

INSURANCE COVERAGE OF MENTAL HEALTH BENEFITS

HEARING BEFORE THE SUBCOMMITTEE ON HEALTH OF THE COMMITTEE ON ENERGY AND COMMERCE HOUSE OF REPRESENTATIVES ONE HUNDRED SEVENTH CONGRESS

SECOND SESSION

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INSURANCE COVERAGE OF MENTAL HEALTH BENEFITS

TUESDAY, JULY 23, 2002

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

The subcommittee met, pursuant to notice, at 10 a.m., in room 2123, Rayburn House Office Building, Hon. Michael Bilirakis (chairman) presiding.

Members present: Representatives Bilirakis, Greenwood, Ganske, Norwood, Wilson, Shadegg, Bryant, Ehrlich, Brown, Waxman, Strickland, Barrett, Capps, Eshoo, Wynn, and Green.

Also present: Representative Roukema.

Staff present: Nandan Kenkeremath, majority counsel; Yong Choe, legislative clerk; and Karen Folk, minority professional staff.

Mr. BILIRAKIS. I now call this hearing to order. I would like to thank our witnesses for appearing before the subcommittee today. Our subcommittee values your expertise, and we are grateful—very grateful—for your cooperation and attendance.

The focus of today's hearing is insurance coverage of mental health benefits. As we all know, Congress has been grappling for some time with what the Federal Government's role should be in mandating insurance benefits. While I think that there is a fairly broad consensus regarding the need to provide Federal protection for beneficiaries from insurance company abuses, many people have concerns about the impacts such mandates would have on costs.

I personally have grave reservations about contributing to already spiraling health care costs, and have no desire to add to the already unacceptable number of uninsured Americans.

This notion was reinforced for me during the Congressional recess of late March and early April. During that 2-week period, I visited with many people in my district and was surprised to find that a primary issue that the business community was concerned with was not a typical bread and butter business issue; it was the cost of providing health insurance.

Those meetings left quite an impact on me and has certainly focused my attention on the effects that decisions we make here in Washington might have on my constituents. These concerns need to be balanced, of course, with the needs of patients, including those with mental illness. Congress recognized this by removing the ability of health plans to impose annual and lifetime limits for mental health benefits that are different and similar limits for medical and surgical benefits.

These provisions, which were enacted into law in 1996, were reauthorized as part of last year's labor health and human services and education appropriations bill. I am aware that there are concerns in the mental health community about the effectiveness of these provisions, and I am aware that many members, including several on this subcommittee, are co-sponsors of legislation that would broadly expand upon this mandate.

I hope that some of our witnesses today will address the notion that every condition outlined in the Diagnostic Statistical Manual of Mental Disorders IV, DSM-IV, warrants full parity. I believe that some mental conditions, just like some physical conditions, do not warrant equal treatment by a health plan.

However, I do want to be clear on this issue. I think serious mental illnesses are problems that deserve serious attention. But I also believe that we have to be careful with our limited health care resources.

While I am fully aware of the perils associated with attempts to define what constitutes a serious mental illness, I support the idea that full parity may be appropriate for some illnesses. Again, defining what is serious would likely prove very difficult. However, I believe that notion gets at what might be a middle ground on these issues.

I am sure I am not alone in my desire to better understand this subject matter, which is why I decided to hold this hearing. Our panel of witnesses should help members of the subcommittee get a better grasp of the issues we are facing and the potential impact of various policy decisions.

I would like to remind members of the subcommittee that committee rules limit member opening statements to 3 minutes. I hope that all members respect this limit, with the exception, of course, of the chairman and ranking member. And I plan to hold to that 3-minute period, and I now yield to the ranking member, Mr. Brown, for his opening statement.

Mr. BROWN. I thank the chairman. I ask unanimous consent, Mr. Chairman, to start with that all members have their statements or comments in the record.

Mr. BILIRAKIS. Of course. Without objection, that is the case.

Mr. BROWN. I thank the witnesses for their testimony this morning. I want to thank my colleague, Patrick Kennedy from Rhode Island, for his sponsorship of the leading mental health parity legislation in this Congress, the Mental Health Equitable Treatment Act, and the topic of today's hearing. I am pleased to be 1 of the 240 co-sponsors—a distinct majority in this body.

My colleague on the subcommittee, Mr. Strickland, who will join us shortly, is also a leader in mental health issues and a champion of mental health parity under Medicare and for all Americans. Today's hearing focuses on the merit of H.R. 4066, the product of bipartisan negotiations on mental health parity. It is a thoughtful compromise bill. It recognizes the concerns of the mental health community as well as those of employers.

The bill prohibits group health plans from imposing treatment limitations or financial requirements on the coverage of mental health benefits, unless there are comparable limitations on medical

and surgical benefits. I think the bill is a compromise responsive to concerns raised by employers.

Like so many chronic and acute diseases covered under mental—under health insurance today—mental illnesses are serious, they can be debilitating, and in most cases they are highly treatable. The fact that health insurance typically has one set of coverage rules for an illness like heart disease, and another set of coverage rules for an illness like clinical depression, is unjustifiable and simply unfair.

Two hundred twenty-six organizations, 66 Senators, a majority of my colleagues in the House, support this compromise, although the opposition to it is vocal and aggressive. The opposition stigmatizes mental illness by mischaracterizing the bill. Mental health may not receive the same insurance treatment as other health care needs, but it should be afforded the same respect as it is debated on Capitol Hill.

I want to, Mr. Chairman, mention a couple of the myths floating in opposition to the bill. Opponents argue that insurers would be required to cover all mental health disorders, including, for example, jet lag disorder. What opponents would like you to believe is that under parity insurers would be required to pay for services rendered by a patient who, after catching the red-eye, couldn't sleep for a night or two.

The truth is that the bill only requires treatment of a medical disorder, if the plan finds that treatment to be medically necessary. An insurer could deny payment in the case of jet lag on the basis that the treatment wasn't medically necessary.

Opponents have also expressed concern that mental health parity would increase the cost of health insurance, forcing employers to drop coverage for health insurance services or drop coverage all—for mental health services or drop coverage altogether.

They say passing the bill would cause mental health costs to skyrocket—the argument that they always use, particularly if this reform coincides with passage of a patient's bill of rights, since they say health plans would have less ability, then, to manage their benefits. There is a difference between managing benefits and short-changing patients.

The cost effect of both of these pieces of legislation has typically been overstated by their opponents. CBO estimates—non-partisan CBO estimates the direct cost of services under the proposed bill would increase group health plan premiums by less than 1 percent. It costs the typical plan an additional \$1.30 per covered person per month.

The patient's bill of rights and mental health parity would pass simultaneously. Health plan premiums would increase according, again, to CBO—not to the Democrats but to CBO—would increase by just 1.1 percent. When parity was implemented in Ohio, treatment costs actually declined because in-patient days dropped by 75 percent. Outpatient visits fell by 40 percent.

As we debate the issue of cost, keep this in mind. This Nation will bear the costs of mental illness, whether mental health parity legislation passes or whether it doesn't pass, whether it is through out-of-pocket costs, emergency room visits, lost job productivity, pa-

tients and businesses in the health care system and the economy are paying for mental illness.

Delayed treatment simply increases the costs across the board to all of us. According to a study 3 years ago by then Surgeon General Satcher, approximately 1 in 5 adults experiences some mental disorder over the course of a year.

Our current health care financing system arbitrarily dismisses or even discriminates against those individuals. That is short-sighted, and it is morally wrong. Health care coverage for mental health is the right thing to do for our people. It is the smart thing and the productive thing to do for our economy.

I yield back.

Mr. BILIRAKIS. The Chair thanks the gentleman. Now, for 3 minutes, Dr. Norwood.

Mr. NORWOOD. Thank you, Mr. Chairman, and thank you for holding this hearing. This is a very important topic, I believe, for our committee to be considering today, and we are grateful.

The issue of mental health parity is a lot, and very simply, about equality. Are we going to continue to treat people with mental illness as second-class citizens? Are we going to continue to stigmatize people with mental health issues?

Mrs. Roukema's bill, H.R. 4066, is based on the parity provisions in the Federal Employee Benefit Plan, which the Members of Congress and other Federal employees and their families presently have. It will give mental health patients the same treatment, cost-sharing, lifetime and annual limits, as those applicable to medical/surgical services, ending discrimination against those with mental illness.

