996 LAW.

TODAY WE WILL LOOK AT THIS ISSUE IN DETAIL. WE WANT TO HEAR THE CONCERNS OF MENTAL HEALTH ADVOCATES ABOUT ACCESS TO MENTAL HEALTH SERVICES.

IN ADDITION, WE WANT EMPLOYERS AND CARE MANAGERS TO EXPLAIN HOW NEW REQUIREMENTS WOULD IMPACT THE CARE THEY PROVIDE TODAY.

WE ALSO HAVE A STATE LAW EXPERT HERE WHO WILL SHED SOME LIGHT ON HOW STATES ARE BALANCING THE CONCERNS OF ADVOCATES AND EMPLOYERS.

AFTER THOROUGHLY EXAMINING MENTAL HEALTH PARITY IN TODAY'S HEARING, THE SUBCOMMITTEE MAY LOOK AT SPECIFIC PROPOSALS THAT WOULD STRIKE THE APPROPRIATE BALANCE BETWEEN THE CONCERNS OF ADVOCATES AND EMPLOYERS.

I LOOK FORWARD TO WORKING WITH MY COLLEAGUES ON THE SUBCOMMITTEE AS WE EXAMINE THIS ISSUE.

RIGHT NOW, I'D LIKE TO WELCOME ALL OF OUR WITNESSES.

WE LOOK FORWARD TO YOUR TESTIMONY AND THE GUIDANCE IT WILL OFFER US AS WE ADDRESS THE ISSUE OF MENTAL HEALTH PARITY.

APPENDIX B - WRITTEN STATEMENT OF CONGRESSWOMAN MARGE ROUKEMA, SUBCOMMITTEE ON EMPLOYER-EMPLOYEE RELATIONS, COMMITTEE ON EDUCATION AND THE WORKFORCE

Testimony of the Honorable Marge Roukema

Congresswoman
United State House of Representatives

March 13, 2002

Thank you Chairman Johnson, Representative Andrews, and my fellow members of the Subcommittee. I want to commend you, and our Committee Chairman, John Boehner, for holding today's hearing on the vital issue of mental health parity. This is the first House hearing on parity, and I am proud that it is before the Subcommittee on which I serve.

As co-chair of the House Working Group on Mental Illness, I have actively promoted mental health parity legislation for nearly a decade, not only by sponsoring the leading House parity bills, but also by helping to educate our colleagues, congressional staff, and other public policymakers on the need to eliminate discrimination against patients who -- for no fault of their own -- happen to have a psychiatric illness.

Discrimination Against Patients Suffering from Mental Illness

Today's hearing is really all about discrimination. For too long, we in Congress have allowed health plans to openly and legally discriminate against one group of patients, by making them pay more out of pocket for their health care, allowing them fewer visits to their treating mental health clinician, arbitrarily limiting their hospital stays, and in some cases denying care altogether. We in Congress would be outraged (and rightly so) if health insurers told diabetics that they had to pay half the cost out of pocket for every visit to their endocrinologist or cancer patients that they could only see their oncologist three times. Why then is it acceptable for health plans to openly discriminate against patients who seek treatment for a mental illness?

I am here to dispel any remaining uninformed opinions regarding mental illness. I hope that there is no longer any debate about the validity of mental illness and the effectiveness of treatments. According to the landmark 1999 Report of the Surgeon General, mental illnesses affect a substantial number of Americans every year. Roughly 20 percent of the U.S. population is affected by mental disorders in any given year. Twenty percent of our children have mental illnesses with at least a mild functional impairment, and some 50 million adults suffer from mental illness (including substance abuse disorders) annually. The nation's elderly are particularly at risk. The rate of suicide among older Americans is the highest for all age groups. These illnesses are real and, left untreated, can have a devastating impact on the lives of patients and their families.

The good news is that mental illnesses can be treated more effectively today than at any other time in our history. Properly diagnosed -- and with timely treatment interventions -- patients, including working Americans, can recover and resume healthy and productive lives. The National Institute of Mental Health, for example, has shown that success rates of treatment for disorders such as schizophrenia, depression, and panic disorder surpass the success rates for treatment of other medical conditions such as heart disease.

As the Surgeon General's report notes, "everyday language tends to encourage a misperception that 'mental health' or 'mental illness' is unrelated to 'physical health' or 'physical illness.' In fact the two are inseparable." The argument over cost and effectiveness of treatment masks this essential truth: mind and body are inseparable and it is time we started treating them as such for insurance purposes.

Lack of Mental Health Parity is Costly to American Businesses

I appreciate the concern that businesses raise about the potential cost of national parity legislation. Certainly, we in Congress should not ignore such concerns. But the reality is that the lack of parity and the lack of access to effective treatment for mental illnesses cost American businesses far more today than a parity law ever will.

The Surgeon General estimates that the direct business cost of lack of parity and lack of access to timely treatment is at least $70 billion per year, mostly in the form of lost productivity (absenteeism and presenteeism), increased use of sick leave, and increased use of other medical services in the absence of access to psychiatric care. The New York Times reported in January, 2001 that "the Chevron Corporation found that it saved $7 for every dollar it spent on an employee assistance program offering mental health resources . . . and research at Johns Hopkins University found that insurance plans with the highest financial barriers to mental health treatment experienced a greater number of disability claims related to mental illness." An article in the September/October 1999 edition of Health Affairs reported that depressed workers use more disability days in any one-month period than other workers, costing employers as much as $395 per worker.

Obviously, an investment in workers' mental health pays off for businesses.

Parity in ERISA (Employee Retirement Income Security Act) Health Plans

Some 34 states have enacted some form of state parity law, although there is considerable variation in the scope of coverage of state laws. Because state law does not cover ERISA plans, more than 128 million Americans are exempted from state parity requirements. The ERISA statute makes it possible for employers to voluntarily provide health care for their employees. For the past 27 years, ERISA has provided uniform federal standards for all employer provided health, pension and welfare plans.

To ensure that Americans with ERISA health plans receive parity in mental illness coverage, Congress enacted the Mental Health Parity Act in 1996. This bill was introduced in the Senate by our colleagues Pete Domenici and Paul Wellstone. I was the House sponsor of the 1996 Act, which required parity for lifetime and annual dollar caps and provided a limited exemption for employers who could show that parity had directly increased their health care costs by at least 1 percent.

As necessary as the 1996 law was, it was a only a limited first step and fell well short of the requirements that many states now impose. It is now time for Congress to correct the shortcomings of our 1996 beginnings. We must enact a comprehensive parity law that truly ends the artificial mind/body coverage distinctions that are common in so many insurance plans today.

H.R. 162, the Mental Health and Substance Abuse Parity Amendments of 2001

In the current Congress, I have introduced H.R. 162, the Mental Health and Substance Abuse Parity Amendments of 2001. This bill -- cosponsored by over 200 of our colleagues -- would simply require those health plans that offer mental illness coverage to provide the same coverage for mental health care as for other medical/surgical care.

I want to emphasize at the outset that this is not a mandate. Rather, it is a coverage condition. H.R. 162 does not require plans to offer mental health coverage. It simply says that health plans cannot discriminate against persons seeking treatment for mental illness by establishing substantially different -- and deliberately discriminatory -- limits on such treatment.

There has been a lot of misinformation and distortion written about my parity bill. The bill does not require employers to offer mental health benefits. It says that if they do, the insurance coverage cannot set arbitrary and discriminatory coverage conditions on mental health services. The bill does not in any way interfere with the ability of health plans to manage the delivery of services. For example, the bill is absolutely clear that health plans may negotiate separate reimbursement rates and service delivery systems. They may manage benefits through pre-admission screening, prior authorization, and any other mechanism designed to ensure that covered services are medically necessary. They are not -- repeat not -- required to provide any specific mental health benefit. Finally, the bill does not equate parity requirements with extremely low- or no-cost services such as preventive care that plans offer as a positive well-patient incentive.

Mr. Chairman, while there are 203 cosponsors of H.R. 162, I recognize the political reality is that the legislation in its current form is not likely to move forward in the House. However, I remain committed to move meaningful parity legislation through Congress as are 245 of our colleagues in the House who have come out in support of mental health parity. As such, I am pleased to announce that Representative Kennedy and I will soon introduce the Domenici-Wellstone parity bill (S. 543) in the House. This bill responds directly to the concerns of business and insurance

groups. It will exempt small businesses with up to 50 employees. It will apply to in-network services only. It will -- albeit with extreme reluctance on my part -- not cover substance abuse. And it will include the same assurances that health plans will be able to manage the care they deliver. Over 230 Members of the House supported this exact legislation when it was attached as an amendment to the Senate FY2002 Labor/HHS/Education Appropriations bill. Unfortunately, this language was not retained in the final conference report.

The Congressional Budget Office estimates that the Senate language -- our new bill -- will have a premium impact of 0.9 percent. Let me stress, this is literally pennies per day for parity. This is clearly affordable. Not a single state that has enacted parity legislation has repealed a parity law, and several states that enacted narrow laws have even gone back to broaden them. We should trust that experience.

Our new bill will essentially codify what is already in place through the Federal Employees Health Benefits Program. The FEHBP covers millions of federal employees, including Members of Congress and our staff. Surely if it is good enough for Congress and staff, it ought to be good enough for millions of Americans who desperately need to be free from artificial and discriminatory limits on their mental health care!

Conclusion

Mr. Chairman, I want to remind everyone that behind the debate about cost and management of services and mandates is one simple fact. The parity debate is about patients. It is about the millions of Americans -- every one of them our constituents -- who are discriminated against because they happen to have a particular mental illness. We in Congress have an obligation to end this arbitrary discrimination against our constituents. I strongly urge this Subcommittee and the House to act this year to enact meaningful mental health parity legislation.

APPENDIX C - WRITTEN STATEMENT OF CONGRESSMAN PATRICK KENNEDY, 1ST DISTRICT OF RHODE ISLAND, U.S. HOUSE OF REPRESENTATIVES, WASHINGTON, D.C.

Testimony of the Honorable Patrick J. Kennedy

Congressman
United State House of Representatives

March 13, 2002

Thank you Chairman Johnson and Ranking Member Andrews for holding this important hearing today. It is my pleasure to be able to join you to discuss the need for parity in health care.

Mental health may have the distinction of being the biggest public health crisis nobody knows about. Fifty-four million Americans, an average of nearly 125,000 in each of our districts, has a diagnosable mental disorder. According to the World Health Organization and World Bank, four of the ten most costly diseases in terms of disability and fatality are mental illnesses. Mental illness and addictive disorders together are the single most burdensome family of diseases in industrialized nations, ahead of even heart disease. Yet the Surgeon General tells us that only one-third of those with mental disorders receive treatment.

These figures give us a sense of the breadth of the problem, but statistics alone do not speak to the importance of this legislation. If this Congress passes our parity bill, we will save lives. I don't mean figuratively. Lives are lost every day because teenagers, seniors, and others can't get the treatment they need. For every two homicides in this nation, there are three suicides, and in 90% of those cases, the victim had a diagnosable mental disorder.

These are the consequences of rationing mental health care. Tracy Mixson of Asheville, North Carolina watched the downward spiral of her friend, Jeff. He exhausted his health insurance and ran out of medication. He tried to see another doctor, but couldn't afford the costs and had to stop going. In her words, AI watched him suffer for a little while, and then it was over. He ended his life.

Can you imagine the anguish of a parent knowing that her bipolar child has barely a fifty-fifty chance of avoiding a suicide attempt? Marilyn Barna-DeWald, of Fairfax, Virginia, is the mother of a 10-year-old boy with bipolar disorder. She and her husband have literally begged insurance companies for appropriate care. Their son, however, does not receive the full range of medical care he needs and they live in terror of what he might do to himself.

What makes Ms. Barna-DeWald's predicament so heart-wrenching is that we know treatment works. As we have made leaps forward in brain research, treatments for mental illnesses have leapt forward as well. Treatment of mental illnesses are more

effective than treatment of many physical ailments, including heart disease. Yet millions of American parents are unable to afford care for their children, care that can save their child's life, because of outdated insurance practices.

How long will we continue to consign our constituents to bankruptcy, unemployment, or death because their kind of brain disorders are not deemed worthy of full insurance coverage? The American Medical Association, the Surgeon General, the National Institutes of Health, and Nobel laureates have documented the scientific basis of mental illnesses. Brain research has demonstrated the interrelation of the physical and mental.

As the Surgeon General's Report on Mental Health explains, a brain disease may be seen as a mental disorder or a physical disorder depending on the functions it disrupts. Drawing a distinction between these two manifestations of brain disease makes no sense.

You will hear, I am sure, that we cannot afford mental health parity. That if we treat mental illnesses the way we treat other diseases, health care costs will rise and people will lose insurance coverage. I believe that this contention is misguided for several reasons.

First, I am confident that nobody on this subcommittee, nobody in this Congress, would countenance rationing health care for cancer or asthma. Like mental illnesses these are potentially fatal, frequently treatable, chronic diseases. Unlike cancer and asthma patients, however, most Americans suffering from mental illnesses find that their health plans hinder access to necessary medical treatment.

If we would not tell asthma or cancer patients that their coverage is too expensive, why would we say that to the mentally ill? Essentially, we are asking the mentally ill to sacrifice potentially life-saving treatment in order to keep health care costs down for everybody else. The unfairness of that request is manifest.

What makes this state of affairs particularly unfortunate is that the cost of equal access to mental health care is not particularly high. As you probably know, the CBO has estimated that the Domenici-Wellstone parity language, which Congresswoman Roukema and I will be introducing in the House next week, would increase mental health costs by 0.9%.

This is not a shot-in-the-dark guess. There is plenty of evidence from the federal government and dozens of states with parity laws that this is very affordable. Each of us, and our families, gets the benefit of mental health parity through the Federal Employee Health Benefit Plan. In fact, our parity legislation has been written to parallel the provisions that are already available to federal employees.

The experience of the federal program so far has shown that costs are manageable. Vermont's comprehensive parity law resulted in no increase in the premiums of Blue Cross, which has 41% of the private market. We know from studies in Ohio,

Texas, North Carolina, and a number of other states that the doomsday scenarios have never come true.

In fact, I would argue that there is good reason to believe that the CBO estimate is too high. No cost estimate that I know of takes into account the savings in physical health care costs that result from better mental health care. The Wall Street Journal has reported that employees who report being depressed have health bills 70% higher than those who do not suffer from depression. This comports with NIMH research showing linkages between depression and physical ailments like heart attacks.

Moreover, these cost studies only look at the impact on private health plans. While the absence of parity means many go without care, many others wind up being cared for by public systems. Public health care systems pay for 42% of all health care costs, but 58% of mental health costs. The barriers to privately-financed mental health care shift the costs of treatment from private to public payers, a situation that can only exacerbate the current Medicaid and Medicare financing dilemmas.

Whatever the correct figure, some will say that any cost increase is too much when health insurance premiums are rising again and we're trying to emerge from a recession. It is clear, however, that the cost to society of not enacting parity far exceeds the costs of passing this bill.

Untreated mental illness is an enormous drag on our economy. The Wall Street Journal says that depression alone costs U.S. employers $70 billion a year in lost productivity and absenteeism. NIMH has estimated that all mental illnesses cost the U.S. over $300 billion each year.

It's not hard to imagine how the absence of parity costs our economy. Take the example of

Molly Close of Louisville, Kentucky. She wrote:

> In 1998 I was hospitalized 3 times for depression with suicidal intent. Each hospitalization was terminated, not because my doctor felt I was ready to leave, but because my insurance company refused to pay for further treatment. When I left the hospital the last time, I was still severely depressed. I was not healthy enough to return to my teaching career of 24 years. Since I had exhausted all my leave days, I was forced to resign my job and go on disability retirement. And, I=m lucky. Most people don=t have that option.

When you multiply stories like Molly Close's by the tens of millions of Americans with mental illnesses, you start to appreciate the magnitude of the costs of untreated mental illness. An inability to receive proper medical care turns potential wage

earners and taxpayers into welfare recipients. Those who remain in the workforce with untreated mental illnesses are twice as likely as their colleagues to miss work. Half of students in special education for emotional disturbances drop out of high school.

If we really want to assess the relative costs of our bill versus the status quo, then we should also add to these productivity factors the costs to society of increased homelessness, crime, and public assistance that are the unfortunate byproducts of mental health care rationing. It is the status quo, not our parity bill, that is too expensive.

When one person is unable to receive needed medical care it is a personal tragedy. When 36 million Americans with mental disorders don't receive the medical care they require, it's a public health crisis.

We cannot wait any longer. Waiting is a death sentence for thousands of mentally ill Americans. Waiting means more bankrupt families. It means more teens dropping out of school, more veterans on the streets, more workers out of jobs, and a perpetuation of the de facto transformation of our prisons to psychiatric hospitals of last resort.

Your colleague on this subcommittee, Congresswoman Roukema, and I have gathered 203 cosponsors for H.R. 162, the Mental Health and Substance Abuse Parity Amendments. While there is obviously broad support for our bill in the House, we have heard the concerns of the other side and thus next week are introducing a scaled-back version that mirrors S.543, the Domenici-Wellstone parity bill from the Senate.

I hope that our compromise bill will gain your support. The costs of inaction to our constituents, our economy, and our society are too great to do nothing. I look forward to working with you to give all Americans the health care they need and deserve. Thank you.

APPENDIX D - WRITTEN STATEMENT OF KAY NYSTUL, BEHAVIORAL HEALTH NURSE AND CASE MANAGEMENT COORDINATOR, WAUSAU BENEFITS, WAUSAU, WI

Testimony of Ms. Kay Nystul

Behavioral Health Nurse and Case Management Coordinator
Wausau Benefits

March 13, 2002

Introduction

Chairman Johnson, I truly appreciate the opportunity to provide a statement on the issue of mental health coverage. I am a registered nurse with over 20 years of experience in the field of mental health and feel very strongly about doing the right thing for patients in need of mental health treatment.

I am also a certified case manager and today work for Wausau Benefits as a behavioral health nurse. As a case manager, I work closely with patients and treatment providers to promote optimal quality of care while at the same time managing the patients' particular psychiatric needs and helping them to wisely use the resources available to them.

One of the primary resources is their health plan. Therefore, public policy that encourages health plan sponsors to continue offering mental health coverage for those who truly need it is vital. There are limits to health benefit plan funds and so choices have to be made. Unreasonable new federal mandates would put these already limited health plan funds at risk.

Employer plan sponsors must choose what coverage to offer or indeed, whether to offer coverage at all. Mandates that prescribe how plan sponsors must provide for mental health coverage and hence how much they must spend, create an incentive for employers to not offer the coverage. I know this is the opposite result of what Congress is trying to achieve. It is also very much at odds with what employer sponsors do voluntarily today.

The vast majority of the plans Wausau Benefits administers provide coverage for mental health benefits. The particular benefits vary widely. Typically inpatient and outpatient services for both psychiatric and chemical dependency are covered as are the prescription drugs needed to treat these conditions.

Wausau Benefits provides employee benefit plan administrative services for 434 employer groups ranging in size from 200 employees to large, national accounts national accounts which may include several thousand employees. The company's Claim Services Operation processes more than nine million claims per year for over two million benefit plan members. We do business with two-thirds of the health

care providers in the United States.

Behavioral Health Management

I have experience working in acute hospital settings, eating disorder units, chemical dependency/ substance support units, and community support programs. Given my clinical experience, I have concluded that while every situation is unique, there are appropriate levels of care that will achieve desired results. That is where case management can be very effective. Levels of care can be high-cost (most restrictive) or low-cost (least restrictive). Most patients prefer the least restrictive treatment setting if at all possible, which is consistent with both case management and quality of care objectives.

In my role as a nurse case manager, my number one job is to be an advocate for the patient. Case management empowers the patient to get to an independent state through education, assistance in accessing treatment options, and developing support systems. People need support and enough information about their illness to be able to make informed decisions. To those ends, nurse case managers communicate directly with the patients' attending physician to address the specific psychiatric needs of that patient.

When a third party payer is involved, experience suggests that money is spent differently than it would be spent if it were coming out of a family budget. On their own nickel, patients tend to be more selective about the level and kind of treatment sought. For some disorders, there are good alternative treatments that will provide the same quality of care as the more expensive clinical settings but at a fraction of the cost.

Furthermore, if all DSM conditions were to be eligible for coverage, there will inevitably be services to spend the money on, whether or not an actual clinical need for such services is proven or effective. It is critical that plans be able to continue using behavioral health management techniques and criteria so mental health dollars are wisely spent.

Mental Health Coverage and Federal Policy

The answer is complex, yet the desired outcome is simple. There is a clear need for mental health resources need to be carefully allocated to the right cases and treatment options.

Some federal proposals would require parity to be applied to all mental health conditions listed in the American Psychiatric Association's Diagnostic Statistical Manual. Federally mandated coverage for all conditions listed in the DSM-IV is not the right prescription for effective allocation and delivery of mental health benefits. A clear distinction needs to be drawn between biologically based mental illness and other conditions listed in the DSM.

Conditions that are biologically based, or where there is a bio-chemical imbalance with identifiable symptoms and significant functional impairment clearly require treatment. It is precisely these kinds of conditions for which health plans earmark their mental health dollars.

Serious mental health illnesses like major depression can affect anyone. These illnesses are treatable. Referral to a mental health specialist for evaluation and treatment is key to recovery. However, people don't always seek services because they don't recognize the symptoms, they have trouble asking for help, fear the stigma sometimes associated with mental health conditions or blame themselves for the state they're in. And, often, people don't know what treatments are available. While benefits and patient advocacy are clearly crucial, the private market response has fulfilled patient needs.

Biologically based conditions are generally more objectively defined and measurable, and more importantly, they respond to known treatment options. On the other hand, treatments for conditions that are not biologically based have few if any objective criteria to determine what treatment is necessary or when treatment has been successful.

I often refer to these people as the "unhappy well." People facing non-biologically based problems may seek treatment because they feel it will help them in some way and that certainly is their right, but an intervention is not likely to improve their situation, as life events will continue to occur. In other words, it can be difficult to determine when treatment should conclude or whether or not it is successful. In these scenarios, an unspecified sum of money can be spent on treatment that produces little or no tangible improvement.

Conditions listed in the DSM include such things as unhappiness in their job, a chaotic home life, or difficult personal relationships, none of which stem from chemical imbalances, but rather from life choices/ stressors that we all have.

Remember, the vast majority of employers do cover mental illness. However, generally plans do not cover mental health conditions that do not cause significant functional impairment. Such impairments include pathological gambling, bereavement, communication disorders, spirituality, sexual and gender identity disorders, conduct disorders, jet lag, and learning disorders. When people are able to function in activities of daily life, yet have a condition that is "diagnosable," the treatment sought should be considered optional or elective rather than necessary even though treatment could potentially increase quality of life. Using high cost treatments for low-impact conditions is not a wise use of limited health plan dollars.

The real tragedy occurs when an individual uses all the available benefit dollars for low-impact conditions and then develops significant symptoms that impact their ability to function in their daily lives. When benefit resources dry-up, other available resources need to be accessed (i.e., their own savings) or the condition goes untreated. Leaving serious mental conditions untreated is not in anyone's best

interest.