This compromised mental health parity bill includes concessions that provide the flexibility and cost containment that employees desire. Health plans will still be able to use managed care techniques and will be able to determine when coverage is medically necessary.

The substance abuse coverage that was included in our previous parity bill, H.R. 162, was removed. I think it is a reasonable approach to mental health parity, and I am proud to be a co-sponsor of the bill.

Now, we are going to hear testimony that tries to suggest the most infrequent of diagnoses are commonplace. We are going to hear testimony about costs that suggest passing mental health parity will destroy health care coverage as we know it—similar claims that I have listened to over and over again in the past 5 years about a patient's bill of rights debate.

I thought they were absurd, then, Mr. Chairman, and I think they are absurd now. And I look forward to discussing exactly how absurd I think these statements are with our panelists.

Mr. Chairman, I urge the committee to move forward with this legislation. I am not the only one supporting mental health parity legislation. So is the majority of this committee. So is the President. Back in April, the President said he wants to sign a bill that "prevents plans from applying less generous treatment or financial limitations on mental health benefits that are imposed on medical or surgical benefits."

We have that bill before us, and I hope we will act before this session ends. I look forward, Mr. Chairman, to the witnesses' testimony, and will be glad to yield back the balance of my time.

Mr. BILIRAKIS. The Chair thanks the gentleman. Mr. Green for an opening statement.

Mr. GREEN. Thank you, Mr. Chairman, for holding this important hearing on insurance coverage for mental health benefits, and this is an important issue that literally touches every family. I am pleased to welcome, as one of our witnesses today, Mr. James T. Hackett, Chairman and President and CEO of the Ocean Energy, Incorporated, headquartered in my hometown of Houston.

I followed Ocean Energy in their efforts to provide energy for our Nation for many years, but I particularly appreciate the progressive nature he has been and his company has been on mental health parity. Mr. Hackett is a model of a business man when it comes to providing equitable mental health benefits for his employees.

He has worked with—not only with his organization to ensure that every one of the employees at Ocean Energy has access to quality mental health care. Additionally, he has reached out to other Houston businesses—Winegarden Realty Investors, which is a great group in Houston, also The Houston Chronicle—and urged them to provide mental health parity for their employees.

If all employers and insurers acted as these organizations have, there wouldn't be any need for this legislation we are discussing today that I am proud to be a co-sponsor of. Unfortunately, far too many people who suffer from some form of mental illness cannot access treatment because of the archaic stigma associated with the disease.

The Surgeon General estimates that approximately 20 percent of the U.S. population, about 60 million Americans, has a diagnosable mental disorder in any given year. Even the most conservative of estimates indicates that the untreated mental illnesses cost American businesses \$70 billion a year in lost productivity and worker absenteeism.

In the United States, mental health disorders collectively account for more than 15 percent of the overall burden of disease from all other causes. It is slightly more than the burden associated with all forms of cancer.

Mr. Chairman, I would like to have my full statement read into—placed into the record, but like a lot of people, when I was—before I was elected to Congress, we had other professions. I was a practicing lawyer in Houston and actually had a probate judge who handled our mental health cases decide 1 day when he came to the legislature nobody understood mental health cases.

And so he appointed me as the lawyer to represent people who were to be—have their freedom taken away for as much as 90 days. And it is—talk about on-the-job training and effort, I realize what mental illness is in our community and all across this country and how it is treatable, and there are ways that we can do it.

The sad part is when you see people go through our psychiatric centers all over our country, they typically have no type of coverage for insurance, so it becomes on the public system to deal with it. And our public system has been overtaxed for many years. In fact,

I think it was just last weekend in Houston our Harris County psychiatric center was no longer taking patients, and it is a state/local cooperation.

So, you know, we have a problem in our public facility for psychiatric patients. What we need to do is make sure the private sector, like Mr. Hackett and his company and companies are willing to pay for it, have that coverage for their employees.

Thank you, Mr. Chairman, for allowing me over my 3 minutes.
[The prepared statement of Hon. Gene Green follows:]

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

Thank you Mr. Chairman for holding this hearing on insurance coverage for mental health benefits. This is an important issue that touches many of us, and many of our constituents.

I am pleased to welcome Mr. James T. Hackett, Chairman, President and Chief Executive Officer of Ocean Energy, Inc., headquartered in my hometown of Houston, Texas.

Mr. Hackett is a model businessman when it comes to providing equitable mental health benefits for his employees.

He has worked with his organization to ensure that every one of the employees at Ocean Energy has access to quality mental health care.

Additionally, he has reached out to other Houston businesses, including Weingarten Realty Investors and the Houston Chronicle, to urge them to provide mental health parity for their employers.

If all employers and insurers acted as these organizations have, there wouldn't be the need for the kind of legislation we are discussing today.

Unfortunately, far too many people who suffer from some form of mental illness cannot access treatment because of the archaic stigma associated with this disease.

The Surgeon General estimates that approximately 20 percent of the U.S. population—almost 60 million Americans—has a diagnosable mental disorder in any given year.

Even the most conservative of estimates indicate that untreated mental illness costs American businesses \$70 billion each year in lost productivity and worker absenteeism.

In the United States, mental disorders collectively account for more than 15 percent of the overall burden of disease from all causes, and slightly more than the burden associated with all forms of cancer.

But where most insured individuals can access appropriate cancer care, far too many must jump through bureaucratic hoops and meet arbitrary standards before they can access their necessary mental health care.

The General Accounting Office (GAO) estimates that 87 percent of health plans routinely force patients to pay more for mental health care than other health care, or put stricter limits on mental health treatment than on other health treatment.

This barrier to care is counterproductive. Study after study have shown that mental health treatment works.

The National Institutes of Mental Health has shown that treatment for schizophrenia is successful 60 percent of the time, depression can be treated successfully 70 to 80 percent of the time, and panic disorder can be treated 70 to 90 percent of the time.

Conversely, heart disease treatment is successful only 45 to 50 percent of the time.

And despite the complaints from the insurance industry, the Congressional Budget Office has scored this bill as an extremely low cost bill. CBO estimates that it will only increase premiums by .9 percent.

And as we all know, CBO is reluctant to incorporate cost-savings—such as increased productivity and lower absenteeism—which could offset the costs of mental health parity even further.

Mr. Chairman, I know that many of my colleagues are concerned about the skyrocketing costs of health care these days.

But I believe that common-sense changes such as mental health parity will only improve our health care system and will likely drive down the costs of mental illness.

That is why I am a strong supporter of H.R. 4066, legislation which would require insurers and employers to provide mental health parity.

This legislation has already been modified significantly from its original form and bill sponsors have worked hard to address some of the concerns of the opponents of parity.

But I see no similar concessions on the part of the insurance industry. They continue to fight for the status quo—a discriminatory system that had its infancy in the dark ages.

We have come so far in our understanding and treatment of mental illness. It is time for our insurance system to catch up with the times and start treating mental illness with the same attitude and policies that it treats all illnesses.

With that, Mr. Chairman, I yield back the balance of my time.

Mr. BILIRAKIS. The Chair thanks the gentleman. Dr. Ganske for an opening statement.

Mr. GANSKE. Thank you, Mr. Chairman. On Sunday, I rode the first leg of the ride across The Register's annual great bike ride across Iowa. It is called Ride Bright. And I pedaled past one of the four mental institutions that Iowa had set up a long, long time ago. Years ago, we began to discharge patients from those mental institutes and treat them with outpatient therapy.

The treatment, though, is dependent on their having benefits. And I don't know that there would be too many people here in this hearing room today that would advocate not treating manic depressive illness or schizophrenia like you would any other disease. It ought to be part of a benefit package.

There probably is some question about how far down that diagnostic list you go in terms of benefits. Do we mandate benefits for everyone who has a neurosis of any type? So there are some questions that we need to get into, but as a physician I would have to say that, you know, manic depressive illness, schizophrenia, and serious mental diseases should be covered as benefits.

Now, let me talk a little bit about the patient bill of rights. We have a bill that should be in conference. I call upon both the Speaker and the majority leader to call the conference for the patient bill of rights.

There is one case in particular that comes to mind as it relates to mental illness that is interesting and also tragic. There was a man down in Texas; his name was Mr. Plosika. He was in the hospital for depression, suicidal. His physician recommended that he stay in the hospital for treatment. His HMO said, "No, he has been here long enough. And you know what? We can determine medical necessity. So we have determined that he doesn't need to be in the hospital anymore."