I am also concerned about proposals that would offer the application of medical necessity criteria as the sole means by which a health plan can control costs. Behavioral health management can be an effective tool to help promote quality of care and to control costs. Its use should be preserved. An environment where health plans can be sued for denying coverage challenges the ability for plans to continue these kinds of programs. Especially in the field of mental health, where there are relatively few clinical objective standards for diagnosis and treatment, applying generally accepted medical management principles becomes extremely risky.

Patient protection proposals now under consideration in Congress would impose a new level of legal liability for wrongfully denied claims for benefits. Were these proposals to become law, behavioral health management would no longer be an effective tool for curbing over-utilization of benefits.

Conclusion

In summary, I believe that case management works. Mandating parity treatment of the entire DSM-IV is not the answer. Federal mental health policy must be crafted in such a way that people who need mental health treatment get it.

Federally mental health policy must not put funding sources at risk; otherwise people will not be as likely to seek care when they need it. When people suffering from serious mental illness receive care when they need it, everybody wins. The employees get their lives back. The employer gets their employees back. No one faces financial devastation.

APPENDIX E - WRITTEN STATEMENT, WITH ATTACHMENTS, OF LEE DIXON, GROUP DIRECTOR, HEALTH POLICY TRACKING SERVICE, NATIONAL CONFERENCE OF STATE LEGISLATURES, WASHINGTON, D.C.

Testimony of Mr. Lee Dixon

Group Director for the Health Policy Tracking Service
National Conference of State Legislatures

March 13, 2002

My name is Lee Dixon. I am the Director of the Health Policy Tracking Service (HPTS) of the National Conference of State Legislatures (NCSL). NCSL is a bi-partisan organization that serves the legislators and staff of the states, commonwealths, territories and the District of Columbia. The HPTS has access to all health legislation in the states, as well as many task force and legislative study committee reports. It analyzes, monitors and publishes information on key legislation that will effect state health policy.

It is a pleasure to be here today on behalf of NCSL during this historic hearing on mental health parity. I am going to describe the standard NCSL uses to define and briefly discuss the current status of parity legislation in the state legislatures. In addition to my statement, I have submitted two documents for inclusion in today's hearing record. The first provides a legislative chronology of parity legislation in the states and a brief description of the laws enacted. The second contains a 50-state table on the current mental illness, alcoholism and other drug addiction parity, mandated benefit and mandated offering legislation.

Parity, as it relates to mental health, prohibits insurers or health care service plans from discriminating between coverage offered for mental illnesses and other physical disorders and diseases. NCSL defines parity as insurance coverage that makes no distinction between mental and physical illnesses covered by the plan. Many states require coverage of mental illness, but permit insurers to limit mental health benefits or to impose cost-sharing and other requirements on the beneficiary that do not apply to coverage of other illnesses. NCSL does not consider these mandated benefit laws parity laws. For additional detail on specific state requirements I have submitted for the record a chart, "Current State Laws Regarding Mental Health/Substance Abuse Parity and Mental Health/Substance Abuse Mandated Benefits."

Currently 23 states have laws that require mental health parity. Among the 23 states that have mental health parity laws, 14 require mental illness parity for all state-regulated carriers; 5 require parity for mental illness and substance abuse; and 4 states require parity for mental illness in their state employee health benefit plans. The map on page four of this statement displays the 23 states with parity laws.

Below is an example of language found in state parity laws.

TYPICAL PARITY PROVISION

The typical parity provision found in state legislation amends current state insurance laws by adding a new section entitled "Insurance Coverage for "X"---"X", being mental health, SMI, chemical dependency or a combination thereof. The amendment usually adds a section stating that:

> "Insurers shall provide benefits for "X" under the same terms and conditions as such is provided for other illnesses and diseases; or
>
> "Insurers [must] provide coverage and cost sharing for "X" on the same basis as other medical conditions."

The typical provision also provides definitions of related terms, including health insurer, serious mental illness, mental illness and medical coverage. In addition, it provides an effective date for the law. All policies issued or renewed after the date set are required to act in accordance with the statute. Benefits include lifetime and annual limits, co-payments, deductibles, visit limits for inpatient days and visit limits for outpatient visits. Benefits may also include partial hospitalization and residential treatment if specified in the law.

Because states define mental illnesses for coverage purposes differently, some variations among state laws exist. For example, **Arkansas** provides broad coverage for all mental illnesses listed in the *Diagnostic and Statistics Manual of the American Psychiatric Association* (DSM). Other state parity laws limit the coverage to a specific list of mental illnesses. Some states make a distinction between "biologically-based" mental illnesses and other mental illnesses, sometimes referred to as "serious mental illness." "Biologically based mental illness" (along with the lay term "serious mental illness") usually includes, but is not limited to the following diagnoses: schizophrenia, schizo-affective disorder, delusional disorder, bipolar affective disorders, major depression, panic disorder, paranoia, autism and obsessive-compulsive disorders.

Current Status of State Legislation

Many states are expanding current definitions of mental illness or adding provisions for substance abuse treatment. As of March 11, 2002, 88 bills related to coverage for the treatment of mental illness and/or substance abuse, including some that would allow for full parity, had been introduced or carried over in 28 states. While no parity laws have been enacted this year, legislation in five states has passed at least one chamber—**California, Colorado, New Hampshire, West Virginia** and **Wisconsin**). Those bills are summarized below. For additional information on the history of parity legislation in the states, I have submitted a brief state legislative history for inclusion in the hearing record.

In **New Hampshire**, HB 672 has passed the House and is pending in the Senate. New Hampshire currently provides full parity for biologically based mental illnesses for group plans. This bill expands that parity coverage to alcohol and drug abuse counseling and

eating disorders.

If enacted, **Colorado**, SB 131, would significantly expand insurance coverage for the mentally ill. Under the bill insurers will be required to provide coverage for the treatment of mental disorders, that is no less extensive than the coverage provided for any other illness. "Mental Disorders" is defined as any condition in the International Classification of Diseases, and the Diagnostic and Statistical Manual of Mental Disorders, including substance-related disorders such as alcohol dependence and alcohol abuse. Currently, only individuals with specific biologically based illnesses are covered. Additionally, any prior authorization or utilization review mechanism used in determining coverage would have be the same as, or no more restrictive than, that used in the determination to provide coverage for any other physical illness. Eliminated by the bill is the exemption under current law for certain small employers. The bill, which passed the Senate, is now in the House Committee on Health, Environment, Welfare and Institutions.

A **West Virginia** bill, HB 4039, mandates mental health insurance parity for individuals with serious mental illnesses who are covered by the Public Employees Insurance Agency, has passed both the House and the Senate, and is eligible for the Governor's signature. The bill defines serious mental illness as an illness included in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders under the diagnostic categories or sub-classifications of: (i) Schizophrenia and other psychotic disorders; (ii) bipolar disorders; (iii) depressive disorders; (iv) substance-related disorders with the exception of caffeine-related disorders and nicotine-related disorders; (v) anxiety disorders; and (vi) anorexia and bulimia. For any covered individual under the age of 19, the bill also provides coverage for attention deficit hyperactivity disorder, separation anxiety disorder, and conduct disorder. The bill includes language that exempts an insurer that can demonstrate that its total anticipated costs for the treatment of mental illness for any plan will exceed or has exceeded two percent of the total costs for the plan in any period.

California's CA SB 599 requiring parity for substance abuse treatment carried over from 2001. It has passed the Senate and is now in the Assembly.

Wisconsin's WI S 157, amends current law and would require insurers that provide coverage for the treatment of nervous and mental disorders and alcoholism and other drug abuse problems to provide the same coverage for that treatment that it provides for the treatment of physical conditions. The bill covers both group and individual plans.

TESTIMONY OF

LEE DIXON
DIRECTOR
HEALTH POLICY TRACKING SERVICE
THE NATIONAL CONFERENCE OF STATE LEGISLATURES

BEFORE THE
SUBCOMMITTEE ON EMPLOYER-EMPLOYEE RELATIONS
COMMITTEE ON EDUCATION AND THE WORKFORCE
U.S. HOUSE OF REPRESENTATIVES

REGARDING
STATE MENTAL HEALTH PARITY LAWS

March 13, 2002

Chairman Johnson and distinguished members of the subcommittee:

My name is Lee Dixon. I am the Director of the Health Policy Tracking Service (HPTS) of the National Conference of State Legislatures (NCSL). NCSL is a bi-partisan organization that serves the legislators and staff of the states, commonwealths, territories and the District of Columbia. The HPTS has access to all health legislation in the states, as well as many task force and legislative study committee reports. It analyzes, monitors and publishes information on key legislation that will effect state health policy.

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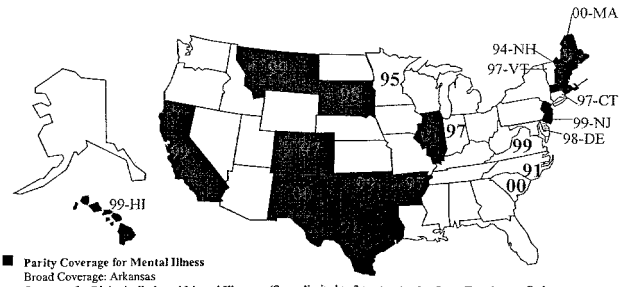
Map 1.

States That Have Enacted Full Parity Legislation



■ **Parity Coverage for Mental Illness**
Broad Coverage: Arkansas
Coverage for Biologically based Mental Illnesses (Some limited to 3 to 10 diagnoses): California, Colorado, Illinois, Maine, Massachusetts, Montana, New Jersey, New Hampshire, New Mexico, Oklahoma, Hawaii, Rhode Island, South Dakota

Parity for State Employees Only
Texas, Indiana, North Carolina, South Carolina
(IN, NC and SC include substance abuse)

Parity Coverage for Mental Illness and Substance Abuse
Connecticut,Delaware, Minnesota, Vermont, Virginia

Source: National Conference of State Legislatures, Health Policy Tracking Service, 2002.

NATIONAL CONFERENCE of STATE LEGISLATURES

The Forum for America's Ideas

HEALTH POLICY TRACKING SERVICE

Current State Laws Regarding Mental Health/Substance Abuse Parity and Mental Health/Substance Abuse Mandated Benefits
(MARCH 2002)

State	Effective Date.	Adopted Full Parity?	Insurance Policies Affected by Law.	Illnesses Covered. (1)	Type of Benefit.	Scope of Inpt.	Scope of Outpt.	Scope of Partial/ Residential	Co-pays and Co -insurance	Dollar Limits-lifetime/ annual
AL	1979	No	Group and HMO.	Alcoholism.	Mandated offering.	30 days.	1 day of inpatient converts to 3 sessions of outpatient.	1 day of inpatient converts to 2 days of partial /residential.	Not specified.	Not specified.
AL	2001	No	Individual and group with a small employer exemption of 50 or less.	Mental illness. (2)	Mandated offering.	Must be equal.	Must be equal.	Must be equal.	Must be equal.	Must be equal.
AK	1997	No	Group- 5 employees or less exempt. 20 or less must offer coverage.	Alcoholism and drug abuse.	Minimum mandated benefits or mandated offering for small group.	Not specified.	Not specified.	Not specified.	Must be equal to other illnesses.	At least $9,600 every 2 years. $19,200 lifetime.
AZ	1998	No	Group with small employer exemption 50 or less, or cost increase of 1% or more.	Mental illness.	Mandate for plans that offer benefits.	Not specified.	Not specified.	Not specified.	Can be different.	Must be equal.
AR	1987	No	Group and HMO.	Alcoholism and drug depend-ency.	Mandated offering.	Not less favorable generally.	Not less favorable generally.	Not less favorable generally.	Not less favorable generally.	$6,000 every 2 years. $12,000 lifetime.
AR	1997	Yes	Group: small employer exemption 50 or less; cost increase 1.5% or more.	Mental illnesses and develop-mental disorders. (3)	Full parity.	Must be equal.	Must be Equal.	Must be equal.	Must be equal.	Must be equal.

State	Effective Date.	Adopted Full Parity?	Insurance Policies Affected by Law.	Illnesses Covered. (1)	Type of Benefit.	Scope of Inpt.	Scope of Outpt.	Scope of Partial/ Residential	Co-pays and Co-insurance	Dollar Limits-lifetime/ annual
AR	7/01	No	Small employer of 50 or less.	Mental health.	Minimum mandated benefit.	Must be equal.	Must be equal.	Must be equal.	Must be equal.	$7,500 lifetime.
		No	Employer of 51 or more	Mental health.	Mandated benefits.	8 days.	40 visits.	8 days.	Must be equal.	Must be equal.
CA	1974	No	Group.	Mental or nervous disorders.	Mandated offering.	Not specified.	Not specified.	Not specified.	Not specified.	Not specified.
CA	1990	No	Group.	Alcoholism.	Mandated offering.	Not specified.	Not Specified.	Not specified.	Not specified.	Not specified.
CA	7/00	Yes	Group, individual and HMO.	Severe mental illness. (4)	Full parity.	Must be equal.	Must be equal.	Must be equal.	Must be equal.	Must be equal.
CO	1994	No	Group.	Alcoholism.	Mandated offering.	45 days.	$500 annually.	Not specified.	Shall not exceed 50% of the payment. Deductible shall not differ.	Not specified.
CO	1992	No	Group.	Mental illness excluding autism.	Mandated benefits.	45 days.	Covered under major medical, not less than $1,000 per year.	90 days.	Shall not exceed 50% of the payment. Deductible shall not differ.	No less than $1,000 per year. Lifetime limits not specified.
CO	1998	Yes	Group.	Biologically -based mental illness. (5)	Full parity.	Must be equal.	Must be equal.	Must be equal.	Must be equal.	Must be equal.
CT	1/00	Yes	Group and individual.	Mental or nervous conditions including alcoholism and drug addiction. (6)	Full parity.	Must be equal.	Must be equal.	Must be equal.	Must be equal.	Must be equal.
DE	1/99	Yes	Group, HMO, individual and state employee plans.	Serious mental illnesses. (7)	Full parity.	Must be equal.	Must be equal.	Must be equal.	Must be equal.	Must be equal.
DE	7/01	Yes	Group, HMO, individual and state employee plans.	Drug and Alcohol Dependencies.	Full parity.	Must be equal.	Must be equal.	Must be equal.	Must be equal.	Must be equal.
FL	1993	No	Group and HMO.	Substance abuse.	Mandated offering.	Not specified.	44 visit maximum. $35.00 maximum reimburse-ment per visit.	Not specified.	Not specified.	Minimum lifetime benefit of $2,000. Annual limits not specified.

State	Effective Date.	Adopted Full Parity?	Insurance Policies Affected by Law.	Illnesses Covered. (1)	Type of Benefit.	Scope of Inpt.	Scope of Outpt.	Scope of Partial/ Resident-ial	Co-pays and Co -insurance	Dollar Limits-lifetime/ annual
FL	1992	No	Group and HMO.	Mental and nervous disorders. (8)	Mandated offering.	30 days.	$1,000 per benefit year.	Up to the equivalent of 30 inpatient days.	May be different after minimum benefits are met.	May be different after minimum benefits are met.
GA	1998	No	Group and individual.	Mental disorders including substance abuse. (9)	Mandated offering.	30 days.	48 visits.	Not specified.	Must be equal.	Must be equal.
HI	7/99	Yes	Group and individual with small employer exemption-25 or less employees.	Serious mental illness. (10)	Full parity.	Must be equal.	Must be equal.	Must be equal.	Must be equal.	Must be equal.
HI	1988	No	Individual, group and HMO.	Mental illness. (11)	Mandated benefits.	30 days.	30 visits.	1 day of inpatient can be converted to 2 days of partial /residential.	Must be compar-able.	Must be compar-able.
HI	1988	No	Individual, group and HMO.	Alcohol and drug depend-ence.	Mandated benefits.	No less than two treatment episodes per lifetime.	No less than two treatment episodes per lifetime.	No less than two treatment episodes per lifetime.	Must be compar-able.	Must be compar-able.
ID	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
IL	1995	No	Group.	Alcoholism.	Mandated benefits.	Not (12) specified.	Not Specified.	Not specified.	Not specified.	Not specified.
IL	1991	No	Group.	Mental, emotional or nervous disorders.	Mandated offering.	Not specified.	Not specified.	Not specified.	Insured may be required to pay up to 50% of the expenses incurred.	Annual benefit may be limited to the lesser of $10,000 or 25% of the lifetime policy limit.
IL	1/02	Yes No	Group with a small employer exemption 50 or less.	Serious mental illness.	Full parity for serious mental illness. Mandated benefits for other mental illnesses.	Must be equal for serious mental illness. 45 days.	Must be equal for serious mental illness. 35 days.	Must be equal for serious mental illness. Not specified.	Must be equal for serious mental illness. Insured may be required to pay up to 50% of the expenses incurred.	Must be equal for serious mental illness. Annual benefit may be limited to the lesser of $10,000 or 25% of lifetime policy limit.

State	Effective Date.	Adopted Full Parity?	Insurance Policies Affected by Law.	Illnesses Covered. (1)	Type of Benefit.	Scope of Inpt.	Scope of Outpt.	Scope of Partial/ Resident-ial	Co-pays and Co -insurance	Dollar Limits-lifetime/ annual
IN	1/00	No Yes	Group, individual and state employees with a small employer exemption 50 or less, or cost increase of 4% or more.	Mental illness. (13), (14)	Mandate for plans that offer benefits. Full parity for state employee plans.	Must be equal for plans that offer coverage. Full parity for state employee plans.	Must be equal for plans that offer coverage. Full parity for state employee plans.	Must be equal for plans that offer coverage. Full parity for state employee plans.	Must be equal for plans that offer coverage. Full parity for state employee plans.	Must be equal for plans that offer coverage. Full parity for state employee plans.
IN	1/01	No	Group, individual and state employees with a small employer exemption 50 or less, or cost increase of 4% or more.	Substance abuse and chemical depend-ency, when the services are required in the treatment of a mental illness.	Mandated benefits.	Must be equal.	Must be equal.	Must be equal.	Must be equal.	Must be equal.
IA	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
KS	1998	No	Group, individual, HMO and state employee plans.	Alcoholism or drug abuse or mental conditions. (15)	Mandated benefits.	30 days.	Not less than 100% of the first $100, 80% of the next $100 and 50% of the next $1,640 per year and not less than $7,500 per lifetime.	Not specified.	Not specified.	Only specified for outpatient treatment.
KS	1/02	No No	Group, HMO and state employee plans. Group and individual.	Mental illness. Alcoholism, drug abuse, or nervous or mental condition.	Mandate for plans that offer mental health coverage. Mandated benefits.	45 days. 30 days.	45 visits. Not less than 100% of the first $100, 80% of the next $100 and 50% of the next $1,640 per year and not less than $7,500 per lifetime.	Not specified. Not specified.	Equal if offered. Not specified.	Not specified. Only specified for outpatient treatment.

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KY	1980	No	Group.	Alcoholism.	Mandated offering.	Emergency detox- 3 days reimbursed at $40 per day.	10 visits reimbursed at $10 per visit.	10 days reimbursed at $50 per day.	Not specified.	Not specified.
KY	1986	No	Group.	Mental illness. (16)	Mandated offering.	To the same extent as coverage for physical illness.	To the same extent as coverage for physical illness.	Not specified.	To the same extent as coverage for physical illness.	To the same extent as coverage for physical illness.
KY	7/00	No	Group with small employer exemption of 50 or less.	Mental illness and alcohol and other drug abuse. (17)	Mandate for plans that offer benefits.	Equal if offered.	Equal if offered.	Equal if offered.	Equal if offered.	Equal if offered.
LA	1/00	No	Group, HMO and state employee benefit plans.	Serious mental illness. (18)	Mandated benefits.	45 days.	52 visits.	1 day of inpatient can be converted to 2 days of partial /residential.	Must be equal.	Must be equal.
LA	1982	No	Group, self-insured and state employee plans.	Mental illness. (19)	Mandated offering.	Must be equal.	Must be equal.	Must be equal.	Must be equal.	Must be equal.
LA	1982	No	Group.	Alcoholism and drug abuse.	Mandated offering.	Not specified.	Not specified.	Not specified.	Not specified.	Not specified.
LA	9/01	No	Group with a small employer exception, or cost increase of 1% or more.	Mental health.	Mandate for plans that offer mental health coverage.	Not specified.	Not specified.	Not specified.	Not specified.	Equal if offered.
ME	1996	Yes	Group with a small employer exemption for 20 or less.	Mental illness. (20)	Full parity.	Must be equal.	Must be equal.	Must be equal.	Must be equal.	Must be equal.
ME	1996	No	Individual plans must offer coverage.	Mental illness. (20)	Mandated offering.	Must be equal.	Must be equal.	Must be equal.	Must be equal.	Must be equal.
ME	1984	No	Group with a small employer exemption for 20 or less.	Alcoholism and drug depend-ency.	Mandated benefit.	Not specified.	Not specified.	Not specified.	May place a maxim limit on benefits as long as they are consistent with the law.	May place a maxim limit on benefits as long as they are consistent with the law.

State	Effective Date.	Adopted Full Parity?	Insurance Policies Affected by Law.	Illnesses Covered. (1)	Type of Benefit.	Scope of Inpt.	Scope of Outpt.	Scope of Partial/ Resident-ial	Co-pays and Co -insurance	Dollar Limits-lifetime/ annual
MD	1994	No	Individual and group.	Mental illness, emotional disorder, drug abuse or alcohol abuse disorder.	Minimum mandated benefit.	Must be equal.	Unlimited visits but subject to different copays.	60 days.	Must be equal. except otpt. 80% - visits 1-5, 65% - visits 6-30, 50% visits 31 and above.	Must be equal.
MA	1991	No	Individual, group and HMO.	Alcoholism.	Mandated benefits.	30 days.	$500 per year.	May convert 2 days of partial/ residential to 1 day of inpatient.	Not specified.	Not specified.
MA	1996	No	Individual, group and HMO.	Mental or nervous conditions. (21)	Mandated benefits.	60 days in a mental hospital.	$500 per year.	May convert 2 days of partial/ residential to 1 day of inpatient.	Not specified.	Lifetime maximum must be equal for inpatient treatment.
MA	1/2001	Yes No	Individual, group, HMO and state employee plans. Small employer exemption of 50 or less that expires 1/1/2001.	Biologically -based mental illness. (22)	Full Parity for bio-based. Mandated benefits for mental illness and substance abuse.	Must be equal for bio-based. 60 days for mental illness and substance abuse.	Must be equal for bio-based. 24 visits for mental illness and substance abuse.	Must be equal.	Must be equal.	Must be equal.
MI	1988	No	Group for inpatient. Group and individual for other levels. Exemption for cost increase of 3% or more.	Substance abuse.	Mandated offering of inpatient and mandated benefits for other levels.	To the extent agreed upon.	$1,500 per year for outpatient and inter-mediate treatment.	$1,500 per year for outpatient and inter-mediate treatment.	Charges terms and conditions shall not be less favorable.	$1,500 per year for outpatient and inter-mediate treatment.
MI	1/2001	No	HMO's only, group and individual contracts, with a cost exemption of 3%.	Mental health and substance abuse	Minimum mandated benefits.	None.	20 visits for MI and $2,968.00 for SA.	$2,968.00 for SA.	Charges, terms, and conditions for the services shall not be less favorable than the maximum for any other compar-able service.	Lifetime not specified $2,968.00 annual limit for outpatient and inter-mediate care for SA treatment.