Now, in Texas, there is a patient bill of rights that was passed. And it requires that in cases where there are disputes that that go to an expedited review. This is the case Plosika v. Nylcare, for those attorneys for the health plan who are here.

That HMO said, "No, he is out of here." They told the family, "You know, you can keep him here if you want to, but we are not going to pay for it." Well, this family doesn't have any resources, so they take Mr. Plosika home. That night he drank half a gallon of antifreeze and committed suicide.

That HMO just totally disregarded the law. The law in Texas required that they—in that case, that they should have gone to an expedited review, and they just ignored it. That is why we need to come to a resolution on the enforcement powers for a patient bill of rights, so that that type of case doesn't happen again.

I am not only concerned about the fact that some plans don't cover diseases like schizophrenia or manic depressive illness, but I am also concerned about the fact that there are millions and millions of Americans who are paying a lot in terms of their health care premiums, expecting to get mental illnesses covered. And then, because of a 25-year old Federal law, their health plan can just willy nilly deny them the type of medical care that they are paying for.

Mr. BILIRAKIS. The gentleman's time has expired.

Mr. GANSKE. Mr. Chairman, that is why we need to come to—we need to get this conference going on a patient bill of rights, because we are closer to getting that done than we are right now for getting this bill done, although this is—I commend my colleague, Mrs. Roukema, for her work on this.

And I yield back.

Mr. BILIRAKIS. Well, I would hope that we can continue to work on this bill and come to some sort of a conclusion.

Ms. Capps for an opening statement. If we limit our opening statements to 3 minutes, we might be able to finish up in time to run over and cast the vote.

Ms. CAPPS. Thank you, Mr. Chairman, for that hint. And thank you for holding this hearing on such a truly important issue.

I am a long-time co-sponsor of legislation that would establish mental health parity, H.R. 4066. I want to commend our colleague, Marge Roukema here, and Patrick Kennedy, for their leadership on this issue. We have leaders in this Congress, and two Senators stand out in my mind—Senators Wellstone and Domenici—for their leadership.

And I just want to acknowledge the wife of Senator Domenici, Nancy Domenici, who has been a pioneer, stellar, working on this issue. When I was a Congressional spouse, she mentored me in this important topic.

This Congress has spent considerable time addressing the concerns of how insurance plans treat beneficiaries. For example, we have considered—and it has been brought up already—a strong patient's bill of rights that would institute protections for patients from the abuses of HMOs. Unfortunately, the majority rejected that plan and supported a weaker version.

It is, therefore, appropriate that we consider today the issue of mental health parity, I hope with a better result. Right now, there are millions of Americans coping with mental disorders that are treatable by the miracles of modern science.

By some estimates, 1 in 5 Americans face mental health disorders. These people often cannot get the treatments they need. Why? Because some accountant in the back room of an insurance company is afraid that it would cut profits too much—Arthur Andersen's revenge.

So we deny these tax-paying citizens the care they need and deserve, even when many of them are paying high insurance premiums. Several studies indicate that mental health parity will not significantly raise costs. CBO estimates that true mental health parity will raise costs by less than 1 percent.

In 1996, Congress did pass the Mental Health Parity Act to address this problem, but the simple truth is that our insurance

plans simply don't want to pay for mental health services, and they quickly have found ways around the law to avoid doing so. Whether they mean to or not, they are discriminating against people who are struggling to cope with a disease. We need to enact true mental health parity to finish the job started 6 years ago.

As a nurse and a Member of Congress, I have worked hard to eliminate the stigma associated with mental health disorders. The discrimination of these insurance plans is adding to the stigma that American people feel. I have supported resources for an anti-stigma campaign and have pushed the administration to make this campaign as broad-based as possible.

Our society is already too quick to dismiss the concerns of people with mental health disorders. We must stop treating them as second-class citizens. And the simple fact is that treating them as such and withholding mental health service costs our society tens of billions of dollars in lost productivity. But when the insurance companies try to deny these benefits, or, even worse, insist that beneficiaries be in special plans, they set this effort back significantly.

I am pleased we are holding this hearing today. Hope it will lead to real action on this critical issue. We have to pass mental health parity now.

Thank you, and I yield back.

Mr. BILIRAKIS. Mr. Strickland for a 3-minute opening statement.

Mr. STRICKLAND. Thank you, Mr. Chairman. As a psychologist, I have seen firsthand the devastating consequences of an untreated mental illness. It wreaks havoc on productivity, our medical costs, our criminal justice system, not to mention the personal devastation felt by individuals and families whose lives are so affected.

Mental health benefits are an integral and a necessary part of adequate general health care. According to the Surgeon General's 1999 report on mental health, about 20 percent of the U.S. population is affected by mental disorders during a given year.

These disorders are very treatable. In fact, successful treatment rates for many mental illnesses are higher than for those of other medical conditions. Furthermore, mental health parity is affordable. The Congressional Budget Office estimates that H.R. 4066 will increase the costs of insurance premiums by just .9 percent.

Discrimination against the mentally ill is wrong. I believe it is immoral. And given that these illnesses are both diagnosable and treatable, it is shameful that we do not require coverage that is simply on par with surgical and medical benefits.

I would like to enter my complete statement into the record, Mr. Chairman, but let me say that I worked for a number of years in a mental health center, a psychiatric hospital, a prison. And what we are not doing to assist those with these illnesses is a shame. And I applaud the President; I applaud my colleagues who support what we are trying to do.

But let me say we ought not to be forced to choose which pain we are willing to tolerate without treatment. And so that is why I believe we need to look very carefully at any effort to impose arbitrary limits on the kinds of illnesses that will be treated under the parity plan that I hope that we are eventually able to pass.

I thank you, Mr. Chairman, for this hearing, and I look forward to hearing the witnesses.

Mr. BILIRAKIS. I thank the gentleman. Mr. Waxman for an opening statement.

Mr. WAXMAN. Thank you, Mr. Chairman. I can't add anything more to the articulate statement made by our colleague, Mr. Strickland. I think he laid out the case in a superb way. I have long advocated the action to establish parity for mental health care. I am pleased to join with the majority of the members of this subcommittee and an overwhelming majority of the House as a sponsor of H.R. 4060 introduced by Congresswoman Roukema and Congressman Patrick Kennedy.

I have a longer statement I would like to put in the record, but I am here to show my solidarity and support for this legislation. [The prepared statement of Hon. Henry A. Waxman follows:]

PREPARED STATEMENT OF HON. HENRY A. WAXMAN, A REPRESENTATIVE IN CONGRESS
FROM THE STATE OF CALIFORNIA

Mr. Chairman, I am pleased that the Subcommittee is holding this hearing today. It is, in my view, long overdue. And I can only hope that it is the first step to this Subcommittee, and this Committee, reporting favorably legislation to provide parity in mental health benefits.

I have long advocated action to establish parity for mental health care. I am pleased join with a majority of the members of this Subcommittee, and an overwhelming majority of the House, as a sponsor of H.R. 4060, introduced by Congresswoman Roukema and Congressman Patrick Kennedy.

Providing parity in coverage in mental health benefits is not, and should not be, a partisan issue. Legislation to accomplish this objective has strong bipartisan support in both Houses of the Congress. There are 67 sponsors in the Senate; there are 240 sponsors in the House. Some 223 national organizations support its passage.

The question before us should not be should we pass this bill; it should be why haven't we done this sooner. I hope we can put both questions to rest by marking 2002 as the year this legislation is signed into law.

Surely in an enlightened society such as ours, the days when people shut away persons with mental illness, or refused to recognize that it is a medical condition that can be treated with success, are long past. Yet our willingness to provide for insurance coverage for the costs of treatment have lagged behind our willingness to put dollars into coverage of other forms of medical care. That must change.

Mental illness is real, it is devastating, it affects the well-being and productivity of countless Americans. It is time to end the discrimination against treatment that pervades too many of our insurance products.

We know treatment can be effective. We know that mental illness can be diagnosed by a clinician, that medical necessity can be established and appropriate treatment regimens established. And we know this is a benefit that can be managed so that costs can be appropriately controlled.

When we consider the benefits of mental health treatments in keeping working Americans working and productive, of keeping families viable, of dealing with problems that can otherwise have devastating effects for society—to me, the question is not whether we can afford this benefit, but rather how can we not afford it.