State	Effective Date.	Adopted Full Parity?	Insurance Policies Affected by Law.	Illnesses Covered. (1)	Type of Benefit.	Scope of Inpt.	Scope of Outpt.	Scope of Partial/ Resident-ial	Co-pays and Co -insurance	Dollar Limits-lifetime/ annual
MN	1995	Yes	Group, individual and HMO's (full parity for HMO's).	Mental health and chemical depen-dency.	Full parity for plans that offer coverage and HMO's.	Must be equal.	Must be equal.	Must be equal.	Must be equal.	Must be equal.
MN	1986	No	Group and individual.	Alcoholism, chemical dependenc y or drug addiction.	Mandated benefit.	At least 20% of the total days allowed but not less than 28 days yearly.	At least 130 hours of treatment per year.	At least 20% of the inpatient days allowed but not less than 28 days yearly.	Not specified.	Not specified.
MS	1975	No	Group.	Alcoholism.	Mandated benefit.	Not specified.	Not specified.	Not specified.	Not specified.	Annual limit of $1,000 per year, lifetime limit not specified.
MS	Jan. 1, 2002.	No	Group and individual with a cost exemption of 1%.	Mental illness.	Mandated offering for small employer's of 100 or less. Minimum mandated benefits for others.	30 days.	52 visits.	60 days.	Must be equal for inpatient and partial, however, payment for outpatient visits shall be a minimum of fifty percent (50%) of covered expenses.	Must be equal.

State	Effective Date.	Adopted Full Parity?	Insurance Policies Affected by Law.	Illnesses Covered. (1)	Type of Benefit.	Scope of Inpt.	Scope of Outpt.	Scope of Partial/ Resident-ial	Co-pays and Co -insurance	Dollar Limits-lifetime/ annual
MO	1995	No	Group and individual.	Alcoholism, chemical depend-ency or drug addiction.	Mandated benefit for alcoholism. Mandated offering for others.	30 days for alcoholism. 80% of reasonable charges, $2,000 max.	30 days for all levels of care total, not for each level.	30 days for all levels of care total, not for each level.	Not specified.	Not specified.
MO	1997	No	Group, individual and HMO.	Mental (23) disorders and chemical depend-ency. (24)	Mandated offering.	90 days for mental disorders and 6 days for detox.	2 visits for mental disorders, 26 visits for chemical depend-ency.	Must be equal for mental disorders, 21 days for chemical depend-ency	Must be equal.	Must be equal for mental illness. Chemical dependenc y may not be limited to less than 10 episodes of treatment.
MO	1/00	No	Group and individual.	Mental illness including alcohol and drug abuse. (25)	Mandate for plans that offer benefits.	Equal for mental illness, at least 30 days for alcohol and drug abuse if offered.	Equal for mental illness, at least 20 visits for alcohol and drug abuse if offered.	Not specified.	Shall not be un-reasonable in relation to the cost of services provided for mental illness.	A lifetime limit equal to 4 times the annual limit may be imposed for alcohol and drug abuse.

State	Effective Date.	Adopted Full Parity?	Insurance Policies Affected by Law.	Illnesses Covered. (1)	Type of Benefit.	Scope of Inpt.	Scope of Outpt.	Scope of Partial/ Resident-ial	Co-pays and Co -insurance	Dollar Limits-lifetime/ annual
MT	1/00	Yes	Group and individual.	Severe mental illness. (26)	Full parity.	Must be equal.	Must be equal.	Must be equal.	Must be equal.	Must be equal.
MT	7/97- law terminates 9/30/01 then law below is effective.	No	Group with a small group exemption (number not specified) or a cost increase of 1% or more.	Mental illness alcoholism and drug addiction.	Mandated benefits.	21 days each with a $4,000 max. every 2 years and a $8,000 max. lifetime for alcohol and drug addiction only.	No less than $2,000 for mental illness and $1,000 for alcohol and drug addiction per year.	One day of inpatient treatment for mental illness may be traded for two days of partial.	No less favorable up to maximums.	See specified maximums under inpatient and outpatient benefits. Aggregate limits may not be imposed more restrictively.
MT	10/1/01	No	Group.	Mental illness alcoholism and drug addiction.	Mandated benefits.	21 days for mental illness only. $6,000 max. every 12 months and until $12,000 max. lifetime is met, then annual benefit may be reduced to $2,000 for alcohol and drug addiction only.	No less than $2,000 for mental illness.	One day of inpatient treatment for mental illness may be traded for two days of partial.	No less favorable up to maximums.	Not specified.
		Yes	Group, individual and HMO.	Severe mental illness.	Full parity.	Must be equal.	Must be equal.	Must be equal.	Must be equal.	Must be equal.
NE	1989	No	Group and HMO.	Alcoholism.	Mandated offering.	30 days per year with at least two treatment periods in a lifetime.	60 visits during the lifetime of the policy.	Not specified.	No less favorable generally than for physical illness.	No less favorable generally than for physical illness.
NE	1/00	No	Group and HMO with a small employer exemption of 15 or less.	Serious mental illness. (27)	Mandate for plans that offer coverage.	Must be equal, if offered.	Must be equal, if offered.	Not specified.	May be different.	Must be equal if offered.

State	Effective Date.	Adopted Full Parity?	Insurance Policies Affected by Law.	Illnesses Covered. (1)	Type of Benefit.	Scope of Inpt.	Scope of Outpt.	Scope of Partial/ Resident-ial	Co-pays and Co -insurance	Dollar Limits-lifetime/ annual
NV	1997	No	Group, individual and HMO.	Abuse of alcohol or drugs.	Mandated benefits.	$9,000 inpatient and $1,500 for detox. per year.	$2,500 per year.	Not specified.	Must be paid in same manner.	Must be paid in same manner to maximum benefit. Lifetime max. not specified.
NV	1/00	No	Group and individual with a small employer exemption 25 or less, or cost increase of 2% or more.	Severe mental illness. (28)	Mandated benefits.	40 days.	40 visits.	1 day of inpatient can be converted to 2 days of partial /residential.	Must not be more than 150% of out-of-pocket expenses required for medical and surgical.	Must be equal.
NH	1993	No	Group, individual and HMO. Specifies different benefits for mental illness under major medical and non-major medical plans.	Mental or nervous conditions.	Mandated benefits.	Ratio of benefits shall be substantiall y the same as benefits for other illnesses under non-major medical plans and $3,000 per year, $10,000 per lifetime under major medical plans.	Ratio of benefits shall be substan-tially the same as benefits for other illnesses under non-major medical plans and not less than 15 hours per year under major medical plans.	Ratio of benefits shall be substantiall y the same as benefits for other illnesses under non-major medical plans and $3,000 per year, $10,000 per lifetime under major medical plans.	Ratio of benefits shall be substantiall y the same as benefits for other illnesses.	Ratio of benefits shall be substantiall y the same as benefits for other illnesses under non-major medical plans and $3,000 per year, $10,000 per lifetime under major medical plans.
NH	1995	Yes	Group.	Biologically -based mental illnesses. (29)	Full parity.	Must be equal.	Must be equal.	Must be equal.	Must be equal.	Must be equal.

State	Effective Date.	Adopted Full Parity?	Insurance Policies Affected by Law.	Illnesses Covered. (1)	Type of Benefit.	Scope of Inpt.	Scope of Outpt.	Scope of Partial/ Resident-ial	Co-pays and Co -insurance	Dollar Limits-lifetime/ annual
NJ	1985	No	Group and Individual.	Alcoholism.	Mandated benefits for care prescribed by a doctor.	Must be equal.	Must be equal.	Must be equal.	Benefits shall be provided to the same extent as benefits for any other sickness.	Benefits shall be provided to the same extent as benefits for any other sickness.
NJ	8/99	Yes	Group and individual.	Biologically -based mental illness. (30)	Full parity.	Must be equal.	Must be equal.	Must be equal.	Must be equal.	Must be equal.
NJ	1/00	Yes	State employee plans.	Biologically -based mental illness.	Full parity.	Must be equal.	Must be equal.	Must be equal.	Must be equal.	Must be equal.
NJ	10/02	No	Individual.	Biologically -based mental illness, and alcohol and substance abuse.	Mandated benefits.	90 days with no coinsuranc e, $500 copayment per inpatient stay for bio-based mental illness only. 30 day with 30% coinsuranc e for alcohol and substance abuse only.	Not specified.	30 days with 30% coinsuranc e for bio-based mental illness. 30 days with 30% coinsuranc e for alcohol and substance abuse.	Not specified.	Not specified.
NM	1987	No	Group.	Alcoholism.	Mandated offering.	30 days per year, limited to no less than two episodes per lifetime.	30 visits per year, limited to no less than two episodes per lifetime.	Not specified.	Consistent with those imposed on other benefits.	Consistent with those imposed on other benefits.
NM	10/00	Yes	Group with different exemptions for small and large employers.	Mental health benefits. (31)	Full Parity.	Must be equal.	Must be equal.	Must be equal.	Must be equal.	Must be equal.
NY	1998	No	Group.	Mental , nervous, or emotional disorders and alcoholism and substance abuse.	Mandated Offering.	30 days-mental illness, 30 days-alcoholism or substance abuse, 7 days-detox.	$700-mental illness and 60 visits for alcoholism or substance abuse.	Not specified.	As deemed appropriate by the superinten-dent and are consistent with those for other benefits.	As deemed appropriate by the superinten-dent and are consistent with those for other benefits.

State	Effective Date.	Adopted Full Parity?	Insurance Policies Affected by Law.	Illnesses Covered. (1)	Type of Benefit.	Scope of Inpt.	Scope of Outpt.	Scope of Partial/ Resident-ial	Co-pays and Co -insurance	Dollar Limits-lifetime/ annual
NC	1985	No	Group.	Chemical depend-ency. (32)	Mandated offering.	$8,000 per year and $16,000 per lifetime.	$8,000 per year and $16,000 per lifetime.	$8,000 per year and $16,000 per lifetime.	$8000 per year and $16,000 per lifetime.	$8,000 per year and $16,000 per lifetime.
NC	1997	Yes	State employee plans.	Mental illness and chemical depen-dency. (32)	Full parity.	Must be equal.	Must be equal.	Must be equal.	Must be equal.	Must be equal.
ND	1995	No	Group and HMO.	Mental disorders, alcoholism and drug addiction.	Mandated benefits.	45 days for mental illness and 60 days for substance abuse.	30 hours for mental illness and 20 visits for substance abuse.	120 days mental illness and 120 days for substance abuse.	No deductible or copay for first 5 hours not to exceed 20% for remaining hours.	Lifetime and annual dollar limits not specified.
OH	1985	No	Group and self-insured.	Mental or nervous disorders and alcoholism.	Mandate for plans that offer mental health coverage. Mandated benefits for alcoholism.	At least $550 for mental illness and $550 for alcoholism per year.	At least $550 for mental illness and $550 for alcoholism per year.	At least $550 for mental illness and $550 for alcoholism per year.	Benefits are subject to reasonable deductibles and coinsur-ance.	Lifetime dollar limits are not specified.
OK	1/00	Yes	Group with a small employer exemption 50 or less, or cost increase of 2% or more.	Severe mental illness. (33)	Full parity.	Must be equal.	Must be equal.	Must be equal.	Must be equal.	Must be equal.
OR	1981	No	Individual.	Alcoholism.	Mandated offering.	$4,500 for in a 24 month period.	$4,500 in a 24 month period.	$4,500 in a 24 month period.	Coverage must be no less than 80% of total.	Lifetime not specified.
OR	7/00	No	Group and HMO.	Mental or nervous conditions including alcoholism and chemical depend-ency. (34)	Mandated benefits.	SA = $5,625 adults and $5,000 children. MH = $5,000 adults and $7,500 children per 24 months.	SA = $1,875 adults and $2,500 children. MH = $2,500 for both per 24 months.	SA = $4,375 adults and $3,750 children. MH = $1,250 adults and $3,125 for children per 24 months.	Shall be no greater than those for other illnesses.	Dual diagnosis MH/SA= $13,125 for adults and $15,625 for children. SA only = $8,125 for adults and $13,125 for children per 24 months.

State	Effective Date.	Adopted Full Parity?	Insurance Policies Affected by Law.	Illnesses Covered. (1)	Type of Benefit.	Scope of Inpt.	Scope of Outpt.	Scope of Partial/ Residential	Co-pays and Co-insurance	Dollar Limits-lifetime/ annual
PA	1989	No	Group and HMO.	Alcoholism or drug addiction.	Mandated benefits.	7 days of detox per year, 28 per lifetime.	30 visits per year, 120 per lifetime.	30 days per year, 90 days per lifetime.	For the first course of treatment shall be no greater than those for other illnesses.	Dollar limits not specified, day and visit limits as specified for each level of care.
PA	4/99	No	Group and HMO-small employer exemption 50 or less.	Serious mental illness. (35)	Mandated benefits.	30 days.	60 visits. 1 day of inpatient can be converted to 2 visits.	Not specified.	Must not prohibit access to care.	Must be equal.
RI	1995	No	Individual, group and self-insured.	Substance dependency and abuse. (36)	Mandated benefits.	Three episodes of detox or 21 days, whichever comes first, per year.	30 hours for each individual under treatment and 20 hours for family per year.	30 days per year not to exceed lifetime limit of 90 days.	Not specified.	Not specified.
RI	1995	Yes	Individual, group, self-insured and HMO.	Serious mental illness. (37)	Full parity.	Must be equal.	Must be equal.	Not specified.	Must be equal.	Must be equal.
RI	1/02	No	Individual, group, self-insured and HMO.	Mental illness, including substance abuse.	Minimum mandated benefit.	Must be equal.	30 visits for mental illness only. 30 hours for substance abuse only. Five (5) detoxification occurrences or 30 days, whichever comes first.	Must be equal.	Must be equal.	Must be equal.
SC	1994	No	Group.	Psychiatric conditions, including substance abuse. (38)	Mandated offering.	$2,000 per year total overall.	$2,000 per year total overall.	$2,000 per year total overall.	May be different.	Lifetime maximum of $10,000.
SC	1/1/2002	Yes	State employee insurance plan with cost increase exemptions	Mental health condition or alcohol or substance abuse. (39)	Full parity.	Must be equal.	Must be equal.	Must be equal.	Must be equal.	Must be equal.
SD	1979	No	Group, individual and HMO.	Alcoholism.	Mandated offering.	30 days care overall each 6 months, 90 days lifetime.	30 days care overall each 6 months, 90 days lifetime.	30 days care overall each 6 months, 90 days lifetime.	On the same basis as benefits provided for other illnesses.	On the same basis as benefits provided for other illnesses.

State	Effective Date.	Adopted Full Parity?	Insurance Policies Affected by Law.	Illnesses Covered. (1)	Type of Benefit.	Scope of Inpt.	Scope of Outpt.	Scope of Partial/ Resident-ial	Co-pays and Co -insurance	Dollar Limits-lifetime/ annual
SD	1998	Yes	Group, individual and HMO.	Biologically -based mental illness. (40) 1999 amend-ment narrows definition.	Full parity.	Must be equal.	Must be equal.	Must be equal.	Must be equal.	Must be equal.
TN	1982	No	Group with with a small employer exemption 50 or less, or cost increase of 1% or more.	Alcohol and drug depend-ency.	Mandated offering.	Must be equal.	Must be equal.	Must be equal.	Must be equal.	Must be equal.
TN	1/00	No	Group with a small employer exemption 25 or less, or cost increase of 1% or more.	Mental or nervous conditions. (41)	Mandated benefits.	20 days.	25 visits.	1 day of inpatient can be converted to 2 days of partial/ residential.	Must be equal.	Must be equal.
TX	1991	Yes	State employee plans.	Biologically -based mental illness. (42)	Full parity.	Must be equal.	Must be equal.	Must be equal.	Must be equal.	Must be equal.
TX	1981	No	Group and self-insured with an exemption for self-insured plans of 250 or less.	Chemical depend-ency. (43)	Mandated benefits with a mandated offering for self-insured of 250 or less.	Lifetime maximum of three separate series of treatments including all levels of medically necessary care in each episode.	Lifetime maximum of three separate series of treatments including all levels of medically necessary care in each episode.	Lifetime maximum of three separate series of treatments including all levels of medically necessary care in each episode.	Must be sufficient to provide appropriate care.	Must be sufficient to provide appropriate care.
TX	1997	No	Group and HMO with a small employer exemption of 50 or less.	Serious mental illness. (44)	Mandated benefits with a mandated offering for small groups of 50 or less.	45 days.	60 visits. Medication checks shall not be counted towards limit.	Not specified.	Must be equal.	Must be equal.
UT	1/1/2001-HMO 7/1/2001-Group	No	Group and HMO's.	Mental illness as defined by the DSM.	Mandated offering.	May include a restriction.	May include a restriction.	May include a restriction.	May include a restriction.	May include a restriction.
UT	1994	No	Group.	Alcohol and drug depend-ency.	Mandated offering.	Not specified.	Not specified.	Not specified.	Not specified.	Not specified.

State	Effective Date.	Adopted Full Parity?	Insurance Policies Affected by Law.	Illnesses Covered. (1)	Type of Benefit.	Scope of Inpt.	Scope of Outpt.	Scope of Partial/ Resident-ial	Co-pays and Co -insurance	Dollar Limits-lifetime/ annual
VT	1998	Yes	Group, individual and state employee plans.	Mental health condition including alcohol and substance abuse. (45)	Full parity.	Must be equal.	Must be equal.	Must be equal.	Must be equal.	Must be equal.
VA	Effective 1/00 to 7/1/2004	Yes	Group and individual with a small group exemption 25 or less.	Biologically -based mental illness including drug and alcohol addiction. (46)	Full parity.	Must be equal to achieve the same outcome as treatment for any other illness.	Must be equal to achieve the same outcome as treatment for any other illness.	Must be equal to achieve the same outcome as treatment for any other illness.	Must be equal to achieve the same outcome as treatment for any other illness.	Must be equal to achieve the same outcome as treatment for any other illness.
VA	Effective until 1/00 and after 7/1/2004.	No	Group, individual and HMO.	Mental health and substance abuse.	Mandated benefits.	25 days for adults and children.	20 visits for adults and children.	Up to 10 days of inpt. can be converted for children to 1.5 days of partial for 1 day of inpt.	Co-insurance for otpt. can be no more than 50% after 5th visit. All others must be equal.	Benefits shall be no more restrictive than for other illnesses except as specified.
WA	1990	No	Group.	Chemical depend-ency.	Mandated benefit.	Not specified.	Not specified.	Not specified.	Not specified.	Not specified.
WA	1987	No	Group and HMO.	Mental health treatment.	Mandated offering.	Not specified.	Not specified.	Not specified.	Reason-able deductible amounts and co-payments.	Not specified.
WV	1998	No	Group.	Alcoholism. (47)	Mandated offering.	30 days.	Not specified.	Not specified.	Must be equal up to 30 days. Can not exceed 50% for otpt.	Not less than $750 annually and not less than an amount equal to the lesser of $10,000 or 25% of the lifetime limit.
WV	1998	No	Group and individual with a cost increase exemption of 1%.	Mental or nervous conditions.	Mandated offering.	45 days in a mental hospital, must be equal in a general hospital.	50% of the eligible expenses up to $500 per year, must not exceed 50 visits.	Not specified.	Not specified.	Lifetime and aggregate limits must be equal.
WY	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Source: Health Policy Tracking Service, National Conference of State Legislatures

NOTES

1. There are 13 DSM diagnoses commonly referred to as biologically-based mental illnesses by mental health providers and consumer organizations. Between 3 and 13 of these diagnoses are referred to in various state parity laws.

2. In AL mental illness is defined as: 1) schizophrenia, schizophrenia form disorder, schizo-affective disorder; 2) bipolar disorder; 3) panic disorder; 4) obsessive-compulsive disorder; 5) major depressive disorder; 6) anxiety disorders; 7) mood disorders; 8) Any condition or disorder involving mental illness, excluding alcohol and substance abuse, that falls under any of the diagnostic categories listed in the mental disorders section of the International Classification of Disease, as periodically revised.

3. Mental illnesses and developmental disorders are defined in AR as disorders listed in the Internal Classification of Disease Manual and the Diagnostic and Statistics Manual of the American Psychiatric Association (DSM).

4. CA defines severe mental illnesses as: 1) schizophrenia, 2) schizoaffective disorder, 3) bipolar disorder (manic-depressive illness), 4) major depressive disorders, 5) panic disorder, 6) obsessive-compulsive disorder, 7) pervasive developmental disorder or autism, 8) anorexia nervosa, and 9) bulimia nervosa.

5. In CO biologically-based mental illness is defined as 1) schizophrenia, 2) schizoaffective disorder, 3) bipolar affective disorder, 4) major depressive disorder, 5) specific obsessive compulsive disorder and 6) panic disorder.

6. CT defines mental or nervous condition as mental disorders, as defined in the most recent edition of the American Psychiatric Association's 'Diagnostic and Statistical Manual of Mental Disorders and includes alcoholism and drug addiction as defined by the DSM.

7. In DE serious mental illness means any of the following biologically-based mental illnesses: 1) schizophrenia, 2) bipolar disorder, 3) obsessive compulsive disorder, 4) major depressive disorder, 5) panic disorder, 6) anorexia nervosa, 7) bulimia nervosa, 8) schizoaffective disorder and 9) delusional disorder.

8. In FL mental and nervous disorders are defined by the Diagnostic and Statistics Manual of the American Psychiatric Association (DSM).

9. In GA mental disorders are defined by the Internal Classification of Disease Manual or the Diagnostic and Statistics Manual of the American Psychiatric Association (DSM).

10. HI defines serious mental illness to mean: 1) schizophrenia 2) schizoaffective disorder, and 3) bipolar mood disorder, as defined in the most recent version of the Diagnostic and Statistical Manual of the American Psychiatric Association, which is of sufficient severity to result in substantial interference with the activities of daily living.

11. In HI mental illness means a syndrome of clinically significant psychological, biological, or behavioral abnormalities that results in personal distress or suffering, impairment of capacity for functioning or both.

12. Statute reads: no policy of group accident and health insurance delivered in this state which provides inpatient hospital coverage for sickness shall exclude from such coverage the treatment of alcoholism. No further specifications are provided.

13. IN defines "coverage for services for mental illness" to include benefits with respect to mental health services as defined by the contract, policy, or plan for health services. However, the term does not include services for the treatment of substance abuse or chemical dependency.

14. IN full parity is for state employee plans only. Other plans have a mandate that if they offer mental health benefits, those benefits must be equal to other health benefits.

15. KS defines nervous or mental conditions to mean disorders specified in the Diagnostic and Statistics Manual of mental disorders, forth edition (DSM-IV), but shall not include conditions not attributable to a mental disorder that are a focus of attention or treatment.

16. KY defines mental illness to mean psychosis, neurosis or an emotional disorder.

17. KY defines mental health condition to mean any condition or disorder that involves mental illness or alcohol and other drug abuse that falls under any of the diagnostic categories listed in the Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition) or that is listed in the mental disorders section of the international classification of disease, or the most recent subsequent editions.

18. In LA severe mental illness shall include any of the following diagnosed severe mental illnesses: 1) schizophrenia or schizoaffective disorder, 2) bipolar disorder, 3) pervasive developmental disorder or autism, 4) panic disorder., 5) obsessive-compulsive disorder, 6) major depressive disorder, 7) anorexia/bulimia, 8) asperger's disorder, 9) intermittent explosive disorder, 10) posttraumatic stress disorder, 11) psychosis NOS (not otherwise specified) when diagnosed in a child under seventeen years of age, 12) rett's disorder, 13) tourette's disorder.

19. In LA mental disorders are disorders other than severe mental illnesses as defined in 15 above.

20. In ME mental illness is defined as: 1) schizophrenia, 2) bipolar disorder, 3) pervasive developmental disorder, 4) autism, 5) paranoia, 6) panic disorder, 7) obsessive compulsive disorder, 8) major depressive disorder.

21. MA defines mental or nervous conditions as defined by the standard nomenclature of the American Psychiatric Association.

22. MA defines biologically-based mental disorders are defined, as described in the most recent edition of the Diagnostic and Statistical Manual of the American Psychiatric Association: 1) schizophrenia, 2) schizoaffective disorder, 3) major depressive disorder, 4) bipolar disorder, 5) paranoia and other psychotic disorders, 6) obsessive-compulsive disorder, 7) panic disorder, 8) delirium and dementia, 9) affective disorders, and 10) any biologically-based mental disorders appearing in the DSM that are scientifically recognized and approved by the commissioner of the department of mental health in consultation with the commissioner of the division of insurance.

23. MO defines recognized mental illness as those conditions classified as "mental disorders" in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, but shall not include mental retardation.

24. MO defines chemical dependency as the psychological or physiological dependence upon and abuse of drugs, including alcohol, characterized by drug tolerance or withdrawal and impairment of social or occupational role functioning or both.

25. MO defines mental illness as the following disorders contained in the International Classification of Diseases (ICD-9-CM): 1) schizophrenic disorders and paranoid states (295 and 297, except 297.3); 2) major depression, bipolar disorder, and other affective psychoses (296); 3) obsessive compulsive disorder, post-traumatic stress disorder and other major anxiety disorders (300.0, 300.21, 300.22, 300.23, 300.3 and 309.81); 4) early childhood psychoses, and other disorders first diagnosed in childhood or adolescence (299.8, 312.8, 313.81 and 314); 5) alcohol and drug abuse (291, 292, 303, 304, and 305, except 305.1); and 6) anorexia nervosa, bulimia and other severe eating disorders (307.1, 307.51, 307.52 and 307.53); and 7) senile organic psychotic conditions (290).

26. In MT severe mental illness is defined as the following disorders as defined by the American Psychiatric Association: 1) schizophrenia; 2) schizoaffective disorder; 3) bipolar disorder; 4) major depression; 5) panic disorder; 6) obsessive-compulsive disorder; and 7) autism.

27. In NE serious mental illness means, prior to January 1, 2002, 1) schizophrenia, 2) schizoaffective disorder, 3) delusional disorder, 4) bipolar affective disorder, 5) major depression, and 6) obsessive compulsive disorder; and Serious mental illness means, on and after January 1, 2002, any mental health condition that current medical science affirms is caused by a biological disorder of the brain and that substantially limits the life activities of the person with the serious mental illness. Serious mental illness includes, but is not limited to 1) schizophrenia, 2) schizoaffective disorder, 3) delusional disorder, 4) bipolar affective disorder, 5) major depression, and 6) obsessive compulsive disorder.

28. NV defines severe mental illness to mean any of the following mental illnesses that are biologically based and for which diagnostic criteria are prescribed in the "Diagnostic and Statistical Manual of Mental Disorders," Fourth Edition, published by the American Psychiatric Association: 1) schizophrenia, 2) schizoaffective disorder, 3) bipolar disorder, 4) major depressive disorders, 5) panic disorder, 6) obsessive-compulsive disorder.

29. NH defines biologically-based mental illnesses as: 1) schizophrenia, 2) schizoaffective disorder, 3) major depressive disorder, 4) bipolar disorder, 5) paranoia and other psychotic disorders, 6) obsessive compulsive disorder, 7) panic disorder and 8) pervasive developmental disorder or autism.

30. NJ defines biologically-based mental illnesses as a mental or nervous condition that is caused by a biological disorder of the brain and results in a clinically significant or psychological syndrome or pattern that substantially limits the functioning of the person with the illness including, but not limited to: 1) schizophrenia, 2) schizoaffective disorder, 3) major depression, 4) bipolar disorder, 5) paranoia and other psychotic disorders, 6) obsessive compulsive disorder, 7) panic disorder and 8) autism.

31. NM defines "mental health benefits" to mean mental health benefits as described in the group health plan or group health insurance offered in connection with the plan but does not include substance abuse or gambling addiction.

32. NC defines "mental illness" to mean: (i) when applied to an adult, an illness which so lessens the capacity of the individual to use self-control, judgment, and discretion in the conduct of his affairs and social relations as to make it necessary or advisable for him to be under treatment, care, supervision, guidance, or control; and (ii) when applied to a minor, a mental condition, other than mental retardation alone, that so impairs the youth's capacity to exercise age adequate self-control or judgment in the conduct of his activities and social relationships so that he is in need of treatment. NC defines chemical dependency to mean the pathological use or abuse of alcohol or other drugs in a manner or to a degree that produces an impairment in personal, social or occupational functioning and which may, but need not, include a pattern of tolerance and withdrawal.

33. OK defines "severe mental illness" as: 1) schizophrenia, 2) bipolar disorder, 3) major depression, 4) panic disorder, 5) obsessive-compulsive disorder, and 6) schizoaffective disorder as defined in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders.

34. OR defines chemical dependency to mean the addictive relationship with any drug or alcohol characterized by either a physical or psychological relationship, or both, that interferes with the individual's social, psychological or physical adjustment to common problems on a recurring basis. For purposes of this section, chemical dependency does not include addiction to, or dependency on, tobacco, tobacco products or foods. It does not provide a specific definition for mental or nervous conditions.

35. PA defines serious mental illness to mean any of the following mental illnesses as defined by the American Psychiatric Association in the most recent edition of the Diagnostic and Statistical Manual: 1) schizophrenia, 2) bipolar disorder, 3) obsessive-compulsive disorder, 4) major depressive disorder, 5) panic disorder, 6) anorexia nervosa, 7) bulimia nervosa, 8) schizoaffective disorder and 9) delusional disorder.

36. RI defines substance dependency and substance abuse as the pattern of pathological use of alcohol or other psychoactive drugs characterized by impairments in social and/or occupational functioning, debilitating physical condition, inability to abstain from or reduce consumption of the substance, or the need for daily substance use for adequate functioning.

37. RI defines serious mental illness to mean any mental disorder that current medical science affirms is caused by a biological disorder of the brain and that substantially limits the life activities of the person with the illness. The term includes, but is not limited to: 1) schizophrenia, 2) schizoaffective disorder, 3) delusional disorder, 4) bipolar affective disorders, 5) major depression, and 6) obsessive-compulsive disorder.

38. SC defines psychiatric conditions to mean those mental and nervous conditions, drug and substance addiction or abuse, alcoholism, or other conditions that are defined, described, or classified as psychiatric disorders or conditions in the most current publication of the American Psychiatric Association entitled "The Diagnostic and Statistical Manual of Mental Disorders".

39. SC defines mental health condition to mean; schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, pervasive developmental disorder or autism, panic disorder, obsessive-compulsive disorder, social anxiety disorder, anorexia, bulimia, asperger's disorder, intermittent explosive disorder, post-traumatic stress disorder, psychosis not otherwise specified when diagnosed in a child under seventeen years of age, Rett's disorder, or Tourette's disorder.

40. SD defines biologically-based mental illness, to mean: 1) schizophrenia and other psychotic disorders, 2) bipolar disorder, 3) major depression, and 4) obsessive-compulsive disorder.

41. TN defines mental or nervous conditions as described and defined in the Diagnostic Standard Manual of the American Psychiatric Association.

42. TX defines biologically-based mental illness as a serious mental illness that current medical science affirms is caused by a physiological disorder of the brain that substantially limits the life activities of the person afflicted with the illness and includes: 1) schizophrenia, 2) paranoid and other psychotic disorders, 3) bipolar disorders (manic-depressive disorders), 4) major depressive disorders, and 5) schizoaffective disorders.

43. TX defines chemical dependency to mean the abuse of or psychological or physical dependence on or addiction to alcohol or a controlled substance.

44. TX defines serious mental illness to mean the following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM): 1) schizophrenia, 2) paranoid and other psychotic disorders, 3) bipolar disorders (hypomanic, manic, depressive, and mixed), 4) major depressive disorders (single episode or recurrent), 5) schizoaffective disorders (bipolar or depressive), 6) pervasive developmental disorders, 7) obsessive-compulsive disorder, and 8) depression in childhood and adolescence.

45. VT defines mental health condition as any condition or disorder involving mental illness or alcohol or substance abuse that falls under any of the diagnostic categories listed in the mental disorders section of the international classification of disease, as periodically revised.

46. VA defines biologically-based mental illness as any mental or nervous condition caused by a biological disorder of the brain that results in a clinically significant syndrome that substantially limits the person's functioning; specifically, the following diagnoses are defined as biologically based mental illness as they apply to adults and children: 1) schizophrenia, 2) schizoaffective disorder, 3) bipolar disorder, 4) major depressive disorder, 5) panic disorder, 6) obsessive-compulsive disorder, 7) attention deficit hyperactivity disorder, 8) autism, and 9) drug and alcoholism addiction.

47. WV defines alcoholism as a chronic disorder or illness in which the individual is unable, for psychological or physical reasons, or both, to refrain from the frequent consumption of alcohol in quantities sufficient to produce intoxication and, ultimately, injury to health and effective functioning.

APPENDIX F - WRITTEN STATEMENT OF HENRY HARBIN, M.D., CHAIRMAN OF THE BOARD, MAGELLAN HEALTH SERVICES, INC., COLUMBIA, MD, ALSO TESTIFYING ON BEHALF OF THE AMERICAN MANAGED BEHAVIORAL HEALTHCARE ASSOCIATION

Testimony of Dr. Henry Harbin, M.D.

Chairman of the Board
Magellan Health Services

On Behalf Of
The American Managed Behavioral Healthcare Association

March 13, 2002

Good Morning, Mr. Chairman and Members of the Committee. I am Henry Harbin, Chairman of the Board of Magellan Health Services. Thank you for the opportunity to speak today about the importance of mental health parity.

Today I am representing my own company, Magellan Health Services, as well as the American Managed Behavioral Healthcare Association (AMBHA). AMBHA is an association of the nation's leading managed behavioral healthcare companies. AMBHA member companies, of which Magellan is one, are collectively responsible for managing mental health and substance abuse services for over 110 million individuals across the country. Approximately 170 million Americans who have either commercial or public insurance coverage for mental health and substance abuse have this coverage through a managed behavioral healthcare organization (MBHO). Most managed care organizations and employers subcontract with MBHOs to provide the mental health and substance abuse component of their health insurance benefit package.

In addition, AMBHA is a member of the Coalition for Fairness in Mental Illness Coverage. The Coalition for Fairness in Mental Illness Coverage members include: the National Alliance for the Mentally Ill, the National Mental Health Association, the American Hospital Association, the American Medical Association, the American Psychiatric Association, the American Psychological Association, the Federation of American Hospitals, and the National Association of Psychiatric Health Systems. These organizations represent consumers, family members, health professionals, and health care systems and administrators. The Coalition for Fairness in Mental Illness Coverage comprises just a few of the over 150 organizations that support mental health parity.

My company, Magellan Health Services, is headquartered in Columbia, Maryland, and is the nation's largest managed behavioral healthcare organization (MBHO). We provide behavioral health, employee assistance and wellness programs to approximately 70 million people across the United States. Magellan serves over 3,000 client organizations representing health plans, government agencies, unions, large corporations and small group employers.

I am here today to express strong support for comprehensive mental health parity legislation. As a psychiatrist with more than 10 years of experience in the public mental health system and over 10 years in the private managed mental health care industry, I can tell you that mental health parity represents a significant opportunity to ensure better, cost-effective coverage for mental illness by prohibiting these benefits from being treated differently from the coverage of medical and surgical benefits.

According to the Surgeon General's Report on Mental Health, about 20% of the U.S. population – that's one in five Americans – is affected by mental disorders during a given year. A shocking 30,000 Americans commit suicide every year, "invariably the result of mental illness," according to Dr. Steven Hyman, director of the National Institute of Mental Health (NIMH) at the National Institutes of Health. The *Global Burden of Disease* study issued in the early 1990s by the World Bank and the World Health Organization revealed that mental illness was the second leading cause of disability and premature death worldwide – second only to heart disease and outstripping the disease burden caused by cancer.

Mental illness is a significant public health issue in this country, one that costs society millions and millions of dollars in healthcare expenditures, lost wages, absenteeism and lower productivity, to say nothing of the intangible cost of otherwise preventable human suffering. This public health issue is exacerbated by the unfortunate stigma associated with seeking help for these types of problems as well as the financial disincentive to do so created by limited mental health benefits.

As a psychiatrist who has treated hundreds of patients over the years, I have seen first hand the detrimental effect that barriers – financial and otherwise – have on an individual's ability to get better and regain their life. By offering comprehensive mental health benefits, all of us – employers, insurers, the government – send the message that mental illness is a disease – just like diabetes, heart disease or cancer – and that treatments for it do work. In fact, the National Institute of Mental Health has shown that success rates of treatment for disorders such as schizophrenia (60%), clinical depression (70-80%) and panic disorder (70-90%) surpass those of some common medical conditions.

But apart from helping to combat stigma, mental health parity offers significant benefits to individuals and their families, employers and society in general. While it is a sad commentary on societal attitudes about these disorders that we must use cost savings to justify treatment, the fact is that it makes real economic sense to improve access to treatment by offering parity-level benefits. More comprehensive benefits mean that individuals have better access to treatment at an earlier point in the development of their illness, which in turn results in less suffering and lower costs associated with that treatment. In addition, many studies have shown that early, effective treatment of mental illness leads to lower morbidity, lower medical costs generally, lower disability costs and less absenteeism in the workplace. The Surgeon General reports that the *indirect cost* of all mental illness imposed a nearly $79 billion loss on the U.S. economy in 1990. According to an article in The Wall

Street Journal, which documented a series of experiential data, Bank One Corporation employees lost a total of 10,859 workdays over a two-year period due to depressive illnesses alone, more than ten times the workdays lost to either high blood pressure or diabetes.

Given the progress made over the last 10 years in the scientific understanding, diagnosis and effective treatment of mental illness, the time is now right to enact comprehensive mental health parity legislation at the Federal level. Legislatures in 34 states have recognized the importance of this issue and passed some form of mental health parity legislation, but a significant percentage of individuals with health insurance are covered under plans governed not by the states, but by Federal regulations such as ERISA.

The Mental Health Parity Act of 1996 passed by Congress was an important first step in addressing the problem of discrimination in health benefit coverage, but access to mental health services remains limited. The 1996 law, which was extended until December 2002 in last year's Labor, Health and Human Services Appropriations bill, prohibits discriminatory annual and lifetime dollar caps for mental health benefits as compared to medical and surgical benefits. However, inequity is still allowed and exists in the areas of treatment limitations and financial requirements. I think we all agree that mental illness is just as real as diabetes or heart disease. So, why would we want to allow such benefit discrimination to exist? Passing mental health parity legislation eliminates such inequitable treatment without mandating that coverage be offered for mental illness. Proposed legislation simply requires that such coverage not be treated differently than medical and surgical benefits.

Opponents of more comprehensive parity legislation have historically raised concerns about its affordability. However, years of real world experience have demonstrated that these concerns have not come to fruition. Having extensive experience managing mental health benefits both pre- and post-parity, my organization, Magellan Health Services, is in a unique position to offer insight into what we might expect in terms of increased health premiums.

As I stated earlier, Magellan is the largest managed behavioral healthcare organization in the country, covering nearly 70 million individuals – that's about one in three insured Americans. We contract with employers, health plans and governments to manage a wide variety of benefit packages, including some with full parity. Our customers include more than 70 health plans across the country including 31 Blue Cross Blue Shield organizations, Aetna and Humana. In addition, we manage programs serving Federal employees, state employees and more than 10 million members in small businesses. We also provide managed behavioral healthcare services in many primarily rural states, including Alaska, Iowa, Maine, Nebraska and Tennessee, some of which have passed state parity bills. In addition, we manage a portion of the health care benefit through direct contracts with over 20% of Fortune 500 companies. Magellan currently manages care for individuals in 29 states with state-sponsored mental health parity legislation as well as Federal

employees, who, as you know, enjoy parity-level mental health benefits also.

From our experience over several years, I can tell you that the implementation of parity legislation results in only a very modest increase in the total healthcare premium for a commercial insurer when one starts with a typical, but limited, mental health benefit. At Magellan we have yet to see an increase of greater than 1% of the total healthcare premium as a result of state parity legislation. In fact, our experience is that cost increases typically range from 0.2% to 0.8% of the healthcare premium. Furthermore, we have found that these modest increases are similar for both large and small employers, and in rural, urban and suburban areas.

Magellan's experience with mental health parity is not unique. William Flynn of the Office of Personnel Management (OPM) related a similar experience of the Federal Employees Health Benefits Program in remarks to the Senate in July 2001. Mr. Flynn noted that at the White House Conference on Mental Health held in June 1999, OPM had been directed to achieve benefit parity for both mental health and substance abuse treatment in the Federal employees program beginning January 1, 2001. Under the program, covered services would include medically necessary treatment for all categories of mental health and substance abuse diseases listed in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. Mr. Flynn reported that the implementation of parity – not only for mental health, but also for substance abuse services – resulted in an average premium increase of 1.64% for fee-for-service plans, 0.3% for HMOs, and an aggregate program increase of 1.3% for 2001.

And, the Congressional Budget Office (CBO) estimated that S. 543, The Mental Health Equitable Treatment Act of 2001, would, if enacted, increase premiums for group health insurance by an average of 0.9%. The cost estimate for S. 543, it should be noted, did not include costs associated with substance abuse treatment, as S. 543 excludes substance abuse disorders.

Clearly, the actual experience of Magellan and others demonstrates that, in combination with an effective managed care program, mental health parity can help expand access to treatment in a very cost-effective manner. Actuarial estimates that are significantly higher than this are often based on more theoretical cost assumptions, which have not been shown to be accurate when applied to the actual experience of managing a mental health benefit.

The fact that no state that has enacted parity legislation has repealed it, despite initial concerns about cost, is telling and speaks to the affordability of parity. In fact, several studies show that net costs for mental health can be reduced under parity if managed care replaces a fee-for-service program when parity is introduced. For example, when parity was introduced for state employees in Texas and North Carolina in conjunction with managed care, the cost of mental health benefits decreased by over 30% at the same time that the percentage of the population accessing care increased.

In testimony before the Senate last year, the American Psychiatric Association related Maryland's experience with state parity legislation. In that state, the introduction of a comprehensive mental health parity bill resulted in an increase of less than 1% of total premiums and most of this increase came from HMO programs that previously had had the most restrictive benefits.

Furthermore, none of these cost estimates, including our own, takes into account the cost savings achieved by employers in terms of their having a healthier, more productive workforce. Many corporations have recognized this fact and expanded mental health benefits for their employees. According to an article in The Wall Street Journal, McDonnell Douglas discovered that covering mental illness makes economic sense. Specifically, the company found a four-to-one return on investment after considering medical claims, absenteeism and turnover. And another study, cited by Behavioral Health Business News, showed that 300 veterans who received abbreviated mental health treatment following a history of excessive medical services utilization were able to reduce outpatient medical visits by 36%.

Some corporations have learned the detrimental effects of limiting mental health benefits. A study reported by Robert Rosenheck, M.D., at Yale University highlighted the negative impact when a national company reduced its mental health benefits by 40% over a 3-year period. As a consequence, the company experienced a 40% increase in its primary healthcare expenses that completely offset the reduction in mental health benefits. In addition, the company's absenteeism rate increased by 20% and worker productivity declined by 5%.

In "Improving Mental Health Insurance Benefits Without Increasing Costs," the Substance Abuse and Mental Health Services Administration reports that 72 percent of people with depression are part of the workforce. Individuals reporting persistent depression (2.2% of the sample) had healthcare costs 70% greater than other employees; those with uncontrolled stress (18% of the sample) had 46% greater expenditures. These two factors had a greater impact on total healthcare costs than did obesity, high blood pressure, high cholesterol, and tobacco use (Journal of Occupational and Environmental Medicine, 40(10), 1-12).

According to a Center for Mental Health Services report entitled "Comprehensive Mental Health Insurance Benefits: Case Studies" a recent study found that depressed workers miss between 1.5 and 3.2 more days for short-term disability than other workers. In 1998 the Journal of Mental Health Policy and Economics (1, 161-172) reported that employees who exhibit more symptoms of mental disorders are absent from work about three times as often as are other employees.

During a recent Robert Wood Johnson Foundation conference, major actuaries and health economists from private, academic, and governmental sectors, who had developed the original cost of parity estimates, came together to address many of the assumptions and methods underlying the parity cost estimates. Although there was no formal consensus from the meeting, the document summarizing the sense of the meeting pointed to several areas of agreement. Baseline costs have decreased;

demand response to lowered co-payments has been less than predicted; and management has been more powerful in decreasing costs than parity has been in increasing costs. Most interestingly, none of the participants could identify an employer or insurer in the past several years where forecasting models had *underestimated* the costs of parity policies.

Mental health parity will eliminate health benefits discrimination for those with mental illness and help reduce stigma, without mandating that employers offer this coverage and without causing dramatic cost increases. I ask all of the members of this Committee to consider also the individuals who have publicly acknowledged their own struggles with mental illness and know that mental health parity not only makes economic sense, it will make a significant difference in improving the quality of the millions of lives touched by these treatable disorders.

APPENDIX G - WRITTEN STATEMENT OF JANE GREENMAN, VICE PRESIDENT AND DEPUTY GENERAL COUNSEL, HUMAN RESOURCES AND COMMUNICATIONS, HONEYWELL INTERNATIONAL, MORRISTOWN, NJ, TESTIFYING ON BEHALF OF THE ERISA INDUSTRY COMMITTEE

Testimony of Ms. Jane F. Greenman

Vice President and Deputy General Counsel, Human Resources and Communications
Honeywell International

On Behalf of The ERISA Industry Committee

March 13, 2002

Mr. Chairman and members of the Subcommittee: My name is Jane Greenman. I am Vice President and Deputy General Counsel, Human Resources and Communications, Honeywell Internal, and a member of the Board of Directors of The ERISA Industry Committee, generally known as ERIC. I submit this statement on behalf of ERIC.

The ERISA Industry Committee

The ERISA Industry Committee (ERIC) represents the Nation's largest employers who sponsor health, pension, savings, disability, life insurance, and other benefit plans covering millions of participants and beneficiaries. ERIC's members share Congress' strong interest in the success and expansion of the employee benefit system in the private sector.