I look forward to action in this Committee this year to deliver the promise of parity in mental health coverage. Thank you.

Mr. BILIRAKIS. Without objection, of course, all of the members' statements will be made a part of the record. That has already been done.

And I would like to say that Mrs. Roukema was here from the beginning, and I trust will return. And if she does return, before we get started again, I will give her an opportunity to make a quick opening statement.

But in any case, we do have a vote, and so, unfortunately, we will have to recess. We will be back right after we cast that vote.

Thank you.

[Brief recess.]

Mr. BILIRAKIS. The Chair recognizes the gentlelady from New Mexico, Mrs. Wilson, who is here with her beautiful red-headed daughter, for an opening statement.

Mrs. WILSON. Thank you, Mr. Chairman. I wanted to thank you for holding this hearing, and thank you for bringing attention to this issue.

Before being elected to Congress, I was the cabinet secretary for Children, Youth, and Families in the State of New Mexico. And we had custody of the abused and neglected children as well as the delinquent children, and operated the children's mental health system in New Mexico.

And we have come a long way in the last 20 years in the treatment of mental illness I think in two ways. The first is the development of medicines and treatment that can provide real relief and allow both children and adults to go on with their lives through medical treatment. And the second is the reduction of the stigma associated with mental illness.

Mental illness is just as serious as diabetes and deserves the same kind of treatment and management in the relief that insulin provides. And we need to take mental illness seriously, because unlike what some—you know, there is always that tendency to say, you know, "Well, you just need to pull yourself out of it." Well, you can't pull yourself out of it any more than you can pull yourself out of a heart attack. We need to treat mental illness and diseases of the brain just like we treat diseases of other vital organs.

I was with President Bush when he announced his support for a health insurance system that treats serious mental illness just like any other diseases. I know that his commitment is a sign to—his commitment to sign a mental health parity bill into law was very sincere, and I look forward to working with the chairman and my colleagues to produce a bill that the President will sign, and that will give hope to families and patients who need access to care.

And I ask that my entire statement be submitted to the record. And, Mr. Chairman, thank you again.

Mr. BILIRAKIS. The Chair thanks the gentlelady.

[Additional statements submitted for the record follow:]

PREPARED STATEMENT OF HON. CHIP PICKERING, A REPRESENTATIVE IN CONGRESS
FROM THE STATE OF MISSISSIPPI

Mr. Chairman, thank you for holding this hearing this morning. Mental illness is a serious issue and I look forward to the testimony from our witnesses this morning. According to the Surgeon General 1 out of 5 people suffer from mental conditions in any given year. While the range and type of mental illness varies greatly, in recent years we have made progress in the diagnosis and treatment of mental illnesses.

I am sure that we all have somehow been touched by mental illness. Whether it is a family member or a friend, we recognize the importance of receiving the quality service that is needed to treat someone who suffers from a mental illness.

In 1996, Congress passed the "Mental Health Parity Act" which required group health plans to remove the cap that was in place on lifetime or annual dollar caps for mental health benefits and created exemption for certain small businesses. Also several states, including my own, have passed mental health legislation that requires coverage for beneficiaries suffering from certain mental illnesses.

We must continue work together as we address this important matter. The mental health of individuals is important and I am committed to reaching a solution to provide the best possible coverage for those suffering from mental illnesses.

PREPARED STATEMENT OF HON. W.J. "BILLY" TAUZIN, CHAIRMAN, COMMITTEE ON
ENERGY AND COMMERCE

Thank you Mr. Chairman, I commend you for holding this important hearing. Mental illness is a serious problem affecting tens of millions of Americans. According to the Surgeon General, approximately one in five Americans suffer adverse mental conditions during any given year. The impact from such illnesses on families can be devastating.

All of us in Congress want to ensure that patients have health insurance for serious and catastrophic mental illness. Certain types of mental illnesses are too important to ignore and deserve to be covered in the same way as many physical diseases or conditions. At the same time, however, we must always remember that our employer-based system is voluntary. Simply increasing mandates may prompt employers to stop offering benefits or coverage.

In an analysis of recent mental health parity legislation, CBO indicated that affected plans would experience an increase of between 30 and 70 percent of their mental health costs. Those are serious numbers for affected plans that could result in reduced access to care. According to CBO, those numbers may go up further if the provisions of the Patients Bill or Rights are enacted.

Last year, employers experienced an estimated 10-12% premium increase. Some estimates for premium increases this year are as high as 16%. As we look at legislation related to coverage of mental health services, we must be very sensitive to the issue of increased costs. During this time of economic uncertainty, we should be doing everything possible to insulate employers and employees from spiraling cost hikes, not the other way around.

Within this debate over mental health coverage, I am specifically concerned about requiring the expansion of health insurance to cover all conditions in the American Psychiatric Association's DSM IV manual. Some of these conditions include: unhappiness in the job, a chaotic home life, difficult personal relationships, spirituality disorder, conduct disorders, and jet lag. Some of these may be important issues. Some of them may warrant emotional, pastoral, family or other counseling, but the question arises: should we mandate their coverage under group health plans? We do not have such federal mandates for non-mental health benefits. Additionally, most states do not come close to mandating anything as sweeping as complete coverage under DSM IV with its far-reaching categories.

Many states that regulate mental health benefits use definitions that involve a substantially smaller number of disorders than listed in DSM IV. Most states use the subcategories of disorders that are biologically-based for purposes of interpreting their mental health parity laws. For the record, let me say that I believe that it will be difficult to implement a sweeping parity concept. Today, health plans simply do not treat all categories of non-mental health benefits equally. For example, outpatient physical therapy, emergency care, specialty care, speech therapy, occupational therapy, chiropractic care, and preventive care often have different limitations than other categories of medical items or services. Differences in categories are often necessary and appropriate. There may well be specific categories, both among mental and other types of services, that need to be treated differently for certain purposes. That shouldn't be precluded in law.

I also do not believe it is proper to say that a state has a discriminatory law when such law treats spelling disorder, mathematics disorder, caffeine intoxication, conduct disorder, sibling rivalry disorder, or relational problems as qualitatively different from schizophrenia or bipolar disorders for insurance purposes. All disorders—while important to the patient—are not equal in their severity.

As we study this important issue and consider legislation in this area, we must make sure that we are only talking about covering well-established diagnosis and treatments and not simply syndromes that are in a research phase. Any new law should have specific scientific standards of proof that demonstrate efficacy.

Mr. Chairman, I look forward to listening to today's witnesses. Given the expiration of the existing federal mental health parity laws at the end of the year, this hearing is particularly timely. This Congress, and this Committee, must decide how to reauthorize this law and determine what refinements are appropriate. This is quite a challenging task, but that's why I'm quite pleased we are having a hearing to explore these complex issues.

Thank you again for focusing on this issue, Mr. Chairman.

PREPARED STATEMENT OF HON. ALBERT R. WYNN, A REPRESENTATIVE IN CONGRESS
FROM THE STATE OF MARYLAND

Mr. Chairman, thank you for holding this important hearing to address the "Insurance Coverage of Mental Health Benefits." Mental health illnesses affect one in five Americans each year. Clearly, mental health coverage is an important issue and I look forward to hearing from today's witnesses.

Over the last two decades, a revolution in science and service delivery has broadened our understanding of mental health and illness that has improved the way in which mental health care is provided. Research about the complex workings of the brain has provided us with the knowledge needed to deliver effective treatment and better services for most mental disorders.

This notion is supported by a Surgeon General's Report on Mental Health from 1999. The report concluded that the efficacy of mental health treatments is well documented, and a range of effective treatments exist for most mental disorders.

Mental health, however, does not only directly affect many Americans, but impacts our economy. It is estimated that untreated mental illness costs the nation \$79 billion in lost productivity.

H.R. 4066, of which I am a cosponsor with 238 of my House Colleagues, is the underlying bill at issue in this hearing. The measure would require insurers that offer mental health benefits to treat that coverage the same as they treat medical or surgical benefits. This legislation, among other things, would help individuals suffering from depression, bi-polar disorder and post-traumatic stress disorder. The measure also includes a small business exemption for companies with 50 or fewer employees.