Voluntary Employee Benefit Plans

Major employers provide valuable and important benefits to their employees through voluntary employee benefit plans. Employers are not required to provide benefits to their employees.

Employers have a strong interest in providing voluntary employment-based health care coverage to employees and their families in order to foster a healthy and productive workforce, respond to workers' concerns about economic security and affordable basic health care, and offer health care coverage as part of a competitive compensation package to attract and retain valued workers. Employers' health care coverage arrangements represent an investment in quality and productivity and are tailored to the specific needs of each employer and its workforce.

Thus, voluntary employee benefit plans have been extraordinarily successful in delivering needed health, retirement, and other benefits to tens of millions of employees and their families. Today, over 80 percent of employees in the private sector receive some form of employee benefit plan coverage.

Employer-sponsored benefit plans can offer advantages that employees could not obtain if they tried to purchase the same benefits on their own. Employers contribute their expertise in plan design and the organization of delivery systems to obtain high-quality benefits that are delivered timely, efficiently, and cost-effectively. Moreover, because employer-sponsored plans represent the interests of groups of employees, they are in a stronger position than individual consumers to bargain to obtain high quality benefits at a reasonable price. Plans sponsored by large employers have been very successful in exercising bargaining power on behalf of their participants and beneficiaries, and an increasing number of small employers are able, through voluntary coalitions, to achieve the same kind of success.

The Fundamental Public Policy Issue:

Whether a Broad Mental Health Parity Mandate Hurts More than It Helps

Mandated broad mental health parity is a poor response to the public policy challenge of providing access to care to those who suffer from mental illness. *ERIC's fundamental concern is that mandating a broad mental health parity requirement, for the reasons discussed below, creates as many or more problems as it solves and harms as many or more people than it helps.*

How to Think About the Cost of Mandating Broad Mental Health Parity

Studies of the estimated average cost of imposing a broad mental health parity mandate reflect an array of disagreement, ranging from less than a percent to more than ten percent. This variation should not be surprising, since mandating broad mental health parity so fundamentally changes the rules governing the health care marketplace that predicting how employer, employee and provider behavior will change is exceedingly difficult. No matter which study you believe, however, it does not tell public policy makers what they really need to know about the impact of mandating broad mental health parity. *What really matters, and what the studies generally can not provide, is adequate information about how increased costs will be distributed among employers and employees.*

Specifically, estimating the *average* cost of implementing broad mental health parity across all employer-provided health plans does not tell policy makers what they need to know about the impact a broad parity mandate will have on *individual employers and their employees*. Many factors contribute to the cost of compliance for individual employers: how much coverage the employer offers now and how much more an employer would have to pay to increase coverage to comply with the parity mandate; the composition of the employer's workforce and its propensity to consume mental health services; how effectively mental health providers market their services in the community where the employer is located. Thus, the *average* cost spread across the marketplace is essentially irrelevant.

The relatively few employers who offer the most generous coverage will experience the most modest increased costs coming into compliance with a broad parity

mandate. Conversely, employers who offer the least generous mental health coverage (relative to medical/surgical coverage) will experience the greatest cost increases and therefore be most likely to cease offering coverage entirely. What this means is that employees and dependents who have generous mental health coverage now might experience a modest increase in that coverage as a result of a broad parity mandate, but employees and dependents who have the *least* mental health coverage now are at high risk of losing it entirely. *Policy makers should not enact a mandate that primarily helps employees and dependents who already have generous coverage but hurts employees and dependents with the least generous coverage.*

Mandating Broad Parity Undermines Affordability and Economic Efficiency

In addition to the distributional impact of mandating broad mental health parity, policy makers should also be concerned that mandating broad parity now restricts employers' benefit design options at the worst possible time. Confronted with 15% to 25% annual cost increases, employers are already being forced to make very hard decisions about significantly increasing employee premium contributions, deductibles and copayments, as well as making other reductions in coverage. Enacting a broad parity mandate now further limits employers' available options, making those decisions even tougher and increasing the likelihood that some employers will simply cease offering mental health coverage at all.

Mandating broad mental health parity also raises serious questions about the long-term affordability of coverage because it impairs employers' bargaining leverage with mental health care providers. The minority of employers who have been able to provide comprehensive mental health coverage at reasonable cost have only been able to do so because they were free to bargain effectively with mental health providers, agreeing to comprehensive coverage in exchange for significant discounts on price and controls on utilization. Mandating broad mental health parity forces employers to make a major economic concession to health care providers without getting any concessions for it in return, increasing price pressure.

Moreover, the assertion that so-called "managed mental health 'carve-out' arrangements" (*i.e.*, separate provider networks for mental health services) are sufficiently cost-effective to keep broad mental health parity affordable is overstated. A significant proportion of current "carve-out" arrangements appear to be prohibited by a broad parity mandate because they too use stricter treatment limitations and financial requirements than the medical/surgical coverage they supplement. Once these "carve-out" arrangements are amended to comply with a broad parity mandate they are likely to be less cost-effective.

Finally, mandating broad mental health parity is problematic because patients have an increased propensity to consume mental health services compared to other medical and surgical services. Experience and research have shown that utilization of mental health services increases much more rapidly than utilization of medical and surgical services when financial requirements and treatment limitations are

reduced. This is particularly true as the industry increases its advertising and public affairs efforts to convince the public of the need for its services. Therefore, employers have relied on increased cost-sharing and other limitations on mental health services to offset this greater propensity for high utilization. A broad parity mandate ignores this reality, thereby exposing employer-sponsored health plans to a significantly increased risk of excessive use of mental health services.

Additional Issues and Considerations

A number of additional arguments have been made in support of mandating broad mental health parity. A critical examination of these arguments reveals them to be seriously flawed.

For example, studies that assert mental health coverage improves productivity and reduces disability costs *do not justify* mandating broad mental health parity. Mandating broad mental parity is not the only means to improve productivity and reduce mental illness-related disabilities. Employers can achieve the same productivity gains and the same disability reductions by offering mental health coverage that uses different deductibles, co-payments, out-of-pockets caps and treatment limitations than their medical/surgical coverage.

The cost of compliance with current state parity laws is not indicative of the cost of complying with a federally mandated broad parity requirement. Most state parity laws require less - often far less - than the broad mental health parity proposals before Congress. Even in the minority of states where the parity requirement is broad, there are often significant differences. In addition, the cost of compliance is a function of how actively the states enforce their requirements. If federal law is amended to include a broad parity mandate, the cost of compliance will be significantly higher because the same rule would apply to all health plans in all states, and plan participants will be able to enforce their rights in private lawsuits as well as through administrative proceedings.

Similarly, the cost of federal employee health benefit plan (FEHBP) compliance with the Office of Personnel Management's parity requirement is not indicative of the cost of compliance with a broad parity mandate on private employer-sponsored coverage. The scope and extent of FEHBP coverage is not comparable to coverage provided by many private employers, especially medium and small employers. Therefore, the cost of bringing FEHBP coverage into compliance with a broad parity mandate is not predictive of the cost many private employers will face coming into compliance with a broad parity requirement. Nor is the ability of private employers to pay for expanded coverage comparable to the federal government's ability to pay for expanded coverage.

All of the concerns expressed above will become even more acute if the Patients' Bill of Rights is enacted. Even without enactment of the Patients' Bill of Rights, litigation costs are rising and class action lawsuits are multiplying. Due to the uncertainty surrounding many mental health diagnoses and courses of treatment,

mental health benefits are subject to frequent disputes over medical necessity and appropriateness. A broad parity mandate will necessitate more active utilization management to keep costs under control, which in turn will generate more disputes and litigation - an undesirable and unpredictable liability exposure many employers will seek to avoid by ceasing to offer mental health coverage at all since it is not in their business interest to enter into arrangements that are likely to result in expensive litigation..

In Conclusion

Employers of all sizes have limited resources to spend on employee benefits. Within their varying budgets they allocate resources among pension, health, vision, dental, mental health, disability, life insurance and other employee benefits according to business needs and employee preferences. Congress should not override these resource allocation decisions by mandating broad mental health parity because the result is more likely to be reduced health care coverage than increased health care coverage. While a few employers, generally those who already offer generous mental health coverage, may increase that coverage to come into compliance with a broad parity mandate, many others are likely to reduce medical/surgical coverage instead. And those that are unwilling to reduce medical/surgical coverage will simply stop offering mental health coverage entirely.

APPENDIX H – SUBMITTED FOR THE RECORD, LETTER FROM MARK UGORETZ, PRESIDENT, THE ERISA INDUSTRY COMMITTEE, TO CHAIRMAN SAM JOHNSON, SUBCOMMITTEE ON EMPLOYER-EMPLOYEE RELATIONS, APRIL 4, 2002

THE ERISA INDUSTRY COMMITTEE (ERIC)
Representing the Employee Benefits Interests of America's Largest Employers
1400 L Street N.W., Suite 350, Washington, D.C. 20005
phone 202-789-1400 / fax 202-789-1120 / e-mail eric@eric.org

April 4, 2002

The Honorable Sam Johnson
Chairman, Subcommittee on Employer-Employee Relations
Committee on Education and the Workforce

Dear Chairman Johnson:

During your March 13, 2002 hearing titled "Assessing Mental Health Parity: Implications for Patients and Employers," Subcommittee members requested of Jane Greenman, who testified on behalf of The ERISA Industry Committee (ERIC), that ERIC provide additional information regarding certain issues raised during the hearing.

The ERISA Industry Committee

The ERISA Industry Committee (ERIC) represents the Nation's largest employers who sponsor health, pension, savings, disability, life insurance, and other benefit plans covering millions of participants and beneficiaries. ERIC's members share Congress' strong interest in the success and expansion of the employee benefit system in the private sector.

Response Concerning Apparent Discrepancies in Cost Impact Studies

Representative Andrews expressed concern regarding the apparent discrepancy between the estimated cost of a comprehensive mental health parity mandate in a 1996 PriceWaterhouse study funded in part by ERIC and a subsequent 2001 PriceWaterhouseCoopers study funded by the American Psychological Association. We have reviewed the 2001 study and identified several differences in methodology and assumptions that account for the different results. Among the differences in the two studies, we would like to call one assumption, in particular, to your attention.

The 1996 study assumed, among other things, that parity applies to the intensity of management of health care services covered under a health plan, such that comparable intensity of management must be applied to mental health services as to medical and surgical services covered by a health plan. In other words, the 1996 study assumed that if a health plan provides medical and surgical benefits through unmanaged fee-for-service indemnity coverage, the health plan is legally required by the parity mandate to provide mental health benefits through comparable unmanaged fee-for-service indemnity coverage. Similarly, if medical and surgical benefits are provided through a preferred provider organization (PPO) that includes an out-of-network option, the 1996 study assumed mental health benefits must also include an out-of-network option. Therefore, the 1996 study provides a range of estimated cost for the imposition of a comprehensive parity mandate: the low end of the range represents the cost if employers

adopt intensive management of their medical and surgical benefits (*e.g.*, switch to HMOs) in order to be able to apply equally intensive management to mental health benefits (*e.g.*, through a managed behavior healthcare organization); the high end of the range represents the cost if employers who provide medical and surgical benefits through less-intensively managed or unmanaged arrangements (*e.g.*, fee-for-service indemnity coverage) comply with the parity mandate by providing less-intensively managed or unmanaged mental health coverage as well.

In contrast, the 2001 study appears to assume that parity does not apply to management intensity at all. If correct, this would mean, for example, that an employer would not be violating proposed federal parity requirements by providing mental health benefits through an intensively-managed closed network of health care providers at the same time it provided medical and surgical benefits through a less-intensively managed, non-network, fee-for-service indemnity arrangement. We do not believe this assumption accurately reflects the requirements of pending parity proposals.

Specifically, the assumption that parity does not apply to management intensity is contrary to the plain language of pending mental health parity legislation. H.R.162 as introduced, and S.543 both as introduced and as passed by the Senate last year, broadly prohibit *any* form of "treatment limitations or financial requirements " on mental health services that do not also apply to medical and surgical services covered under the same health plan. With one exception,[1] nothing in these bills explicitly permits plans to more intensively manage utilization of mental health services than medical and surgical services. It is not sufficient to include a rule of construction that merely clarifies that utilization management techniques are not *per se* prohibited by the legislation, since a health plan using otherwise permissible utilization management techniques must still comply with the parity requirement with respect to its particular actual benefit design. Rather, the legislative language must expressly exempt all forms of utilization management from the definition of parity itself.

Parity advocates argue that intensive management is the key to making mental health coverage affordable. The relatively low cost estimates presented in the 2001 study assumes that every health plan can take advantage of intensive management of mental health services regardless of the intensity of management of medical and surgical services covered by the health plan. Yet the text of H.R.162 and S.543 requires exactly the opposite, and thus will have a significantly greater impact on plan costs unless pending proposals are amended to conform reality to assumptions.

Moreover, we are unaware of any study of the cost impact of a federal comprehensive mental health parity mandate that adequately accounts for the fact that many managed behavioral healthcare organizations use "treatment limitations and financial requirements " that will, depending on the specific medical/surgical coverage they are paired with, violate proposed parity requirements. Managed behavioral healthcare organizations will only be in compliance with proposed federal parity requirements when they are offered in conjunction with medical/surgical coverage that includes equally

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[1] S.543, as passed by the Senate last year, includes an exception from parity for mental health coverage with respect to out-of-network benefits so long as in-network benefits comply with parity.

or more stringent "treatment limitations and financial requirements." If a managed behavioral healthcare organization must reduce its deductibles, copayments and out-of-pocket caps, and increase the number of covered office visits and inpatient days, to match the provisions of the particular medical/surgical coverage with which it is paired in order to attain parity, it will not be as cost effective as current coverage.

Response Concerning Relevance of State and FEHBP Experience

Representative Roukema raised concerns about the assertion that the estimated cost of compliance with state comprehensive parity laws and the federal employee health benefit program (FEHBP) parity requirement have limited relevance to predicting the cost impact of a federal comprehensive mental health parity mandate.

Advocates of a comprehensive federal mental health parity requirement frequently cite cost analyses of state mental health parity laws as evidence for their claim that federal parity would be affordable for employers and other health benefit plan sponsors. These cost estimates are a poor barometer of the impact of a federal comprehensive parity mandate, however, because it is difficult, if not impossible, to equate the effects of comprehensive parity at the state level with those at the federal level.

Many state parity laws - even those that purport to impose a broad parity mandate - impose significantly less stringent requirements on health care coverage than the federal comprehensive parity legislation under consideration. The majority of states that have passed mental health parity statutes only require partial parity. For example:

Some states apply parity only to select conditions (*e.g.*, to severe, biologically-based mental illnesses, as in Texas), or to select groups (*e.g.*, to state employees and teachers, as in North Carolina).

Other states include significant exceptions to their parity requirements. Maryland's mental health parity law, which many advocates point to as a prime example of an affordable comprehensive parity law, requires parity in copayments for mental health outpatient visits only for a limited number of initial visits - health plans can require a higher copayment for any additional visits.[2]

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[2] Specifically, the state of Maryland requires that health plans cover, after all deductibles have been paid, at least 80% of the costs of the first five visits in a calendar year or one-year benefit period a patient makes to a mental health provider. For the 6th through 30th visits per calendar year or benefit period, however, health plans are required to cover only 65% of visit costs. Finally, any visits over 31 per calendar year or benefit period are required to be covered at only 50% of visit costs. Thus, the more visits a patient makes to a provider, the higher the co-payments for the patient.

Since pending federal comprehensive parity proposals do not permit these or similar exceptions to parity, the cost of complying with these state laws represents only a portion of the cost of complying with a federal comprehensive parity requirement.

In addition, states such as Connecticut, Minnesota, and Vermont that have comprehensive parity mandates have permitted and even *encouraged* the use of managed behavioral healthcare organizations to contain the costs incurred by health plan sponsors. A study commissioned in June 1998 by the Milbank Memorial Fund found that "in almost every instance the adoption of mental health parity had been relatively recently preceded by, or was accompanied by, or will be closely followed by, a switch to some form of managed care,"[3] because, in the words of one managed behavior care organization executive, "*parity without managed care is possible, but very costly*"[4] (*emphasis added*). But as noted above, pending federal parity proposals generally prohibit the use of managed mental health care except when medical and surgical services are subject to equally intensive management.

Finally, states cannot enforce parity laws to the same extent, and may not be enforcing parity laws in the same manner, that pending federal parity proposals would be enforced. A federal parity mandate would apply to all private health care coverage, not just the portion of that coverage within an individual state's jurisdiction. In addition, states have relatively limited resources to direct toward enforcement compared to the federal government. Enacting a federal parity mandate would not only bring the resources of the federal government to bear on enforcement activities, but would also be enforceable by private lawsuits under ERISA and other federal laws. In short, a federal parity mandate would have a far more pervasive impact on the health care marketplace and litigation than any state law, and therefore is likely to have a more profound impact on the cost of coverage.

Like the state parity requirements discussed above, the parity imposed on coverage provided to federal employees is not comparable to pending legislative proposals. For example, based on our review of the "Memorandum for Personnel Directors of Executive Departments and Agencies" issued by Janice R. LaChance, OPM Director, on July 13, 2000[5] we note the following significant differences:

Parity in FEHBP apparently means that coverage must be identical with regard to deductibles, coinsurance, copays, catastrophic maximums and day and visit limitations; pending proposals apply parity to *any* treatment limitations or financial requirements.

The use of managed behavioral healthcare organizations, gatekeeper referrals to network providers, authorized treatment plans, pre-certification of inpatient services, concurrent review, discharge planning, case management, retrospective review, and disease management programs is permitted

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[3] Alan L. Otten, "Mental Health Parity: What Can It Accomplish in a Market Dominated by Managed Care?" (New York, NY: Milbank Memorial Fund, 1998), p.8

[4] ibid.

[5] Available at http://www.opm.gov/insure/health/html/071300_mental_health.htm.

and actively encouraged by OPM without any apparent requirement that these same cost management techniques must also be used for medical/surgical services in order to comply with parity; pending parity proposals require comparable intensity of management for medical/surgical services.

Parity in FEHBP is based on benefit categories for comparable medical treatment, such as, inpatient hospital, professional office visits for specialists, diagnostic tests, and pharmacy benefits; with one exception,[6] pending parity proposals do not apply parity based on benefit categories.

In Conclusion

The ERISA Industry Committee appreciates the opportunity to provide this supplemental information for the hearing record. We would be pleased to respond to any additional questions or issues raised by members of the Subcommittee.

Very truly yours,

[signed]

Mark J. Ugoretz
President
The ERISA Industry Committee

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[6] H.R.162 applies parity to "comparable settings" but does not distinguish between other benefit categories identified by FEHBP.

APPENDIX I – SUBMITTED FOR THE RECORD, STATEMENT OF RICK POLLACK, EXECUTIVE VICE PRESIDENT, AMERICAN HOSPITAL ASSOCIATION, WASHINGTON, D.C. AND MARK COVALL, EXECUTIVE DIRECTOR, NATIONAL ASSOCIATION OF PSYCHIATRIC HEALTH SYSTEMS, WASHINGTON, D.C., MARCH 13, 2002

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STATEMENT ON "MENTAL HEALTH EQUITABLE TREATMENT ACT"

Rick Pollack, Executive Vice President, American Hospital Association
Mark J. Covall, Executive Director, National Association of Psychiatric Health Systems

March 13, 2002

Every year, untreated mental disorders cost employers more than $130 billion in employee absenteeism, turnover and retraining expenses. Also a cause of poor morale, lower productivity and injury, untreated mental disorders have been linked to poor physical health and disease. Experience and research show that mental health parity increases productivity and economic well being for individuals, families, and communities.

As associations representing behavioral health care organizations, professionals and employers, we fully support passage of the Mental Health Equitable Treatment Act (S.543), which was passed by the Senate with strong bi-partisan support. **We urge the House to act to pass mental health parity this year.**

This measure would ensure that medically necessary mental health services, diagnosed and provided by a licensed professional, receive the same coverage considerations as medical and surgical services. Mental health parity would be provide for in-network services and techniques to manage the mental health benefit, as other benefits are managed, are explicitly included in S. 543.

This reasonable and cost-effective legislation is modeled after the benefit now included in all plans participating in the Federal Employees Health Benefit Plan (FEHBP). An extensive Congressional Budget Office analysis has estimated that businesses would experience cost increases of less than 1% to implement full parity for mental health coverage. Finally, 34 states have adopted and implemented mental health parity laws, indicating broad support for this common sense measure among states and the general public.

This legislation is an important step in assuring that people have access to care when they need it. We encourage the House and Senate to pass mental health parity this year.

APPENDIX J – SUBMITTED FOR THE RECORD, STATEMENT OF JAMES HACKETT, CHAIRMAN, PRESIDENT AND CHIEF EXECUTIVE OFFICER, OCEAN ENERGY, INC., HOUSTON, TX, MARCH 13, 2002

Statement of James T. Hackett
Chairman, President and Chief Executive Officer of Ocean Energy, Inc.
to the
Subcommittee on Employer-Employee Relations,
Committee on Education and the Workforce
concerning Mental Health Parity

March 13, 2002

Mr. Chairman and Members of the Subcommittee, thank you for you the opportunity to address mental health parity. I am James Hackett, Chairman, President, and CEO of Ocean Energy, one of the largest U.S. independent oil and gas exploration and production companies with an approximate $3 billion market capitalization. We are based in Houston and employ 1,000 employees around the world.

The acts of terror that occurred on September 11 – viewed repeatedly by millions—have raised lingering questions about their impact on the mental health of many Americans. There is no better time than now for U.S. businesses to review their health insurance policies to ensure parity between mental health benefits and coverage for medical and surgical care. This long overdue step should not require a government mandate; it is a tangible way to reduce the enormous cost of lost productivity that results from untreated mental illness. As long as stigma clouds businesses judgment, however, H.R. 162, the Roukema-Kennedy parity bill, is necessary.

The statistics tell the story. According to a 1999 Surgeon General's report, nearly 30 percent of the population has a diagnosable mental disorder. The National Institute of Mental Health estimates that the annual cost of untreated mental illnesses is more than $300 billion, with one half of that amount related to productivity loss from absenteeism or premature death. An MIT study concluded that clinical depression costs American businesses nearly $30 billion a year in missed days and poor work performance.

Federal law does not currently require employers to provide adequate health insurance for mental illness. As a result, the millions of Americans who experience this affliction are likely to encounter uneven and often inadequate mental health coverage, usually in the form of disproportionately higher co-payments and limits on inpatient and outpatient visits

Recently, Ocean Energy and two other Houston companies announced that they would establish parity in insurance coverage for mental health and substance abuse services beginning in 2002. The increase to total annual health costs for each of the companies is estimated to be less than one percent – a minor amount that will be more than offset by avoided costs of lost employee productivity. While our companies took this step voluntarily, we adamantly support the Mental Health and Substance Abuse Parity Amendments, H.R. 162, and implore our legislators to move quickly on its passage for the health and welfare of this nation's workers.