Unfortunately, the bill does not require plans to provide coverage for benefits relating to alcohol and substance abuse. Currently, the number HMOs that cover alcohol and substance are limited. In the year 2000, according to the Department of Health and Human Services, 14 million Americans used illegal drugs and nearly 60 million Americans are binge or heavy alcohol drinkers. Half of state and a third of Federal prisoners reported committing their offense under the influence of alcohol or drugs. Alcohol and substance abuse is clearly an illness for which we must provide adequate treatment. It will not only improve the lives of those who suffer from alcohol and substance abuse, but could possibly reduce crime levels, improving neighborhoods.

While H.R. 4066 has significant flaws because it omits alcohol and substance abuse coverage, the measure on balance is helpful. H.R. 4066 would provide much needed relief for many patients who are forced to pay more for mental health care than other health care costs.

Ms. Barna-DeWald and her husband are upper middle class professionals living in Fairfax, VA. Her ten-year old son, Adam, has suffered from bi-polar disorder since the age of three. Unfortunately, treatment restraints placed on Adam by insurance companies and HMOs deny him access to experts in the field and limited access to therapy, diagnostic screenings and appropriate hospitalization. If her child suffered from a broken leg, her insurance would have covered significant costs for x-rays, treatment, and physical therapy. Instead, Adam's medical care is limited because of the stigma associated with an illness of the brain. The unfortunate reality is that a lack of treatment of brain disorders often leads to the death by suicide of a bi-polar individual. This story is quite sad. However, consider this scenario with a low-income, single mother.

Some health insurers are opposed to mental health parity laws like H.R. 4066 because of concerns that they will drive up costs and insurance premiums. However, Magellan Health Services, the nation's largest Managed Behavioral Health Care Organization covering nearly 70 million individuals, reported that it had yet to see a premium cost of more than one percent as a result of implementing state mental health parity requirements.

Twenty percent of Americans are affected by mental illness, which unfortunately costs our economy nearly \$80 billion in lost productivity. Scientific research indicates, that when treated properly, most mental illnesses are curable at little additional cost to health insurers. Therefore, the health benefits provided by health insurers for physical illness should equal that of mental illness. It's a matter of fairness and common sense.

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

Chairman Bilirakis, thank you for convening this hearing on insurance coverage of mental health benefits. I am pleased to see that the Subcommittee is taking action on such an important issue within our jurisdiction.

During my years of advocating for America's patients, one of my objectives has been to ensure that patients get the health insurance coverage they have paid for. Many health plans serve their enrollees well and provide access to appropriate doctors and hospitals when these services are medically necessary. Unfortunately, we are all familiar with stories of those with health insurance who did not receive the care they needed.

This lack of access to care is happening to health plan enrollees with mental illness. Mental illness is not rare; one in five adults suffers from a mental disorder in any given year. And yet over two-thirds of them never receive any treatment.

Why? Partly because health plans provide unequal coverage for mental health care. Almost 90 percent of health plans place additional limits on mental health benefits—often in the form of fewer covered hospital days or higher cost-sharing for outpatient services—that do not exist for other types of medical care.

The bill that my colleagues, Representatives Roukema and Kennedy have introduced, H.R. 4066, would level the playing field for patients suffering from mental illness. This bill has the support of 239 members of the House and a majority of members of this Subcommittee. It has been scored by the Congressional Budget Office, and the cost is minimal.

Because this bill has some cost associated with it, certain parties oppose its passage. They argue it is unfair to saddle employers and employees with another cost increase on top of rising health insurance premiums. They ask, why should everyone else be expected to shoulder the cost burden of treating plan enrollees with mental illness?

The answer is simple. Unequal insurance coverage of mental health benefits discriminates against people who suffer from mental illness. I am not aware of any health plans balking at the portion of premium increases associated with heart disease, or arguing that it is unfair to require all plan enrollees to share the costs of treating people who happen to get cancer.

Mental illness strikes people of all ages, in all economic classes, and in all parts of the country. Members of Congress know that the mental health benefits they or their families may need some day will be there; the plans in the Federal Employees Health Benefits Program are required to provide equal coverage for mental health services as for other medical services. We have no excuse for not extending the same assurance and protection to all other employees and their families with health insurance coverage.

We will go right into the panel at this point. Dr. Charles M. Cutler, M.D., is Chief Medical Officer for the American Association of Health Plans; Dr. Darrel Regier is the Director of Office of Research of the American Psychiatric Association; Dr. Neil Trautwein is Director of Employment Policy for the National Association of Manufacturers; Mr. James T. Hackett, who was introduced by Mr. Green, he is Chairman and President and CEO of Ocean Energy in Houston, Texas; and Ms. Kay Nystul is Psychiatric Registered Nurse, Manager, Clinical Management Coordinator, Wausau Benefits, Wausau, Wisconsin.

Your opening statements are a part of the record. I would hope that you would complement them, or supplement them if you will, orally. And we will proceed with Dr. Cutler at this point.

STATEMENTS OF CHARLES M. CUTLER, CHIEF MEDICAL OFFICER, AMERICAN ASSOCIATION OF HEALTH PLANS; DARREL A. REGIER, DIRECTOR, OFFICE OF RESEARCH, AMERICAN PSYCHIATRIC ASSOCIATION; E. NEIL TRAUTWEIN, DIRECTOR OF EMPLOYMENT POLICY, NATIONAL ASSOCIATION OF MANUFACTURERS; JAMES T. HACKETT, CHAIRMAN, PRESIDENT, AND CHIEF EXECUTIVE OFFICER, OCEAN ENERGY, INC.; AND KAY NYSTUL, PSYCHIATRIC REGISTERED NURSE, CERTIFIED CASE MANAGER, CLINICAL MANAGEMENT COORDINATOR, WAUSAU BENEFITS, INC.

Mr. CUTLER. Thank you, Mr. Chairman. Mr. Chairman and members of the committee, my name is Dr. Charles Cutler, and I am the Chief Medical Officer of the American Association of Health Plans, AAHP.

AAHP is the principal national organization representing HMOs, PPOs, and other network-based health plans. Our member plans provide coverage for approximately 170 million members nationwide, including enrollees in the commercial market as well as participating in Medicare, Medicaid, State and Federal employee plans, and Tri-care.

We appreciate the opportunity to discuss health plan coverage and mental health benefits. In this environment of rising costs, employers are facing some very difficult decisions about coverage and affordability. And it is important to avoid enacting legislation that may inadvertently reduce access to health benefits.

According to the AAHP annual survey, 96 percent of health plans cover mental health and substance abuse services, including drugs to treat mental illness. In fact, many health plans reported that the drugs used to treat mental illness ranked among the top three most frequently utilized classes of drugs.

What has been a significant factor in enabling health plans to expand access to mental health care is care management. Tools such as early identification, use of treatment plans and care managers, group therapy, physician education and feedback, and quality measurement, have increased access and improved quality.

In light of the progress we have made and the current environment of rising health care costs, we have several concerns with H.R. 4066, the Mental Health Equitable Treatment Act of 2002. First, Members of Congress should be troubled by the prospect of codifying a manual developed by a non-governmental body, and it was never intended to be used as a standard for insurance coverage.

The DSM was designed to be used for clinical, research, administrative, and educational purposes. By requiring parity for every condition in the DSM, except substance abuse, H.R. 4066 creates a tremendous conflict of interest to the group of professionals responsible for developing this directory of conditions.

Second, by codifying the DSM, H.R. 4066 would require parity for a broad list of disorders, including jet lag, academic, occupational, and religious problems, where there is little evidence that treatment actually improves clinical outcomes. This is in direct conflict with the Institute of Medicine's recommendations to move toward a more evidence-based system of health care delivery.

Additionally, requiring parity of this broad list of disorders has the potential to divert resources away from conditions where treatment has proven effective and crowd out these conditions in favor of other more peripheral conditions.

Third, we are concerned that H.R. 4066 would impede the very care management tools that have enabled plans and employers to expand mental health benefits by making them more affordable. As evidenced by our industry survey results, more patients with previously undiagnosed mental illness are being identified. Patients with mental illness are benefiting from disease management, care managers, and the use of evidence-based guidelines and quality measurement.

Because there are fewer well-defined protocols in mental health, health plans need the flexibility to manage mental health benefits differently in order to ensure that the patient is receiving the most appropriate care possible, yet it is not clear that this would be permitted under H.R. 4066.

Fourth, H.R. 4066 takes a step back from the goal of uniformity by adding Federal requirements on top of an already complex and confusing patchwork of State laws. In doing so, H.R. 4066 would increase the cost of compliance and result in more confusion for consumers, employers, and plans over which law applies.