Many businesses have set arbitrary and lower limits on mental health care because of misunderstandings regarding mental illness, the perception of its additional insurance costs, and confusion about its ability to be effectively treated. Mental illness is usually treatable through psychotherapy and prescriptive medicines; it is a physiological problem at its heart, not the result of character flaws. Business leaders should voluntarily enact policies that support the millions of Americans who work through each day without getting the mental health treatment they need. Today, more than ever, managers of every corporation have the opportunity to support their employees while, at the same time, reducing the cost to their company of mental health-related productivity losses.

I do believe that in time, most business leaders will realize, as I have, that providing mental health benefits on par with physical health benefits is good for the bottom line. But quite frankly, we cannot afford to wait for that time. Mental health parity is good for American workers and good for the American economy, and for that reason I support the Roukema-Kennedy legislation.

I thank the Subcommittee for holding this hearing and encourage you to pass H.R. 162 as introduced. Thank you.

APPENDIX K – SUBMITTED FOR THE RECORD, STATEMENT OF LISA R. COHEN, NATIONAL MENTAL HEALTH ASSOCIATION, ALEXANDRIA, VA, MARCH 13, 2002

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Gary Tauscher, Chair of the Board ▪ **Michael M. Faenza**, President and CEO

Statement for Hearing on Mental Health Parity

before the

Subcommittee on Employer-Employee Relations

Committee on Education and the Workforce

March 13, 2002

Lisa R. Cohen

105 W. Chestnut Street
Bordentown, NJ 08505
609-324-7646
215-923-9627

Mr. Chairman and Members of the Subcommittee:

My name is Lisa Cohen. I consider myself to be lucky. I'm certainly not lucky to have a mental illness, nor am I lucky to have a physical illness; I am, however, extremely lucky that I have been able to receive the treatment I need despite the roadblocks of unequal insurance coverage and stigma that I have had to cross in the process of learning to live successfully with chronic illness since 1988.

The insurance industry's discriminatory practice of providing far less coverage of mental than of "physical" illnesses has made my struggle to live a healthy and productive life much more difficult. And it makes no sense, since the costs to society of untreated mental illness are greater than the costs of providing treatment.

Fourteen years ago, I dropped out of college in Ohio and returned home to Philadelphia in a cloud of severe depression. At the time, I did not know what I was suffering from or why. All I knew was that I could no longer function and all I felt was futility, failure and hopelessness. With the support of my family, I was soon in the care of a psychiatrist.

The diagnosis of clinical depression and later bipolar illness or manic-depression, was a blessing and a curse. Finally, I knew that I had an actual illness, with available treatments and the possibility of a return to a "normal" life. What I didn't realize at the time was that along with this diagnosis came the need for long-term treatment, expensive and uncovered care, and, of course, the stigma of having a mental disorder.

A few months later, in October of 1988, I was diagnosed with a rare blood disorder called Idiopathic Thrombocythemia. In simple terms, this means that I have too many platelets in my blood. The result of such a condition is the high risk of clotting diseases such as strokes and heart attacks. Just as my mental illness does, this disease demanded immediate treatment as well as continued medical attention. This included bone marrow testing, frequent blood tests, monitoring of side effects and numerous doctor's visits.

For three very long years, I struggled to maintain a semblance of order in my life as I went from psychiatrist to hematologist, from therapy to medication and eventually numerous hospitalizations.

To me, the two illnesses I have do not seem to be that different; one affects my blood the other my brain chemistry. Untreated, either illness can be fatal but with continued care and careful vigilance on the part of myself and my doctors, both can be treated successfully.

Unfortunately, my insurance company chooses to view these illnesses with an unequal eye. Receiving coverage for my mental illness has not been easy, fair or complete.

I learned this lesson early on when I was hospitalized for the third time for bipolar disorder. My stay exceeded the 30 days allotted to me by my insurance company, *by one day*. While I was in the midst of a severe episode, the insurance company was essentially kicking me out of the hospital. It was a horrific experience. I can only liken it to being three quarter's of the way through surgery, and the insurance company coming in and saying they won't pay for you to be

stitched up. Here again, I was lucky. My family stepped in. They made an arrangement with the hospital to pay them directly for any extra days needed. That is the only way I got the care I needed. Fearful of further hospitalizations, upon discharge I applied for Medicaid so that I would not be refused future MH treatment.

Meanwhile, my insurance company had no trouble paying for any & all care for my blood disorder, including more tests than I care to count. No questions asked, no limits on doctor's visits or hospital stays.

Over the last five years, my life has been more stable with newer medications that have yielded better and more consistent results. This has allowed me to maintain full-time employment, despite the fact that I still contend with occasional bouts of depression and hypo-manic episodes, continued medication changes (22 & counting) and all kinds of side effects to go along with both illnesses. However, through careful monitoring and continued doctor's care, I have managed to remain out of the hospital, complete college, pursue a Master's degree in Social Work, maintain a job in Philadelphia's public behavioral health system, manage a relationship, live independently, and, overall, happily. For this, I can say I am *very* lucky.

Currently I am under an insurance plan through my employer which affords me complete coverage for my hematologic condition but limits the amount of outpatient doctor's visits I may have, the amount of days I can be hospitalized for, and the maximum amount of money they will put out for my psychiatric care. And, by the way, I pay *extra* (about $70/month) for the *privilege* of enrolling in this health plan.

While my insurance company affords me complete care from my hematologist - all I must do is pay a $10.00 co-pay at each visit, my psychiatric outpatient care costs me a minimum of $80 a visit!

If I need to go into the hospital for psychiatric reasons, I can go in for 30 days per year. That is it. If I become severely depressed and need hospitalization for more than 30 days per year, I am, essentially, sunk. I will have to quit my very decent job that I have had for nearly 7 years and go on Medicaid to cover the hospital bill.

On the other hand, if I have to go into the hospital for hematologic reasons, I can go in for as many days as needed. No lengthy arguments with the company over the phone trying to justify my stay, or the reality of my illness. After all, a blood disorder is a real medical condition in the eyes of my insurance company.

I see no difference between my physical illness and my mental illness. My physical disorder can be fatal and requires long-term monitoring and continued care for the rest of my life. My mental disorder can be fatal and requires long-term monitoring and continued care for the rest of my life. Right now, the only difference is in the blatantly unequal and inadequate insurance coverage.

I present this testimony because I want you to understand how outrageous it is that there is no mental health insurance parity - that because of stigma, greed and lack of proper Federal legislation, I am denied equal and adequate coverage solely based on the fact that I have a mental illness.

As members of the United States House of Representatives, you have a great opportunity before you to put an end to an unjust system and enable millions of people to receive the mental health coverage they desperately need by enacting legislation to end insurance discrimination against people with mental illness. I implore you to do so, for people like myself and those who have not been so lucky, for those who do not have the means on their own, or the family to help them pay for the mental health care that they need in order to live healthy and productive lives.

Thank you.

APPENDIX L – SUBMITTED FOR THE RECORD, STATEMENT OF STANFORD J. ALEXANDER, CHAIRMAN, WEINGARTEN REALTY INVESTORS, HOUSTON, TX, MARCH13, 2002

Statement of
STANFORD J. ALEXANDER
Chairman, Weingarten Realty Investors
before the
Subcommittee on Employer-Employee Relations
Committee on Education and the Workforce
on
Mental Health Parity
March 13, 2002

Mr. Chairman and Members of the Committee:

I am Stanford Alexander, Chairman of Weingarten Realty Investors. Our company is a Houston, Texas based real estate investment trust with 284 income-producing properties in 18 states that spans the southern half of the United States from coast to coast. Our company is a public company and listed on the NYSE under the symbol "WRI". Included in our portfolio are 225 shopping centers, 57 industrial properties, one apartment complex and one office building aggregating 34 million square feet. The company has a total market capitalization exceeding $3 billion dollars.

As a business leader, and as a father, a husband and an employer, I have witnessed for many years the deplorable inequity in health insurance coverage for mental illness. This inequity doesn't make good business sense. It doesn't make good human sense. It doesn't save money. It doesn't, more importantly, save lives.

I am proud to lend my voice in support of H.R. 162, legislation introduced by Rep. Marge Roukema of this Committee. I commend Rep. Roukema and the more than 200 Members of the House who have cosponsored this bill. I commend you as well, Mr. Chairman, for scheduling this hearing. I am strongly committed to mental health parity and to the enactment of legislation to end discrimination in health insurance against people with, or at risk of, mental illness. With the passage of legislation like H.R. 162, we have an opportunity to do something about a disparity that is shameful, antiquated, and costly to American business, costly to American families and costly to the many individuals who do not receive the medical treatment they deserve.

Because our family, like so many others, has been touched by the silent debilitator of mental illness, I am passionate about changing society's perceptions and attitudes with respect to these devastating illnesses, which are epidemic in scope.

These are not illnesses of choice, nor are they character defects. They are the result of biologically based imbalances in the brain. And yet, deplorably, our predominant health care providers are too often our streets and our jails.

Is it because we do not believe that treatment can be effective that we fail to provide adequate insurance coverage for it? Treatment has been proven effective, with rates of success that rival and even surpass those of other major physical illnesses.

Perhaps we fail to provide insurance coverage because we think it might cost too much. As a businessman, I am interested in making sure that health care costs are controlled. But study after study has demonstrated that mental health parity in conjunction with managed care can actually sometimes even reduce health care costs.

Or do we fail to provide health insurance coverage for mental illness because we do not believe that wonderful, brave, smart and valuable people can experience mental illness?

I know firsthand that people in all walks of life suffer because of such a belief. Because of such experiences I have joined in partnership with the Mental Health Assn. of Greater Houston to help eradicate the stigma of mental illness. And it is because I know that treatment can help, that I have changed the insurance coverage in my own firm to provide total parity, whether the treatments are for physical or mental illnesses.

When I decided to undertake this challenge, I first investigated my own company's health plan and medical statistics. Our company is predominantly self-insured, and in fiscal 2000, we reimbursed an average of $7,000 per employee for their medical expenses. I was disappointed to discover that, while we reimbursed 90 percent of all medical expenses, we reimbursed only 70 percent of mental illness treatment. This certainly was not parity. Our company provides approximately 250 employees and their families with health insurance. Last year our company paid out in insurance claims approximately $1,450,000 under our former self-insurance plan.

Today, WRI's health plan reimburses our associates 90 percent of all their medical expenses, including treatment for mental illness.

In my investigation, I also discovered a hidden problem that no doubt reflects the stigma of seeking treatment for mental illness. When we had 70% parity, our company only spent $16,000 (that's an average of $64.00 per employee) on treatment for mental illness out of a total of $1.5 MM for ALL healthcare costs. After WRI went to parity, we spent $34,000 out of a total $1.5 MM for all healthcare costs. Moreover, there was one unusual case, so this amount is probably not typical and next year will probably be back around $16,000.

I would like to think our company is blessed with such a low incidence of mental illnesses, but I doubt we are so fortunate. I have concluded that employees or their family members who suffer from any mental disorders are either not seeking the help they desperately need, or they are paying such medical expenses out of their own pockets for fear of being penalized or even fired, if we were to discover their true plight.

Neither one, of course, would ever happen. Nevertheless, this is a sad commentary on society today, and a perception that we, at WRI, are actively seeking to change by encouraging our associates to seek medical help for their personal sake, for their family's sake and for the benefit of our company.

With this kind of support and good health insurance, I know that people who might otherwise suffer in isolation and self-doubt, who might lose jobs, who might lose families, will be better able to seek help and benefit from modern medication and supportive service. With such treatment, they can remain on the job, they can avert crises, and they can get the support they need to maintain their lives in a stable and productive way.

It makes good human sense. It makes good business sense. It saves money. And more importantly, it saves lives.

Our society has swept the issue of mental illness under the rug for far too long. Surgeon General David Satcher pointed out in his 1999 report on mental illness that at least one in five Americans will have some form of mental illness in their life. Given the numbers who experience mental illness, it is a wonder that we have not taken more proactive steps towards helping these individuals. The passage of the Mental Health Parity Act of 1996 was a step in the right direction. It represented congressional recognition of the impact of mental illness and the need to assure the same access to treatment through health insurance as is afforded for physical ailments. The House of Representatives now has the opportunity to close the loopholes in that law and end the shameful discrimination that denies so many people access to needed treatment.

We now know mental illnesses can be treated effectively. If these illnesses are caught and treated properly they have better rates of successful treatment than other physical medical conditions such as heart disease. Schizophrenia has a success rate of 60%, depression can be successfully treated 70-80% of the time, and those who suffer from panic disorder can be helped 70-90% of the time. These figures compare to a success rate for heart disease of 45 to 50 percent. Mental illness, like any physical ailment, can be treated and in many cases cured.

Why, then, do our insurance policies continue to discriminate? The answer is the stigma that continues to surround these diseases. Allowing companies to retain discriminatory insurance policies perpetuates this stigma. The failure to act would send a de facto message that says, "Mental illness is not as important as physical illness." This is not a message we should be sending and it is certainly not a message that the people of America agree with. A National Mental Health Association poll conducted in 1999 found that nine out of ten Americans say that health insurance companies should provide coverage for mental illness that is more than or equal to that provided for physical illness or injury.

A majority of states have now recognized mental health parity in some form of legislation. In recent years, 17 states passed legislation, bringing the total number of states with parity laws to 32. While state legislation is important, it is crucial that Congress improve our parity laws because of the large number of employees whose insurance coverage is not affected by state law. Many large, self-insured corporations can only be impacted by federal legislation.

Those who oppose mental health parity legislation cite fears of rising costs. Industry voices pressed the same concerns with the 1996 law. Such fears are unfounded. The data on the cost of parity contradict the assumption that parity means a large increase in expense. In fact, many cases show that companies have actually saved money by implementing parity.

Other companies have also gone above and beyond the bare minimum that the law requires and have received great dividends. AT&T, Delta Airlines, Texas Instruments, Dell Computers and Verizon are just a few companies that have brought mental health parity to their coverage. Despite the example of these large corporations adopting parity, many other business lag behind. The cost of failing to provide good mental health coverage is lost productivity and worker absenteeism. In my view, legislation like H.R. 162 would not only protect employees, it would provide savings to companies through productivity increases.

The costs of untreated mental illnesses alone warrant action. As reported by the Surgeon General, the cost to the economy of not treating mental illness is huge, estimated to have totaled some $79 billion in 1990 principally due to loss of productivity. A 1995 report by the MIT Sloan School of Management showed that clinical depression alone costs American businesses $28.8 billion a year in lost productivity and worker absenteeism. A 1993 paper from the Journal of Clinical Psychiatry estimated that the economic cost per depressed worker was $600 with only one-third of those costs in treatment, while the other two-thirds were costs related to absenteeism and lost productivity. Without equal spending caps and coverage, most individuals cannot afford to get the health care they need. As a result, these are the very real costs that businesses and society will face if parity legislation is not enacted.

The belief persists that it costs more to treat mental illness than to ignore it. This is not the case. The National Institute of Mental Health's Interim Report to Congress in 1998 pointed out that introducing mental health parity in conjunction with managed care actually results in a 30 to 50 percent decrease in total mental health care costs. In systems already using managed care, implementing parity results in a less than one percent increase in premiums. Such studies demonstrate clearly that mental health parity is both affordable and cost effective.

Passage of legislation like H.R. 162 will benefit American workers and American businesses. With its passage Congress can take an important step to ensure parity and eliminate the high costs of stigma versus mental illness.

It is time to acknowledge that mental illnesses are real, treatable and like any other illness, insurable.

APPENDIX M – SUBMITTED FOR THE RECORD, STATEMENT OF THE AMERICAN PSYCHIATRIC ASSOCIATION, WASHINGTON, D.C., MARCH 13, 2002

Statement of the American Psychiatric Association
On Mental Health Parity
To the Subcommittee on Employer-Employee Relations
March 13, 2002

Chairman Johnson, Representative Andrews, and members of the Subcommittee, on behalf of the American Psychiatric Association (APA), this statement is presented in support of making parity health insurance coverage for treatment of mental illness (including substance abuse disorders) our nation's law. The APA is the national medical specialty representing some 38,000 psychiatric physicians. Our members are the frontline specialists in the medical treatment of mental illness. We practice in all settings, including private practice, group practice, hospital-based services, nursing facilities, and community-based care, along with all health programs under the auspices of the Federal Government such as the Public Health Service, the Indian Health Service, and the Department of Veterans' Affairs (VA health system). In addition, psychiatrists serve as academic faculty and practice in academic medical centers of excellence, and are at the forefront of research into the sources of and new treatments for mental illness.

First and foremost, APA commends you for holding the first hearing on mental health parity in the House of Representatives. Our thousands of members and hundreds of thousands of our patients also wish to express for the record their deep gratitude to Representative Marge Roukema, a member of the Subcommittee, for her unyielding commitment to making parity coverage of treatment for mental illness, including substance abuse disorders, the law of the land. Millions of Americans have directly benefited from her advocacy for parity. We also wish to extend to Representative Roukema our best wishes for a full and speedy recovery.

1. Mental Illnesses are Prevalent

We trust that there is no longer any debate in this body about the scope and impact of mental disorders on your constituents. As the landmark 1999 Surgeon General's report on mental health noted, "few families in the United States are untouched by mental illness." About 20 percent of the U.S. population are affected by mental disorders in any given year, although recent work by Narrow, et al ("Revised Prevalence Estimates of Mental Disorders in the United States," *Archives of General Psychiatry*, February 2002) suggest that the use of a clinical significance criterion provides a more useful, accurate -- and lower -- prevalence measure. According to Narrow, "For adults older than 18 years, the revised estimate for any disorder was 18.5%." Regardless of the exact level of prevalence, the impact of mental illness is indisputable. The Global Burden of Disease study issued in the early 1990's by the World Health Organization found that mental illness was the second leading cause of disability and premature death worldwide, second only to heart disease and outstripping the disease burden caused by cancer.

2. Mental Illnesses Are Costly to the Economy and to Businesses

Clearly, by any standard, mental illness has a major impact on the lives of millions of Americans, and their families -- and employers -- every year. This is a crucial point in the national debate about parity: mental illness costs the American economy and American businesses tens of billions of dollars each and every year. In fact, the Surgeon General found that the lack of parity

coverage of treatment for mental illness costs businesses over $70 billion every year in lost productivity, increased use of sick and disability leave, and higher use of non-psychiatric medical services. Put another way, every American taxpayer and every American business -- big or small -- is paying directly for our failure to require non-discriminatory access to medically necessary treatment for mental illness, including substance abuse disorders.

3. The Knowledge Base is Growing

Ironically, the struggle in Congress to eliminate arbitrary insurance discrimination against patients seeking treatment for mental illness occurs at a point when the diagnostic science and treatment options have never been better. Mental illness diagnosis and treatment is accelerating as the most exciting frontier of biological science. The bipartisan support in Congress for doubling the budget of the National Institutes of Health, including the National Institute of Mental Health has directly contributed to the strengthening of the science base in our understanding of brain functioning and the impact of mental disorders. Last year's Nobel Prize winner, Eric Kandel, is a psychiatrist. His selection underscores the message that scientific advances are leading to understanding the molecular basis of cognitive processes that are affected by mental disorders.

4. Treatment Works, But Barriers to Treatment are Significant

This is good news: we understand how the brain works -- and how mental disorders affect the brain -- better today than at any time in our nation's history. Our ability to diagnose mental illnesses has never been more precise. And our ability to effectively treat mental illness has never been stronger. Yet the good news is tempered by the fact that for Americans in every walk of life, the ability to secure all medically necessary care for their mental illness is largely negated by open, legal, and blatant insurance discrimination. As the Surgeon General's report puts it so eloquently, "the mental health field is plagued by disparities in the availability of and access to its services. A key disparity often hinges on a person's financial status: *formidable financial barriers block off needed mental health benefits from too many people regardless of whether one has health insurance with inadequate mental health benefits . . .*"

5. Parity Opponents Misrepresent Current Legislation

Much of the opposition to parity is based not on what the various parity bills actually would do, but on what opponents fallaciously assert they would do. Both the Roukema/Kennedy bill in the House (H.R. 162) and the Domenici/Wellstone bill in the Senate (S. 543) would leave medical necessity determinations up to the health plan, and would give employers and insurance companies wide latitude in benefit design and in management of the services delivered. These and similar bills are not mandates but should be properly viewed as coverage conditions. The legislation says, in effect, that it is no longer acceptable to single out one group of patients for special, deliberately discriminatory and limited care that is uniquely applied to them because they are diagnosed with a mental illness. It is frankly difficult to comprehend how those opposed to parity can continue to sanction the disenfranchisement of patients with one type of medical condition -- mental disorders -- from the full rights accorded to all other patients for their own medical or surgical care.

6. The DSM-IV is an Effective, Precise Diagnostic Tool

Because the generic "anti-mandate" complaints of some business and insurance groups has lost its effectiveness, much of the current objection to parity has focused on concern that the diagnostic

criteria for mental disorders, codified in the fourth edition of the APA's Diagnostic and Statistical Manual (DSM-IV), are allegedly too broad. These allegations are simply unfounded. NIH and NIMH research applications, FDA treatment indications for new drug products, and legal determinations of competence to stand trial all are predicated on widely accepted DSM criteria.

The truth is that DSM-IV criteria are included in virtually all state Medicaid legislation, the Federal Employees Health Benefits Program guidelines for parity, and in fact the "medical necessity" criteria of virtually all managed behavioral health companies employed by general health insurance companies to manage their benefits. Thus, the same companies that complain that DSM criteria are too broad currently use DSM criteria every day for documentation and treatment justification when determining claims outcomes.

Parity opponents have also focused on peripheral conditions -- those identified in DSM not as DSM diagnoses but as conditions for the focus of clinical attention -- in an effort to imply that if parity is adopted the floodgates would open for conditions such as "malingering" and "jet lag sleep disorder." Yet no insurance company can demonstrate claims data with more than a miniscule proportion of such codes because -- as they perfectly well know -- billing procedures for treatment require **"clinically significant impairment."**

In fact, the identification of such conditions for the focus of clinical attention would actually save insurance companies money because these disorders would not meet the requirement for "clinically significant distress or disability" required of all DSM-IV disorders. The carefully crafted language in both the House and Senate parity bills fully protects the ability of health plans to make such determinations. Thus, "malingering" is no more likely to be covered in a post-parity world than it is today.

7. Treatment Guidelines Focus on Effective Care

Others question the range of treatments available to patients with mental illness, implying that because treatments vary, there is no standard of effectiveness. This is also not true. The evidence-based production of treatment guidelines is now developing rapidly in psychiatry as in the rest of medicine, and we are making every effort to quickly evaluate the effectiveness of new treatments. As clinical trials are conducted, previous and less effective treatments for disorders are generally discarded and no longer appear in treatment guidelines. This is no different than the rest of medicine. For example, when clinical trials showed that the use of carotid endarterectomy as a means of preventing strokes from atheromatous plaques was associated with more deaths than medical management, use of the surgical intervention largely declined. The same was true, for example, of the use of renal dialysis for schizophrenia, which was at one time proposed as a means of eliminating "brain toxins" that caused psychotic symptoms. The fact is that treatments for mental illness -- typically involving the combination of pharmacotherapy and psychotherapy -- have never been better than they are today.