This is a significant issue for the employee benefit community and one I am sure that Mr. Trautwein can address further. But it is an issue that Congress needs to confront on terms broader than just mental health parity legislation in light of current health care cost trends.

In conclusion, AAHP and our member plans are committed to continuing to expand Americans' access to effective mental health benefits. However, we are concerned that rather than benefit consumers, the restrictive requirements could have the unintended effect of narrowing or eliminating benefits altogether at a time when we are debating how to expand access to currently uninsured individuals.

Thank you, and I look forward to answering any questions.
[The prepared statement of Charles M. Cutler follows:]

PREPARED STATEMENT OF CHARLES M. CUTLER, CHIEF MEDICAL OFFICER, THE
AMERICAN ASSOCIATION OF HEALTH PLANS

INTRODUCTION

Mr. Chairman and members of the Committee, my name is Charles Cutler, M.D., and I am the Chief Medical Officer for the American Association of Health Plans (AAHP). AAHP is the principal national organization representing HMOs, PPOs, and other network-based health plans. Our member organizations arrange for health care services for approximately 170 million members nationwide.

AAHP and its member plans strongly believe in the value of quality mental health services. In fact, health plan coverage and management of these services has resulted in millions of Americans having access to mental health care. Moreover, medical management techniques have been essential to efforts to expand the scope of covered mental health services, including increased access to prescription drugs that effectively treat mental illnesses.

We appreciate the opportunity to testify today on the important issue of insurance coverage of mental health care services. Our testimony will focus on the following three areas:

- (1) The extent to which health plans already cover mental health services;
- (2) Why new legislative requirements must be carefully weighed in light of rising health care costs; and

- (3) Why pending legislation would reduce the quality and increase the cost of mental health care services.

I. HEALTH PLAN COVERAGE OF MENTAL HEALTH SERVICES

By keeping coverage affordable, health plans have enabled millions of Americans to afford health insurance who otherwise would have been unable to afford coverage. In fact, a recent study PricewaterhouseCoopers (PwC) conducted for AAHP illustrated that, without managed care, the cost of private health insurance would be expected to increase an additional \$182 billion over the next five years, or about \$1,600 per policyholder. In addition to expanding access to coverage, health plans have made a wider range of benefits available to more Americans.

Health plans routinely cover mental health services. In fact, in AAHP's 2002 Industry Survey, which surveyed plans representing nearly 40 million enrollees, 96 percent of plans reported covering mental health/substance abuse services. Health plans also routinely cover pharmaceuticals used to treat those with mental illnesses. Indeed, many health plans report that drugs used to treat mental illnesses rank among the top three most frequently utilized classes of drugs, and nearly half of plans report spending more money on drugs to treat mental illness than on any other class of drugs.

Most impressive is the innovation health plans have demonstrated in administering mental health benefits to consumers. For example, the majority of health plans have established disease management programs for individuals with depression. These disease management programs include regular encouragement of providers to screen patients for depression and dissemination to providers of clinical guidelines on the treatment of depression. They may also include such beneficial practices as the use of care managers, group therapy, physician education and feedback, and quality measurement. As a result, a substantial percentage of plans have reported demonstrable improvement in closing the gap between what the scientific evidence tells us are beneficial practices and what actual practice has been with respect to the treatment of depression.

These effective strategies are starting to cross over into the management of other mental health conditions, with a significant number of plans implementing or planning to implement disease management programs for bipolar conditions, schizophrenia, anxiety disorders, substance abuse, and Alzheimer's disease. For example:

- Medica Health Plan worked with its partner, United Behavioral Health, to establish a demonstration project that uses community-based caseworkers to facilitate access for Medicaid beneficiaries to clinical mental health and substance abuse benefits and improve compliance with treatment recommendations. Case managers work with employment services to coordinate behavioral and vocational plans. Case managers also help participants address barriers to treatment and employment, such as housing, child care, transportation, and legal problems. To date, more than 80 percent of program participants have completed assessments and are following treatment recommendations.
- HIP Health Plan of New York ensures that the appropriate follow-up is provided to individuals who have been hospitalized for mental health conditions by offering three levels of case management programs. First, case managers ensure that members are scheduled for follow-up visits within two or three days following discharge. Second, any individuals who fail to receive their follow-up visit are then either contacted by phone by trained mental health professionals or seen by visiting nurses in their homes. Third, those with high levels of impairment are offered the plan's intensive case management (ICM). By promoting more care in an outpatient setting, HIP has seen an 88 percent decrease in the number of readmissions and a 70 percent decrease in the number of hospital days.
- PacifiCare Behavioral Health, a subsidiary of PacifiCare Health Systems, launched a program to promote the integration of behavioral health care services with other aspects of a member's health care and reduce fragmentation of care. This effort focuses on developing comprehensive treatment plans that address prescribing guidelines, treatment compliance, and clinical outcomes measurement. To date, the program has impacted approximately 13,000 patients and 7,000 providers, and has resulted in a 16 percent improvement in treatment compliance.

This range of approaches in providing access to mental health benefits is an important indicator of how the market has evolved to meet consumer and purchaser needs. It is critical that these and other management tools developed in the future be preserved and promoted, since they have largely been responsible for improving the quality and accessibility of mental health benefits for millions of Americans.

RISING HEALTH CARE COSTS

In April of this year, AAHP commissioned PricewaterhouseCoopers (PwC) to conduct a study of the factors fueling rising health care costs. The PwC study concluded that, of the 13.7 percent increase in health insurance premiums experienced by large employers between 2001 and 2002, government mandates, increased litigation, and fraud and abuse accounted for over a quarter of new spending.

Given the significant role government mandates play in contributing to rising health care costs, more and more states are considering ways to evaluate the merits and tradeoffs of proposed mandates *before* they are enacted. More than half a dozen states have instituted processes to analyze the prospective costs and benefits of proposed mandates, including the impact on the number of uninsured Americans.¹ We believe Congress should have a similar process in place. An evaluation of the aggregate impact of mandates at the federal and state level, including those proposed in H.R. 4066, is warranted. If Members of Congress wish to require employers and health plans to offer a specific benefits package to their employees and members, or to limit the utilization of techniques to promote affordability, there should be an explicit discussion about that objective and a recognition of the resulting tradeoffs that such mandates will force employers to make. The continuing effort to enact mandates one by one at both the federal and state levels prevents a thoughtful discussion of these tradeoffs.

With respect to mental health parity proposals, cost estimates vary. The Congressional Budget Office (CBO) has estimated that the provisions of H.R. 4066 would increase premiums by only 0.9 percent on average. We do not believe this estimate reflects the true costs of the bill, in part, because CBO relied on the experience in the Federal Employees' Health Benefits Program (FEHBP), which had less than one year of experience with complying with mental health parity requirements at the time of the CBO estimate.

Other sources have estimated more realistic cost increases. The California Public Employees' Retirement System (CalPERS) has reported that mental health parity legislation would cause premiums for its two PPO options to increase by 3.3 and 2.7 percent, respectively, in 2003. Similarly, a 1998 study commissioned by the Substance Abuse and Mental Health Services Administration (SAMHSA) estimated that a mental health parity law would increase premiums by an average of 3.4 percent. Specifically, the study found that a federal parity mandate would cause expenditures on mental health services to increase by 111 percent for enrollees in PPO plans, by 63 percent for enrollees in point-of-service plans, and by 11 percent for enrollees in HMO plans.

These projected cost estimates cannot be taken lightly when it has been estimated that for every 1 percent increase in premiums, an additional 300,000 Americans lose their health insurance. In fact, earlier this year, Governor King of Maine vetoed an expanded mental health coverage bill because of cost concerns. As he said in his veto message, "As we look for ways to reduce the costs of health care, we must not exacerbate the problem by adding new mandates. When you are in a hole, the first rule is not to dig any deeper."

III. CONCERNS WITH PENDING LEGISLATION

In light of the progress we have made in expanding access to mental health services, and the current environment of rising health care costs, it is important to seriously consider the substantive concerns we have with H.R. 4066, the "Mental Health Equitable Treatment Act of 2002."

H.R. 4066 Would Require Parity for Every Condition in the DSM (Except Substance Abuse)—Even Those Conditions Not Based on Medical Evidence. Current federal parity law maintains a health plan's ability to construct mental health benefits that specifically address the needs of its enrolled population. However, H.R. 4066 would require parity for all of the conditions listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), which includes a broad list of disorders, some of which are not based on scientific evidence. For example, jet lag (circadian rhythm sleep disorder; jet lag type, code 307.45), caffeine intoxication (code 305.90), and academic, occupational, and religious problems (codes V.62.3, V.62.2, and V.62.89, respectively) are all conditions listed in the current version of the DSM that plans would be required to cover on par with medical and surgical benefits.

Aside from the obvious conflicts this raises with the national goal recently articulated by the Institute of Medicine to move towards a more evidence-based

¹ States that have enacted mandate review commissions or panels include the following: AR, FL, MD, ME, PA, SC, VA, and WA.

system of health care delivery, the bill also raises the appropriateness of essentially codifying a diagnostic manual developed by a non-governmental body that was designed to be used for clinical, research, administrative and educational purposes and never intended to be the standard for insurance coverage.

Moreover, while proponents of this legislation have maintained that this bill does not require plans and employers to cover any specific mental health services and would, in fact, permit exclusions of mental health services from coverage, the reality is quite different. The bill clearly states that any exclusions of coverage of mental health services may not result in a “disparity” between coverage of mental health and medical surgical benefits. “Disparity” is not defined, leaving its meaning, and its implications, ambiguous at best. At worst, this ambiguity will generate increased litigation and could undermine any flexibility for plans and employers to design mental health benefits that best meet the needs of their enrollees and employees.

It is also important to point out that a number of states require plans to cover certain mental health conditions, but permit cost-sharing and other limitations. In these instances, the plan would be mandated to cover mental health benefits under state law, but any allowance to use different financial and visit limitations would be overruled by the federal law to cover those mandated benefits on par with medical/surgical benefits under federal law.

H.R. 4066 Would Impede the Use of Medical Management Techniques for Mental Health Services. Health plan medical management techniques have enabled more Americans to receive affordable, quality mental health care. As evidenced by our industry survey results, patients with mental illnesses have benefited from disease management, care managers, preventive screening, treatment plans, evidence-based guidelines, quality measurement, and self-referral. H.R. 4066 would impede the very medical management tools that have enabled employers to expand mental health benefits by making them affordable. If Congress were to preclude the utilization of these tools, it will have a direct impact on employees and the choices that employers can offer.

Advocates point to language in the bill that purports to permit medical management of mental health benefits. But a closer reading of the language shows that: (1) the requirement that “treatment limitations” (very broadly defined) be comparable arguably extends the parity requirement to medical management; and (2) even if the definition of “treatment limitation” was found not to include medical management techniques, the rule of construction allowing medical management still requires that medical management be “comparable” to that used for medical/surgical benefits. While this sounds harmless enough, the fact of the matter is that medical management techniques such as care managers and treatment plans are sometimes used more often with mental health care than with other non-mental health disease categories. This is because there are oftentimes less well-defined protocols on the mental health side.

Medical and surgical care for many diseases have more clear care plans, milestones and outcome measures. For example, most hospitals have specific care plans for bypass surgery based on the ideal clinical protocol, measures of the patient’s heart and lung functions, and the specific care needed to reach the best outcome. However, this is not the case for mental health conditions. The timeline, steps in treatment, milestones and outcomes are much less defined than on the medical/surgical side. When an individual has heart surgery, we know when the heart is functioning well and when the wounds have healed. Progress in treating mental health conditions is evaluated using more subjective physician and patient self-assessment or a patient’s ability to perform activities of daily living. Therefore, health plans need the flexibility to manage mental health benefits differently in order to ensure that the patient is receiving the most appropriate care possible. More frequent use of treatment plans, care managers, and other management techniques, are often necessary to ensure that patients are getting the most appropriate care for the condition, yet it’s not clear that this would continue to be permitted under H.R. 4066.

H.R. 4066 Would Exacerbate the Problem of Inconsistent and Often Conflicting Federal and State Requirements Applying Simultaneously. By only narrowly preempting state law, H.R. 4066 would add federal requirements on top of an already complex and confusing patchwork of state laws. In doing so, H.R. 4066 would increase the cost of complying with this patchwork of state and federal laws, and result in more confusion for consumers, employers, and plans over which law applies.

Also, as mentioned earlier, a number of states have made the decision to require coverage of certain mental health conditions but permit limitations in days, visits, and cost-sharing. The regulatory reality of this legislation before

Congress and its interaction with state law is that this bill does not respect those state decisions. Plans operating in those states would be required to cover the benefits mandated by state law, but then would also be required to cover those mandated benefits on par with medical/surgical benefits under federal law.

CONCLUSION

AAHP and our member health plans are committed to continuing to work to expand Americans' access to effective mental health benefits. However, we respectfully oppose doing so through mandates or restrictions on proven strategies that have largely been responsible for increasing access to health benefits. Rather than benefit consumers, restrictive requirements could have the unintended effect of narrowing or eliminating benefits altogether at a time when we are debating how to expand access to currently uninsured individuals.

Thank you and I look forward to answering any questions.

Mr. BILIRAKIS. Thank you very much, Dr. Cutler.
Dr. Regier, please.

STATEMENT OF DARREL A. REGIER

Mr. REGIER. Chairman Bilirakis, Representative Brown, members of the committee, and especially Mrs. Roukema, we would like to thank you for your sponsorship of the bill, and we would also like to thank you for holding this hearing.

I am Darrel Regier. I am the Director of Research of the American Psychiatric Association and the Executive Director of the American Psychiatric Institute for Research and Education.

Prior to coming to the American Psychiatric Association, I served as a senior research director and associate director of the National Institute of Mental Health, and for 25 years as an assistant surgeon general in the United States Public Health Service, who edited several sections of the Surgeon General's 1999 report.

Our 38,000 members and their patients wish to express their appreciation to the subcommittee for this support. I will briefly summarize the main points of my written statement, and would then be pleased to answer any questions that you may have.

I trust there is no longer any debate about the scope and impact of mental disorders in America. As the 1999 Surgeon General's report put it, few families in the United States are untouched by mental illness.

Mental disorders know no racial, cultural, ethnic, religious, geographic, or economic boundaries. The World Bank and the World Health Organization found that mental illness was the second leading cause of disability and premature death worldwide, following only heart disease and impact. Because of a variety of factors, including chronic underfunding of the public system and loss of State hospital bed space, our jails and prisons have become the new institutions for many with severe mental disorders, as Mr. Strickland mentioned.

Meanwhile, private insurance is reducing coverage and shifting costs to the public sector. In Minnesota, for example, Blue Cross/Blue Shield pressured parents of severely ill children to place them in foster care, so Medicaid would pick up treatment costs and refused to pay for treatment of near fatal anorexia because life-threatening eating disorders were not among the serious mental disorders covered. Fortunately, the State forced Blue Cross/Blue Shield to alter its practices.

Opposition to parity is economically short-sighted. The Surgeon General found that the lack of parity coverage of treatment for mental illness costs American businesses over \$70 billion every year in lost productivity, increased use of sick and disability leave, and higher use of non-psychiatric mental services.

For example, one study found that depressed workers use more work disability days than others with an average salary impact of between \$200 and \$400 per worker. Another study found that when a national company reduced its mental health benefits by 40 percent over a 3-year period, the company paid out 40 percent more in primary health expenses, coupled with a 20 percent increase in absenteeism and a 5 percent decline in productivity.

Now, the good news is that we understand the science of mental illness better today than at any time in our history. Simply put, our treatments do work. Yet Americans seeking effective treatment for mental illness can't get the care they require because of open and now legal insurance discrimination.

We believe that short-sighted opposition to parity is led by an insurance industry that has clear incentives to offer substandard coverage and avoid risk for selected populations such as those with mental illness. Competition by insurance plans to avoid enrolling individuals who are at risk for mental illness is wasteful and inefficient as mentioned in a New England Journal of Medicine article by economist Richard Frank, and serves only to maximize insurance profits at the expense of business and the economy.

Market segmentation and risk avoidance are precisely the reason why Congress passed the Health Insurance Portability and Accountability Act, the HIPA law, to prevent insurance companies from refusing coverage to individuals with preexisting conditions. The same principle is at work with mental health parity.

I understand that Congress is very wary of overregulating the economy, but what we have right now is a marketplace that does not work. Insurance works best by spreading the risk equally over the largest possible population. Lack of parity is a distortion that prevents the market from working properly.