8. Treatment of Symptoms is Not Unusual in All of Medicine

Other opponents of parity assert that we treat symptoms rather than causes. It is fair to say that for many mental disorders, we do not fully understand the causal mechanisms, although through NIMH and other research our understanding of brain functioning and the impact of mental disorders on brain functioning are rapidly growing. In the absence of certainty of the precise cause of some mental

disorders, we do indeed treat the symptoms -- and treat them very effectively. This is not different than many other medical surgical conditions.

For example, we know that certain forms of arthritis are associated with joint inflammations that we are unable to prevent because we do not now know the full causation, but we nevertheless control symptoms with non-steroidal anti-inflammatory agents. Likewise, we know that certain forms of depression and anxiety disorders are associated with low levels of seratonin and norepinephrine in certain areas of the brain, and with cognitive and mood symptoms, that we are presently unable to fully prevent. However, we have very effective medications that, in combination with cognitive-behavioral treatments, offer very substantial symptomatic reductions. Arguing against parity coverage of mental illness treatment because we are not absolutely certain of the precise cause of mental illness is like arguing against treating cancer because we are not absolutely certain what triggers abnormal cell growth.

9. 34 States, Soon to be 35, Have Parity Laws

Mr. Chairman, opponents of parity will always find one more excuse why Congress should continue to permit discrimination against patients with mental illness. APA believes that the time has come for our national legislature to say "Enough." 34 states (and we are pleased to note that West Virginia is on the verge of becoming the 35th) have enacted some form of parity legislation. While the definitions of parity and the scope of coverage vary, the fact remains that not a single state parity law has been repealed, and several narrow laws have been expanded. Unfortunately, state parity laws do not, of course, extend to ERISA plans, which is why we are here today.

10. Time to End Legal Insurance Discrimination

The struggle over parity has been, in our view, a struggle for basic human rights, and for the triumph of science over stigma and ignorance. There can be no doubt that mental illness exacts a terrible toll on our economy and our patients. There is no doubt that our understanding of the causes of mental illness has never been greater, and our ability to effectively treat these devastating illness has never been better. Why then do we continue to treat one group of patients differently from all others? On behalf of our 38,000 physician members, their patients, and their patients' families, we urge you to require simple equity in the treatment of mental illness. Pass parity now.

STATEMENT OF

THE AMERICAN PSYCHIATRIC ASSOCIATION

TO THE

HOUSE EDUCATION AND WORKFORCE SUBCOMMITTEE ON EMPLOYER-EMPLOYEE RELATIONS

HEARING ON

ASSESSING MENTAL HEALTH PARITY: IMPLICATIONS FOR PATIENTS AND EMPLOYERS

WEDNESDAY, MARCH 13, 2002

For Additional Information:
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APPENDIX N – SUBMITTED FOR THE RECORD, STATEMENTOF THE AMERICAN PSYCHOLOGICAL ASSOCIATION, WASHINGTON, D.C., MARCH 13, 2002

AMERICAN
PSYCHOLOGICAL
ASSOCIATION
PRACTICE ORGANIZATION

Testimony for the Record of
The American Psychological Association
Regarding the
Subcommittee on Employer-Employee Relations
Committee on Education and the Workforce
U.S. House of Representatives
Hearing on Mental Health Parity
Wednesday, March 13, 2002

Mr. Chairman and Members of the Committee:

The American Psychological Association (APA), the largest membership association of psychologists with more than 155,000 members and affiliates engaged in the study, research, and practice of psychology, appreciates the opportunity to submit this testimony for the record regarding mental health parity. We are longtime supporters of parity, having strongly advocated for passage of the original Mental Health Parity Act of 1996 (1996 Parity Act). We are grateful to the Chairman and the members of the Committee for holding a hearing to discuss the need to end widespread discrimination in health insurance coverage of mental disorders.

APA strongly urges passage of full mental health parity legislation -- the logical extension of the 1996 Parity Act -- to end this discrimination. Only full mental health parity legislation will provide coverage for mental health benefits equal with that provided for medical and surgical benefits. Only full mental health parity legislation offers the solution originally promised by the partial parity of the 1996 Parity Act.

We emphasize four key points in our testimony today:

First, despite clear evidence of the significant mental health needs of our citizens and despite passage of the 1996 Parity Act, inadequate access to mental health treatment continues. Only enactment of full parity legislation will ensure that employees have nondiscriminatory mental health coverage. This means that full parity must be required for all aspects of coverage, including day and annual visit limits or other limits on duration or scope of treatment, deductibles, co-payments, maximum out-of-pocket limits, or other cost sharing requirements.

Second, all persons with mental illness diagnoses need and deserve the protection of parity. Only broad-based parity legislation will protect people with all forms of

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mental illness, not just those on a random list of diagnoses such as a list of "severe mental illnesses" (SMI).

Third, the cost of full parity for all persons afflicted with mental illness is very affordable. The Congressional Budget Office (CBO) has estimated that full mental health parity, as provided in the "Mental Health Equitable Treatment Act of 2001" (S. 543) (introduced by Senators Pete V. Domenici and Paul Wellstone), will cause premiums to rise on average by a mere 0.9%. This extremely low cost impact is born out by the actual experience of states that have enacted full parity.

Fourth, there is no reason to believe that the very modest additional costs on the private sector of offering full parity will lead to a significant number of workers losing their mental health benefits or losing their health insurance coverage. Again, actual experience with parity in 34 states demonstrates that parity will not lead to widespread loss of insurance coverage.

I. Only enactment of full parity legislation will ensure that employees have nondiscriminatory mental health coverage equal to their coverage for medical and surgical benefits.

Three years ago, the U.S. Surgeon General issued a comprehensive report documenting the mental health needs of our nation. The Surgeon General found that about one in five Americans are affected by mental disorders during any given year. (Office of the Surgeon General, the U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General,* 1999.) In a subsequent report focusing specifically on children's mental health, the Surgeon General found that one in ten children and adolescents suffer from mental illness severe enough to cause some level of impairment, while the unmet need for services remains as high now as it was 20 years ago. (Office of the Surgeon General, the U.S. Department of Health and Human Services, *Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda,* 2001.) Health insurers and employers, however, traditionally have offered less coverage for mental health services than for medical/surgical services and have imposed more restrictions.

The 1996 Parity Act was an important step forward in recognizing the need for mental health parity coverage in our nation; it provided limited parity in annual and lifetime dollar limits. Nevertheless, despite clear evidence of the need for mental health treatment for many Americans and despite enactment of the 1996 Parity Act, health insurers and employers have continued to discriminate against people with mental illness.

Two years ago, the General Accounting Office (GAO) issued a study of the 1996 Parity Act's effects. GAO found that most employers have been offsetting the narrow lifetime and annual dollar limit parity requirement by instead restricting other mental health benefits design features, such as outpatient visit limits, inpatient days, or co-payment requirements. As GAO reported:

> Although most employers' plans now have parity in dollar limits for mental health coverage, 87 percent of those that comply contain at least one other plan design feature that is more restrictive for mental health benefits than for medical and surgical benefits . . . . [M]any employers may have adopted newly restrictive mental health benefit design features since 1996 specifically to offset the more generous dollar limits they adopted as a result of the federal law. About two-thirds of these newly compliant employers changed at least one other mental health benefit design feature to a more restrictive one compared with only about one-fourth of the employers that did not change their dollar limits. (GAO, *Mental Health Parity Act: Despite New Federal Standards, Mental Health Benefits Remain Limited,* Pub. No. HEHS-00-95, 2000)

During debate on the passage of the 1996 Parity Act, APA and other mental health parity advocates hoped that employers would implement its lifetime and annual dollar parity requirement forthrightly due to the projected very low impact on claims costs. CBO had predicted a rise in employers' share of premiums of a mere 0.16%. Despite the very low cost associated with the 1996 lifetime and annual dollar limit parity requirement, many employers reacted by simply restricting other components of mental health coverage. By reducing any part of an employee's benefit to meet a parity requirement, Congress' intent of ending unfounded discrimination against persons needing mental health services through their private coverage is thwarted. APA, therefore, strongly supports legislation that offers full parity in all mental health benefit design features.

S. 543, for example, provides for full parity for in-network services with respect to outpatient visits and inpatient days, co-payments, deductibles, and maximum out-of-pocket requirements, in addition to parity for annual and lifetime dollar limits as currently required by the 1996 Parity Act. An employee's mental health coverage, when offered and when in-network, would have to be equal in every respect to the employee's medical/surgical coverage. Full parity would mean that employers could not simply reduce certain design features so that employee access to mental health benefits does not improve in the aggregate.

II. All persons with mental diagnoses listed in the Diagnostic and Statistical manual of Mental Disorders (DSM-IV) need and deserve the protection of parity, not just those on a random list of diagnoses commonly known as "severe mental illnesses" (SMI).

The issue of whether mental health parity legislation should be narrowed to cover only those conditions considered to have a biological basis was raised at the hearing. APA believes that it is simply wrong and bad public policy to condition health insurance coverage on the cause of the illness, and we strongly urge the Subcommittee to reject this strategy. When a person has cancer or heart disease, insurance coverage does not turn on the cause; our society just provides the needed care. We must do the same for mental illness.

Many people suffer debilitating mental health disorders, some of which are thought to have a biological basis (most commonly considered to be only Schizophrenia, Schizoaffective Disorder, Bipolar Disorder, Major Depression, Panic Disorder, and Obsessive-Compulsive Disorder) and some of which are not. Since science cannot say with certainty which mental illnesses are completely biologically-based, an SMI list is necessarily a random list. To adopt such a causality standard is to enshrine – in Federal law – a policy that officially condones inferior insurance coverage for many patients, including:

> Women suffering from mental and emotional problems stemming from rape or assault;
>
> Children suffering from pervasive developmental disorders, such as Autism; Pica (a serious eating disorder); Tic disorders; Attention Deficit/Hyperactivity Disorder; and many more disorders;
>
> Adolescents and adults suffering from eating disorders, such as Anorexia Nervosa and Bulimia; Schizophreniform Disorder (a mild form of Schizophrenia that most often sadly progresses to Schizophrenia or Schizoaffective disorder); Trichotillomania (recurrent pulling out of one's hair, often beginning in childhood); Multiple Personality Disorder; Dementia due to Parkinson's Disease; and many more debilitating, even devastating, disorders.

Moreover, there is no scientific justification for covering only SMI conditions, but not other mental illnesses. Success rates for treatment of some non-"biologically based" mental disorders have been shown to surpass those for some "biologically based" mental disorders (see attached chart "Treatment Efficacy (Early Treatment Outcome) for Eight Mental Disorders and Two Cardiovascular Surgical Procedures"). Treatment success rates for Post-Traumatic Stress Disorder (65%), Dysthymic Disorder (a chronic low-level depression) (65%), and eating disorders such as Anorexia Nervosa and Bulimia (78%) all equal or exceed those for Schizophrenia (60%), Major Depression (65%), and Obsessive-Compulsive Disorder (60%). Indeed, treatment success rates for these mental disorders, as well as Panic Disorder (80%) and Bipolar Disorder (80%), all greatly exceed treatment success rates for two common surgical procedures for heart disease (45-50%).

Recognizing there is no need and no good reason to offer the protection of parity only for biologically-based mental disorders, fifteen states have enacted broad-based parity laws for all mental illness diagnoses (i.e., Alabama, Arkansas, Connecticut, Georgia, Indiana, Kentucky, Maryland, Minnesota, Mississippi, New Mexico, North Carolina, Rhode Island, Tennessee, Utah, and Vermont). Two of these states, Connecticut and Rhode Island, just recently expanded their original SMI parity laws to broad-based parity covering all mental illness diagnoses.

Broad-based parity means equal coverage for all mental diagnoses listed in the DSM-IV and/or the International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9-CM), a publication of the World Health organization. The DSM-IV requires that

all disorders be required to have clinically significant impairment (in one or more important areas of functioning) or distress (painful symptoms). The DSM-IV is the insurance industry standard for determining mental diagnoses for purposes such as claims reimbursement. DSM codes are used by the Centers for Medicare and Medicaid Services. DSM codes are in agreement with the ICD-9-CM. The Federal Employee Health Benefits Plan (FEHBP) provides parity coverage for all DSM-IV diagnoses. Eight broad-based state parity laws expressly cover all diagnoses listed in the DSM-IV and/or the ICD-9-CM (i.e., Alabama, Arkansas, Connecticut, Georgia, Kentucky, Tennessee, Utah, and Vermont). Many other broad-based state parity laws do not expressly reference the DSM-IV, but the DSM-IV still applies as the industry standard used to judge which conditions should be given the protection of parity under the statute (i.e., Indiana, Maryland, Minnesota, Mississippi, New Mexico, North Carolina, and Rhode Island).

Although the DSM-IV contains the full range of possible diagnoses, the enactment of broad-based parity legislation will not require coverage for every possible DSM-IV diagnosis. Insurers today do not cover all diagnoses, even in states that offer broad-based parity for all DSM-IV diagnoses. Rather, insurers currently employ a variety of managed care techniques, including determinations of medical necessity, to evaluate whether to cover a particular diagnosis. Under S. 543, managed care techniques and medical necessity determinations still will govern eligibility for coverage. In fact, a Senate Committee amendment to S. 543 specifically allows insurers to use their own standards for determining medical necessity.

Moreover, Congress can provide broad-based parity for all diagnoses for about the same cost as providing parity only for SMI. In 1996, CBO estimated that parity for a typical SMI diagnosis-based list costs 90% as much as parity for all diagnoses. The Substance Abuse and Mental Health Services Administration (SAMHSA) subsequently confirmed CBO's cost estimate. In considering leading parity cost studies, SAMHSA found that expenses for this type of diagnosis-based list represent 89% of the increase for all mental health diagnoses due to parity. (Merrile Sing, et al., SAMHSA, U.S. Department of Health and Human Services, *The Costs and Effects of Parity for Mental Health and Substance Abuse Insurance Benefits*, 1998). Thus, parity can be provided on an equitable basis for all persons with mental diagnoses with little additional cost impact.

III. The cost of full parity for all persons with mental illness is very affordable.

CBO estimates that the cost of full mental health parity, as provided in S. 543, will cause premiums to rise by a mere 0.9%. (CBO, *Cost Estimate for S. 543, Mental Health Equitable Treatment Act of 2001*, 2001.) This cost increase is shared between the employer and employee, with the employer typically paying 0.36% of the total. Actuarial analysis by PricewaterhouseCoopers agrees, and shows that S. 543 would cost the typical plan only four and one-half cents per covered person per day.

In addition to the CBO score for S. 543, we now know from the *actual experience* of states with full parity laws, that the cost is about 1%, or even well below 1% in some states. For example:

- Vermont enacted a full mental health parity law that became effective on January 1, 1998. Vermont's full parity law is similar to that offered FEHBP. As insurers filed their proposed rates for 1998 with the State Division of Insurance, insurers identified the proportion of their rate increases attributable to parity. Blue Cross Blue Shield of Vermont estimated the impact at 0% for the Vermont Health Partnership (a managed care plan product), 1-3% for its comprehensive plan, and 2% for its base plan. Kaiser Permanente/CHP estimated a 2.07% increase attributable to parity. (Elizabeth R. Costle, *Report of the Department of Banking, Insurance, Securities and Health Care Administration on Mental Health and Substance Abuse Parity (Act 25) to the Vermont General Assembly,* 1999.)

- Maryland implemented full parity in 1995. Shortly after, a small increase was observed in the number of inpatient admissions, but that increase was more than offset by a more significant decrease in the average length of inpatient stays. For one insurer, the proportion of the total medical premiums attributable to its mental health benefit actually decreased by 0.2%. A second managed care company with extensive experience in the state subsequently confirmed that its average expense per member per month increased by less than 1% during the first seven months after implementation of full parity. Additional data received in 1997 indicated that, after an initial increase following parity implementation, costs receded towards pre-parity base line levels. (Harold Varmus, M.D., National Institute of Mental Health, U.S. Department of Health and Human Services, *Parity in Coverage of Mental Health Services in an Era of Managed Care: An Interim Report to Congress by the National Advisory Mental Health Council,* 1997.)

- Minnesota's full parity law became effective on August 1, 1995. To date, there have been no recognized cost concerns or exodus of insured plans to ERISA status in order to avoid the state's parity mandate. The Minnesota Department of Commerce, which regulates indemnity insurance, estimated costs of 1% of total premium dollars for mental health parity. Medica, an independent consulting organization, estimated state costs for mental health parity at 26 cents per member per month. (Varmus, *Interim Report to Congress.*)

Actual state experience indicates that full parity coverage has had a minimal impact on claims costs, and in fact closely mirrors the CBO projection. SAMHSA confirmed this finding, documenting that due to the ability of managed behavioral health care organizations to control costs state parity laws have had only a small effect on insurance premiums. (Sing, *The Costs and Effects of Parity*). The benefit gained by employees through full parity, however, far outweighs its very low cost. With enactment of full parity, employees are assured that their insurance coverage provides nondiscriminatory mental health benefits should they need these benefits.

IV. The enactment of full parity will not lead to a mass of employers dropping their mental health benefits or health insurance coverage.

There is no reliable data or experience showing that full mental health parity legislation will cause large numbers of employers to drop their health insurance coverage overall, or even their mental health benefit coverage. In the 34 states that have enacted parity laws, parity for mental health coverage has not led to widespread loss of insurance coverage anywhere, and no state that has enacted a parity law has ever later narrowed or repealed it. Indeed, as discussed earlier, states' experiences with parity have led some to expand upon their original parity laws, most recently Connecticut and Rhode Island. Further, in studying possible employer reactions to state parity laws, SAMHSA also found that employers neither suddenly decided to self-insure to circumvent state parity laws, nor did employers pass on the full cost of parity to employees. (Sing, *The Costs and Effects of Parity.)*.

Moreover, amendments in the Senate markup of S. 543 already have addressed many concerns raised by employers. Under S. 543, parity for substance abuse is not required and small employers of 50 or fewer employees are exempted from the bill. S. 543, like the FEHB program on which it is modeled, proposes parity only for in-network services, leaving employers and health plans free to use preadmission and other managed care review techniques to deliver cost-effective mental health care.

There is no reason to believe that the very modest additional costs on the private section associated with S. 543 will lead to any significant number of workers losing their health insurance coverage. The Office of Personnel Management (OPM), in weighing the claim that parity would result in fewer people having insurance coverage, concluded that this argument appears to be a myth. (OPM, *Mental Health & Substance Abuse Parity Questions and Answers,* 2000).

There is also a significant cost to employers of <u>not</u> providing parity for mental health benefits. The 1999 Surgeon General's report on mental health estimated that workers with untreated or undertreated mental illness add some $70 billion annually to employer costs through absenteeism, turnover and retraining expenses, lower productivity, and increased medical costs. (Office of the Surgeon General, *Mental Health: A Report of the Surgeon General.*)

Conclusion

The time has come for Congress to build upon the 1996 Parity Act and end discriminatory mental health coverage by passing full mental health parity legislation, such as S. 543. CBO has stated, and actual state experience has shown, that completely banning discrimination will result in an average premium increase of less than 1%. The benefit from this small impact on premiums will be enormous. Employees will be assured that their mental health benefits are available, like their medical/surgical benefits, when they need them, and families will no longer be devastated by the financial implications of the illness of a loved one.

APPENDIX O – SUBMITTED FOR THE RECORD, STATEMENT OF THE AMERICAN MEDICAL ASSOCIATION, WASHINGTON, D.C., MARCH 13, 2002

STATEMENT

for the Record

of the

American Medical Association

to the

Subcommittee on Employer-Employee Relations
Committee on Education and the Workforce
United States House of Representatives

RE: ASSESSING MENTAL HEALTH PARITY: IMPLICATIONS FOR PATIENTS AND EMPLOYERS

March 13, 2002

Mr. Chairman and members of the Committee, the American Medical Association (AMA) and its physician and student members thank you for the opportunity to share our views with the Committee regarding this critical issue of mental health parity. We especially thank this Committee for holding this hearing and for addressing the need to provide adequate mental health coverage and treatment to those who are mentally ill.

THE CHALLENGE

Inadequate Access to Mental Health Treatment – A Lack of Parity

The U.S. Surgeon General, in a comprehensive report on mental health released in December 1999, found that approximately 15% of all adults use mental health services each year. According to the American Psychiatric Association (APA), 48% of all Americans between the ages of 15 and 54 experience a psychological disorder during their lifetime.

Mental illness takes a significant personal toll on virtually everyone it afflicts, as well as on their families, friends, and often their colleagues. Nevertheless, health insurers are generally much more restrictive in covering mental illness than covering other medical illnesses. We have heard countless stories of patients suffering from mental illness and being arbitrarily refused coverage. Many health plans, for instance, set arbitrary limits on the number of inpatient days or outpatient visits for which their beneficiaries will be covered while being treated for a mental illness.

Insurers that offer coverage for mental illness also typically impose various financial restrictions on their beneficiaries. Health insurers, for instance, frequently establish low annual and lifetime limits for mental health treatment, while setting high deductibles and copayments. As a result, patients who are fortunate enough to be able to access mental health treatment often suffer the misfortune of having to pay proportionately higher out of pocket expenses and sometimes face catastrophic financial losses when the costs of their care exceed the arbitrarily set limits. These restrictions also frequently determine the extent to which they can access treatment, which can affect the quality of care they can eventually obtain.

Access Problems Encountered by Children and Adolescents

The problem of inadequate access to mental health treatment applies equally, and perhaps more acutely, to children. In January 2001, the Surgeon General reported on health services for children and adolescents with mental health problems and explained that 10% of children in the United States suffer from mental illness severe enough to cause some level of impairment. However, fewer than one in five of these children receives needed treatment.

The mental health needs of children and adolescents are increasing while access to behavioral health, mental health, and substance abuse services is decreasing. In the past 20 years, the rate of psychosocial problems identified in children in primary care has increased from 7% to 18%. Currently, it is estimated that at least 13 million children are in need of treatment for mental illness, and insurers' attempts to restrain costs have resulted in decreased availability of these services.

Part of the problem stems from the fact that for nearly half the children with serious emotional disturbances, the public school system has been the sole mental health provider. When children and adolescents have complex and long-term mental health problems, required services are typically not covered by their parents' health plans because of arbitrary limitations on mental health coverage. Families must either pay for the services themselves or obtain the services through the public sector. In many states, parents are forced to give up custody of their children to the state child welfare system in order to obtain needed residential services. This unfortunate choice has resulted from a limited supply of public sector services and special requirements for gaining access to them.

FINDING A SOLUTION

Mental Health Parity – Good for Patients, Good for Society

Mental health parity acknowledges that mental health disorders are true illnesses which demand medical treatment. Parity would require health plans that offer mental health benefits to provide them as they provide medical and surgical benefits. Health plans should not be able to set different treatment limits or financial requirements, such as higher patient

copayments, fewer hospital days, higher patient deductibles, and fewer outpatient visits on mental illness treatment than are currently set for other medical treatments.

Mental health parity clearly benefits patients. Most medical experts concur that diagnoses for mental illness have well-established biological bases, can be made reliably, and treatment is effective. The National Institute of Mental Health, in fact, has reported that treatment success rates for mental health disorders surpass those of other medical conditions. Treatment success rates for schizophrenia (60%), clinical depression (70-80%), and panic disorder (70-90%), for instance, all exceed the treatment success rate for heart disease (45-50%). OPM, commenting on this fact, recently stated that "[w]e believe that this is important because adequate mental health and substance abuse benefits coverage has been shown to improve patient health, provide patients with greater financial protection against unforeseen costs, and to reduce work place absences and employee disabilities."

Mental Health Parity – Good for Business

Left untreated or undertreated, mental illness takes not only a significant toll on people's lives, but it also takes a financial toll on businesses. According to the 1999 Surgeon General's report on mental health, lack of parity for coverage of mental illness costs businesses more than $70 billion per year, resulting from lost productivity and increased use of sick leave. Clinical depression costs American businesses $28.8 billion a year in worker absenteeism and lost productivity, according to a 1995 MIT Sloan School of Management report.

Mental health parity would actually benefit businesses financially. Studies have found that access to treatment for mental illness can offset general medical costs, decrease absenteeism,

reduce the psychiatric disability claims made by employees, and offset court and prison costs. In June 1999, the *Wall Street Journal* reported that a "four year study of program effectiveness at McDonell-Douglas yielded a four-to-one return on investment after considering medical claims, absenteeism and turnover."

Additional Federal Action Needed

The Federal Mental Health Parity Act of 1996, as amended, which sunsets in December 2002, helped alter the design of health-benefit plans by eliminating lifetime and annual financial caps. Under the law, group health plans providing mental health benefits may not impose a lower lifetime or annual dollar limit on mental health benefits than exists for medical or surgical benefits. The law does not apply, however, to companies with fewer than 50 employees, and no company has to meet this standard if they opt out of offering mental health coverage altogether. In addition, any company can request a waiver if the cost of parity exceeds more than 1% of the plan's health care costs. Consequently, with its many loopholes this law has not been as effective as its original sponsors had intended.

Nevertheless, recognizing that mental health parity benefits patients and society, in 2001 the federal government began offering its nine million employees improved mental health benefits equal to those for physical ailments. This new policy offers further evidence that parity in coverage is gaining wider acceptance and is workable. Thirty-two states also now have laws that in some way address insurance disparities, and many large corporations provide equal coverage for their employees, believing that doing so saves money in the long run.

A federal bill introduced last year was modeled after the mental health parity policy implemented for the Federal Employee Health Benefits (FEHB) Program. Senators Pete Domenici (R-NM) and Paul Wellstone (D-MN) last year introduced the "Mental Health Equitable Treatment Act of 2001," S. 543. This bill would ensure greater parity for mental health benefits coverage by prohibiting group health plans from treating mental health benefits differently than medical and surgical benefits. The AMA strongly supports both the FEHB Program policy, as well as S. 543.

Responding to Parity Opponents

Many who have opposed mental health parity have argued that the cost of parity would be exorbitant and would result in fewer people having insurance coverage. The facts and experience have proven this argument to be false.

In a comprehensive analysis submitted to Congress in June 2000, the National Mental Health Advisory Council found that, on average, mental health parity increased total health insurance premiums by only 1.4%, far less than the 10% or 15% predicted by critics. In addition, case studies of five states that had a parity law for at least a year revealed a small effect on premiums, at most a change of a few percent, plus or minus. Separate studies of laws in Texas, Maryland, and North Carolina have shown that costs actually declined after parity was introduced under certain circumstances.

When reviewing the effects of state parity laws, the Office of Personnel Management (OPM), citing a "growing body of research and actual industry experiences" found that these laws have had a nominal effect on premiums due primarily to careful management of mental health

services. OPM also stated that "[r]ecent advancements in the treatment and management of mental illness have left no justifiable rationale for disparate treatment of mental illness."

CONCLUSION

Enacting legislation that would require mental health parity would benefit patients, society, and businesses. For too long health insurers have gotten away with blatant discrimination against those suffering from mental illness by demanding higher co-payments and deductibles, and allowing fewer physician visits or days in the hospital. By passing meaningful mental health parity legislation, Congress would finally put an end to this discriminatory and unfair practice by the health insurance industry.

Thank you again for the opportunity to submit our thoughts and suggestions regarding mental health parity. The AMA offers this Committee our assistance and resources in helping to address more effectively the medical needs of those suffering from mental illness.

APPENDIX P – SUBMITTED FOR THE RECORD, STATEMENT OF JIM MCNULTY, PRESIDENT, NATIONAL ALLIANCE FOR THE MENTALLY ILL (NAMI), BRISTOL, RI, MARCH 13, 2002

NAMI

STATEMENT OF JIM MCNULTY
PRESIDENT
NATIONAL ALLIANCE FOR THE MENTALLY ILL (NAMI)
REGARDING MENTAL ILLNESS PARITY
SUBMITTED TO THE
SUBCOMMITTEE ON EMPLOYER-EMPLOYEE
RELATIONS
COMMITTEE ON EDUCATION AND THE WORKFORCE
U.S. HOUSE OF REPRESENTATIVES
MARCH 13, 2002

Chairman Johnson, Representative Andrews and members of the Subcommittee, I am Jim McNulty of Bristol, Rhode Island, President of the National Alliance for the Mentally Ill (NAMI). In addition to serving as NAMI's President since July 2001, I also live with bipolar disorder, also known as manic-depression. I was first diagnosed in 1987 and have experienced the full impact of mental illness first hand, and as a family member of other individuals suffering from mental illness. My first experience with mental illness (then diagnosed as a "nervous breakdown") occurred as a college sophomore in 1970. I was fortunate enough to have a supportive psychiatrist and friends who helped me embark on the process of recovering from manic depressive illness – an experience common to few consumers.

I was first elected president of the Manic Depressive and Depressive Association of RI (a chapter of National DMDA) in 1990, and I currently serve on the board and the executive committee of the National Alliance for the Mentally Ill of Rhode Island, as well as the Mental Health Consumer Advocates of Rhode Island, a statewide organization for mental health consumers. In July 1999, I was appointed to the Governor's Council on Mental Health, a statutory body which advises the executive branch of Rhode Island government on mental health issues. I also serve on the Rhode Island State Planning Council. As a beneficiary of psychiatric research on medications and services myself, I recognize the vital importance of encouraging further development of research on these aspects of mental illness. I have also facilitated peer education and support groups that focus on recovery for the last 11 years.

NAMI Supports Parity

For the past decade, insurance parity has remained NAMI's top legislative priority. As the nation's largest organization representing individuals with serious brain disorders and their families, with 220,000 members and over 1,200 affiliates, we know why a minimum standard for parity in insurance coverage is desperately needed. Our members – individuals with mental illnesses and their families – know first-hand what it means to face discrimination in health insurance.

NAMI members understand what it is like to exhaust their coverage with a single hospital stay, to be forced to pay higher deductibles and co-payments, and to run through unfair limits on inpatient days and outpatient visits. What makes these discriminatory limits so unjust is that they apply only to illnesses of the brain, and not to any other organ or system of the body. As I will discuss in greater detail in my testimony, NAMI believes strongly that insurance parity for the treatment of severe mental illness is at its core an issue of discrimination. We believe that mental illnesses are brain disorders, that treatment for these illnesses is just as (if not more) effective than for other diseases, and that health plans should not be allowed to impose limits and conditions in insurance plans that do not apply to all other diseases. In short, we are not asking for special treatment, merely the coverage that any of us expect when we need treatment.

Mental Illnesses Are Brain Disorders

A mental illness is, more accurately, a brain disorder; and brain disorders--like epilepsy--are biologically-based medical problems. The newest medical technology can take "pictures" that show differences between brains with disorders and normal brains. In any given year, about five million American adults suffer from an acute episode of one of five serious brain disorders: schizophrenia, manic depression, severe depression, obsessive-compulsive disorder, and panic disorder. Even many of America's children--more than three million--suffer from these disorders.

Untreated, disorders of the brain profoundly disrupt a person's ability to think, feel, and relate to others and to his or her environment. Despite age-old myths and misinformation, "mental illnesses" are not caused by bad character, poor child-rearing, or an individual's behavior. The "PET" scans attached to my statement graphically demonstrate how schizophrenia and depression are directly linked to variances in brain structure, chemistry and firing of neurons.

Brain disorders are shrouded in stigma and discrimination. For centuries they have been misunderstood, feared, hidden, and often ignored by science. Only in the last few decades has the first real hope for people with mental illnesses surfaced, and that hope has grown from pioneering research that found both a biological basis for brain disorders and treatments that work. NAMI's efforts to combat discrimination and stigma received a major boost in December 1999 with the release of the U.S. Surgeon General's Report on Mental Health. This historic report

documents the scientific evidence that treatment is effective and concludes that there is no justification for health plans to cover treatment for serious brain disorders such as schizophrenia and bipolar disorder differently from any other disease.

Treatment Works
As Surgeon General David Satcher noted in his 1999 landmark report, science has proven that severe mental illnesses are treatable. The current success rate for treating schizophrenia is 60 percent. The success rate for treating manic depression is 65 percent, and for major depression it is 80 percent. By contrast, treatment efficacy rates for interventions such as angioplasty (41 percent) and atherectomy (52 percent) are lower. Mental illnesses can now be diagnosed and treated as precisely and effectively as other medical disorders. Tragically, the stigma associated with these illnesses too often prevents individuals from accessing treatment that science has proven is effective. More importantly, the fact that health insurance plans have historically imposed limitations and conditions on the coverage for treatment of severe mental illness compounds this stigma.

Discrimination is Wrong
Discrimination in health insurance takes many forms. The most common techniques that apply only to mental illness treatment are: higher cost sharing requirements for outpatient visits and prescriptions, lower treatment limits on inpatient days and outpatient visits and lower annual and lifetime dollar limits. The use of these discriminatory limits and conditions has been well documented.

Numerous studies compiled prior to the enactment of parity laws (including surveys of plans by the U.S. Bureau of Labor Statistics) found that 85 percent of all plans limited inpatient care and more than 98 percent limited outpatient care. In 1991-92, the BLS Employee Benefit Survey also found that one-half of plans were restricting hospitalization to 30 to 60 days. More than 70 percent of plans were found to have limited either the dollar value of outpatient benefits, or the actual number of visits. These surveys also found that arbitrary limits were often unrelated to actual treatment needs. While the federal Mental Health Parity Act (MHPA) and the 34 state parity laws are changing this reality, clearly a legacy of discrimination still exists in the private health insurance market.
While these studies are persuasive, what is more important from NAMI's perspective are the personal stories that vividly describe how insurance discrimination has touched people's lives.

- Martin Stanley of Roy, Utah is the father of 13 year-old Ben, who is diagnosed with bipolar disorder. Up until last year, Roy and his family were able to get the treatment needed to keep Ben fairly stable. However, in June 2001, Ben had to be hospitalized and eventually needed an extended stay in a residential treatment setting as a result of an adverse reaction to a medication. The Stanley's health plan imposes strict limits on psychiatric inpatient services and day treatment that do not apply to medical-surgical conditions. The Stanleys exhausted their coverage late last year, just as Ben was switched to a new medication and experienced psychosis, paranoia and eventually suicidal ideation. Eventually with their inpatient and day treatment coverage exhausted, the Stanleys were faced with the prospect of having to pay completely out of the pocket at as much as $1000 per day. Martin is quick to add that none of these strict limitations on coverage would have applied to Ben's treatment if he were diagnosed with diabetes.
- Stephen Bacallao of Orlando, Florida is the father of a son with schizophrenia and an anxiety disorder. Prior to his son's diagnosis, his health plan maintained a strict $10,000 lifetime ceiling on mental health benefits. A few years ago, their son was not responding to treatment and had to be hospitalized. After 7 days in the hospital with little progress, his health plan notified Stephen that it would be imposing a 10-day limit on inpatient coverage and suggested that he be prepared to come forward with the minimum of $1000 a day in costs after the 10th day. Once Stephen refused, the health plan pressured doctors to attest that a new medication was effective in order discharge their son on the 10th day. Once home, Stephen's son spent most his time on the couch in the fetal position and within a week was back in the hospital for a 3 week stay at significantly higher costs.
- Anne Renee Hansard of Thomasville, Georgia was first diagnosed with bipolar disorder in 1982 at age 19 when she was an honor student at the University of Virginia. A hospitalization in the mid-1980s resulted in her exhausting her policy's very limited inpatient benefit. At the time of her discharge when her benefits ran out, she was nearly catatonic and unable to care for herself. With no inpatient benefit left to fall back on, Anne was forced to leave the job market altogether and apply for disability benefits in order to get health care coverage – all at taxpayer expense. Now more than a decade later, Anne has still not been able to return to work. Parity

would have prevented Anne from ever having to leave the workforce to get coverage for the treatment she needed.

- Bonnie Putnam of Florence, South Carolina has been diagnosed with major depression since 1979. Even though she has worked for the same company for more than 25 years, she is on the verge of losing her job because she cannot afford to pay for the treatment she needs on her own. Her employer qualifies for the small business exemption under the MHPA. South Carolina's parity law is of little benefit to Bonnie because it still allows her health plan to strictly limit coverage for outpatient medication and therapy – limits she long ago exceeded. Passage of South Carolina's law actually made things worse for Bonnie since her health plan responded by further limiting outpatient coverage. Bonnie Putnam needs parity.
- Susan Delaney of Monrovia, Maryland and her daughter know first-hand how the expected protections of health insurance seem to immediately vanish with the onset of an illness such as bipolar disorder. When Susan's daughter was diagnosed with bipolar disorder at 18, she quickly ran through her $20,000 lifetime limit. Even when Susan switched to COBRA coverage after leaving her job, her insurer carried over the $20,000 limit and refused to cover any additional treatment. The result is that Susan's daughter was forced to go into a state psychiatric hospital after her symptoms substantially deteriorated – at substantial cost to taxpayers.

These personal stories are just a small sample of the experiences that NAMI members go through everyday in trying to access coverage for the treatment they need from an unresponsive health insurance system.

The 1996 Mental Health Parity Act Was An Important Step Forward, But Full Parity Is Needed
The first major step toward ending discrimination in health insurance came in 1996 when President Clinton signed the federal Mental Health Parity Act (P.L. 104-204) into law. With the leadership of Senators Pete Domenici (R-NM) and Paul Wellstone (D-MN), this landmark law establishes a standard of parity for annual and lifetime dollar limits only. The law applies only to employers that offer mental health benefits; i.e., it does not mandate such coverage. More importantly, the MHPA allows for many cost-shifting mechanisms, such as adjusting limits on mental illness inpatient days, prescription drugs, outpatient visits, raising co-insurance and deductibles, and modifying the definition of medical necessity.

As the General Accounting Office (GAO) noted in testimony before this Committee in 2000, lower limits for inpatient and outpatient mental illness treatments have continued, and in some cases, actually expanded to help keep costs down. However, it is important to note that the MHPA does not apply to either fully insured state-regulated health plans and self-insured plans that are exempt from state laws under the Employee Retirement Income Security Act (ERISA), which are regulated by the Department of Labor. Existing state parity laws are not preempted by the MHPA (i.e., a state law requiring more comprehensive coverage is not to be weakened by the federal law, nor does it preclude a state from enacting stronger parity legislation, which many have). Other critical limitations in the MHPA include a small business exemption (for firms with 50 or fewer employees) and an increased cost exemption (employers that can demonstrate a one percent or more rise in costs due to parity implementation will be allowed to exempt themselves from the law).

NAMI is encouraged by the GAO findings presented at this hearing that 86 percent of surveyed health plans are complying with the MHPA. While it is alarming that 14 percent of the surveyed plans are not in compliance, we view this as an issue of lack of effort on the part of state insurance commissioners, the Centers for Medicare and Medicaid Services (CMS) and the Pension and Welfare Benefits Administration (PWBA) to educate employers about the new law. Likewise, as the GAO noted, compliance is based largely on a complaint-driven process, thereby placing responsibility on aggrieved plan participants to come forward – something made more difficult through the stigma associated with mental illness. In order to ensure greater compliance with the MHPA, and all future federal parity efforts, NAMI urges Congress to push CMS and PWBA to do more to educate employers and health plans about their responsibilities under the law and to randomly audit representative samples of large, medium and small employers for compliance.

Mr. Chairman, it is interesting to note that while the opponents of the MHPA in 1996 attempted to vastly expand the scope of this increased cost exemption during regulatory implementation of the MHPA, relatively few employers have used it. NAMI believes that this is due in part to accountability measures included in the regulations (by retrospective examination of claims data, disclosure to employees when a firm seeks an exemption, etc.). However,

the reality that fewer than ten employers have sought the one percent cost exemption is a development that is more than likely due to the fact that parity is affordable and costs simply have not gone up.

34 States and FEHBP Have Adopted Parity
As is often the case, states have taken the lead ahead of Congress in moving to end insurance discrimination. The original idea behind parity was modeled on legislation in the 1960s that prohibited cancer exclusions in insurance coverage. Mental health parity was first successful with state employees in Texas, then in Maine, New Hampshire, Rhode Island, Maryland. By the early 1990s, parity laws had been passed in six states. Although these laws do not apply to ERISA self-insured companies, they give employees some protection and they serve to statistically validate the fact that parity is affordable. After enactment of the federal MHPA in 1996, we saw the passage of nine more state parity laws in 1997 and seven (unfortunately three were vetoed) in 1998. In 1999, 11 more states enacted parity laws, bringing the total number of states with such laws to 28. With the addition of California in 1999, more than half the population is living in states that require non-discriminatory coverage.

In 2001, Illinois and Kansas became the latest states to pass parity laws. Clearly, the trend to pass state parity legislation is picking up momentum. Even today, NAMI affiliates are continuing to seek out legislative leaders to sponsor parity bills of all types in the states with the ultimate goal of ending all insurance discrimination against those who suffer from mental illnesses. NAMI will continue to provide documentation of the experiences of the states that passed parity laws in the early 1990s and other evidence of the affordability of parity and the effectiveness of treatment. NAMI will seek coverage that is equal to that of other medical conditions covered in each policy written, and we will not turn away from this effort until the discrimination has ceased.

Beginning in January 2001, the Office of Personnel Management (OPM) began requiring all health plans competing in the Federal Employees Health Benefits Program (FEHBP) to offer parity level benefits for mental illness. As you know, FEHBP is the largest health insurance program in the nation, covering 9.5 million federal employees, retirees, and their families.

Parity is Affordable
One of the principal lessons learned from the experience in the states that have enacted parity laws – as well as with preliminary estimates by OPM for FEHBP – is that parity is extremely affordable. This is especially the case for laws that focus the parity requirement on a categorical list of severe diagnoses.

As you have seen at this hearing, the cost of paying for health insurance parity for mental illness unfortunately remains a hotly debated issue. This is disturbing to us at NAMI given the overwhelming evidence through multiple studies that demonstrate the minimal cost impact resulting from parity. As the GAO found in its report on MHPA implementation, only 3 percent of surveyed plan administrators found that cost went up as a result of compliance. For the record, I would like to briefly summarize just a few of these studies – most of them from independent sources with no stake in the policy debate over parity – that have come forward in recent years:

- Congressional Budget Office Assessment of S 543 (August 1, 2001)– CBO prospective estimate of the impact of the Senate full parity bill projects that it would increase premiums on average on .9%.
- Background Report: Effects of the Mental Health Parity Act 0f 1996 (March 30, 1999) -- Issued by the Substance Abuse and Mental Health Services Administration (SAMHSA), results of this national survey showed that 86 percent of employers who made changes in health plans to comply with the 1996 federal law did not make any compensatory reductions in other benefits because the cost of compliance was minimal or nonexistent.
- Parity in Financing Mental Health Services: Managed Care Effects on Cost, Access & Quality (July 15, 1998) -- The second in a series of reports to Congress issued by the National Advisory Mental Health Council found that full parity costs less than one percent of annual healthcare costs. When implemented in conjunction with managed care, parity can reduce costs by 30 to 50 percent.
- Rand Corporation Study (November 12, 1997) -- Equalizing annual limits (typically $25,000) - a key provision of the Mental Health Parity Act of 1996 - will increase costs by only about $1 per employee per year under managed care. An even more comprehensive change required by some state laws (i.e., removing limits on inpatient days and outpatient visits) will increase costs by less then $7 per enrollee per year. The main

beneficiaries of parity were found to be families with children who, under current conditions, are more likely than adult users to exceed their annual benefit limits and go uninsured for the remainder of the year.

- National Advisory Mental Health Council's Interim Report on Parity Costs (April 29, 1997) -- The introduction of parity in combination with managed care results in, at worst, very modest cost increases. In fact, lowered costs and lower premiums were reported within the first year of parity. Maryland reported a 0.2 percent decrease after the implementation of full parity at the state level; Rhode Island reported a less than 1 percent (0.33 percent) increase of total plan costs under state parity; Texas experienced a 47.9 percent decrease in costs for state employees enrolled in its managed care plan under parity.
- Lewin Study (April 8, 1997) -- In a survey of New Hampshire insurance providers, no cost increases were reported as a result of a state law requiring health insurance parity for severe mental illnesses.

Let's Finish the Job – Full Federal Parity

As I noted above, the combined effect of the MHPA, the 34 state laws and parity for FEHBP, while substantial and historic, still leaves too many individuals with mental illness behind. Parity is becoming a reality in our country, but discrimination persists – particularly for individuals in ERISA self-insured plans and with respect to cost sharing requirements that apply only to mental illness treatment.

NAMI believes strongly that the legislation soon to be introduced by your colleagues Representatives Marge Roukema and Patrick Kennedy, the Mental Health Equitable Treatment Act of 2002, is needed to address these gaps in the parity quilt and finish the job of ending discrimination for persons living with the most severe and disabling forms of mental illness. As they noted in testimony provided at this hearing, they will soon be introducing the same full parity bill that was introduced last year by Senators Pete Domenici and Paul Wellstone (S 543) that was passed by the Senate HELP Committee last August by a 21-0 and was later passed a full Senate voice vote. NAMI's consumer and family membership is extremely grateful for the leadership of Representatives Roukema and Kennedy in seeking to once and for all end discrimination.

This legislation contains a simple message – that mental illnesses are real diseases and that coverage for their treatment must have the same limitations as those imposed on medical and surgical benefits. Put simply, this legislation means full insurance parity for people with mental illnesses and effectively removes all inequitable limits including on copays and deductibles, and on inpatient days and outpatient visits. It would cover all of the disorders listed in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM IV). This includes schizophrenia, bipolar disorder (manic depression), major depression, obsessive compulsive disorder, panic disorder, post-traumatic stress disorder, autism and other severe and disabling mental disorders such as anorexia nervosa and attention deficit/hyper activity disorder.

This landmark legislation is core to NAMI's vision of ensuring that the next generation of individuals with mental illness and their families will not have to live out their lives on disability or in public institutions, unable to get the very care that would give them back productive lives. Insurance discrimination enforces the false message that mental illnesses are "untreatable" and "hopeless." As I have noted above, parity is both affordable and cost-effective. With parity as envisioned in the Roukema-Kennedy bill, businesses in fact stand to gain from reduced absenteeism; reduced healthcare costs for physical ailments related to mental illnesses; increased employee morale; and increased productivity overall.

Conclusion

Chairman Johnson, Representative Andrews and members of the Subcommittee, I would like to thank you for the opportunity to share NAMI's views on this important issue. We look forward to working with all members of this Subcommittee to ensure that the House acts on full parity this year.

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