Because of this anti-competitive distortion, insurers are given a clear incentive to race to the bottom to avoid risk and reduce their own costs and liability. This segments the market from mental health insurance and shifts costs from insurers to employers, who are unable to take advantage of competition. It is the antithesis of free market economics.

Worst, lack of parity penalizes responsible employers, such as those we will hear later, who recognize the value of non-discriminatory mental health coverage. In effect, insurers are subverting responsible employers by segmenting risk and cost and shifting the obligation of mental health care onto an already overburdened public sector.

Now, the parity costs are low. Despite what you will hear today, every significant health economist and actuary who has published credible evidence over the past 8 years, met at a major Robert Wood Johnson conference that is summarized in this report in May of 2001.

They completely back the Congressional Budget Office estimates of nine-tenths of 1 percent at max, and, in fact, that is a high end

required by the Unfunded Mandates Act in which if you really look at what the impact will be it is four-tenths of 1 percent after management response, which could not be considered under the Unfunded Mandates Act.

Now, experience in States and in Federal Employees Health Benefits Program amply sustains the finding that a Federal parity law such as envisioned in H.R. 4066 and S. 543 will result in negligible cost increases to employers. In fact, our largest concern is not cost overruns; it is assuring that the management will be, in fact, appropriate and will provide the appropriate access that we are seeking to obtain with this bill.

Now, DSM—

Mr. BILIRAKIS. Please summarize, Doctor, if you would.

Mr. REGIER. Okay. While lacking any other effective arguments, parity opponents have lately started attacking the Diagnostic and Statistical Manual as too broad and imprecise to serve as the foundation for covered diagnoses.

I think this is a smokescreen. First of all, the ICD-10 has 12,000—or IC-9 CM has 12,000 diagnoses for all disorders. DSM has some 200 disorders for mental disorders. Having a code on a list of disorders does not guarantee payment. What is required is to have a clinical procedure or a treatment code, a CPT code, and a treatment plan in order to obtain payment.

So the fact that there are DSM outlier codes that are not as serious as schizophrenia is no different than the fact that you have premature baldness, freckles, and a range of—and diaper rash in the ICD-10. And those are covered at parity with breast cancer under current law. What we are asking is for, in fact, equal treatment for the whole range of disorders, so there isn't this artificial segmentation of disorders in the mental health area.

So, Mr. Chairman, we would like to—would be happy to discuss some of the DSM issues that you have raised in the question period, and we welcome further questions on either the cost or the DSM issues.

[The prepared statement of Darrel A. Regier follows:]

PREPARED STATEMENT OF DARREL A. REGIER, DIRECTOR, OFFICE OF RESEARCH,
AMERICAN PSYCHIATRIC ASSOCIATION

Chairman Bilirakis, Representative Brown, and members of the Subcommittee, I am Darrel A. Regier, M.D., M.P.H. I am currently Director of Research for the American Psychiatric Association and Executive Director of the American Psychiatric Institute for Research and Education (APIRE). Prior to joining the American Psychiatric Association, I served as a Senior Research Director for the National Institute of Mental Health, and as an Assistant Surgeon General in the United States Public Health Service.

My testimony today is presented on behalf of the American Psychiatric Association (APA), 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). Our psychiatric physician members also provide service and leadership as academic faculty and practitioners in academic medical centers of excellence, and are at the forefront of research into the sources of and new treatments for persons with mental illness, including substance use disorders.

First and foremost, APA commends you for holding this hearing on the vital topic of ending insurance discrimination against patients seeking medically necessary

treatment for mental illness. Our members, and hundreds of thousands of our patients, also wish to express their appreciation to the many members of your Subcommittee on both sides of the aisle who have cosponsored H.R. 4066, the Mental Health Equitable Treatment Act of 2002, or who have expressed support for parity in other ways.

As you know, 240 Members of the House have cosponsored H.R. 4066, President Bush has called on Congress to send parity legislation to him for signing this year, and 66 Senators have sponsored S. 543, the Senate companion bill to H.R. 4066. This broad support underscores our message that there is a moral imperative for ending discrimination against patients seeking treatment for mental illness, and particularly that parity is a health policy issue, not a partisan political issue. We are deeply grateful for your support, and look forward to working with you, the Subcommittee, and Chairman Tauzin to make parity the law of the land.

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, Regier, 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 the article, "For adults older than 18 years, the revised estimate for any disorder including substance abuse was 18.5%." The full text of the article is attached to this statement.

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.

Major problems continue to exist in the public safety net and in the availability of effective out-patient treatments for acute and chronic mental disorders. Access to any specialty mental health services has increased from 0.8% of the population in 1950, to 3% in 1975, about 6% in 1983, and up to 7.0% in 1996. In addition, primary care settings have become an increasingly important part of the mental health service system providing such care to 6-7% of the population. Likewise, voluntary support group services have expanded over three-fold in the past 15 years (from 1% to 3% of the population).

A tragic consequence of our nation's previous attempts to reform the mental health system from the Community Mental Health Centers of the 1960s and 1970s to the current blend of managed Medicaid and State categorical programs, is that those with the most severe mental disorders have often seen their services diluted as expansion has occurred for those with less disabling conditions. As a result of deinstitutionalization of the State Mental Hospitals over the past 50 years, with beds decreasing from 550,000 in 1955 to about 54,000 in 1997, jails and prisons have become the new institutions for many with severe mental disorders, with many others left to fend for themselves as homeless street people. Congress—and particularly Representative Strickland and Senator DeWine among others—has sought to address the problem through promising mental health courts legislation that would help divert some segments out of the forensic system and into treatment. This is both humane and cost-effective, but it is only part of the solution to a complex problem.

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's report on mental illness 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.

In a similar vein, an MIT/Sloan School of Management report (1995) found that clinical depression costs American businesses nearly \$30 billion a year in lost productivity and worker absenteeism. An article in *Health Affairs* (1999) reported that depressed workers have between 1.5 and 3.2 more short-term work disability days

in a given 30-day period than other workers, with an average salary equivalent cost of disability for these workers of between \$182 and \$395 per depressed worker. 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.

Notably, 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, with a consequent offsetting *increase* of its primary health care expenses by 40%. The company's absenteeism rate increased by 20% and its worker productivity experienced a 5% decline. Presumed savings from reduced mental health benefits had significant adverse health and productivity consequences, hidden by a narrow focus on cost of the mental health benefit alone.

The literature is replete with examples of the clear benefits to employers of good coverage of treatment of mental illness. For example, *Health Economics* reports that treating workers with depression with prescription medications resulted in a decline in medical costs of nearly \$900 per employee per year, and that absenteeism dropped by 9 days. The Wall Street Journal (1999) reported that a four-year study of EAP mental health program effectiveness by McDonnell Douglas "yielded a four-to-one return on investment after considering medical claims, absenteeism, and turnover." A 1998 study by Johns Hopkins and UNUM Life Insurance found that employer plans with good access to outpatient mental health services have lower psychiatric disability claims costs than plans with more restrictive arrangements. Clearly, there is little economic sense for employers to selectively limit access to mental illness treatment.

3. THE KNOWLEDGE BASE IS GROWING

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. Breakthrough advances in psychopharmacology as well as rigorously tested psychosocial treatments are research peers to those in cancer and heart disease. Disorders of the central nervous system are on the cutting edge of science for genetics, neurophysiology, functional imaging, and the study of the interaction between environmental and genetic factors that pose risks or protections against the development of disorders and disease.

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 illness 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...*"

In the absence of parity-level insurance coverage for mental and addictive disorders, our patients in the private sector are falling farther behind current standards of access for medical and surgical services. Over the period of 1988 through 1997, we saw mental health costs *decrease* by over 50% while there were minimal changes in medical/surgical costs. In an uncertain economy, we are concerned that mental health services will fall even further behind, and patients requiring care will see disproportionate cuts in services.

While a parity law will not remove every barrier to mental health care, it will be a major step forward. We believe that the opposition to a national parity law is

led by an insurance industry that wants to avoid regulation and has clear incentives to offer poor coverage for select populations, such as those with mental illness. Congress addressed problems with pre-existing conditions exclusions through the Health Insurance Portability and Accountability Act. Now legislation is needed to prevent insurance companies from offering meager mental health benefits to avoid attracting beneficiaries in need of the services.

Writing in the *New England Journal of Medicine* (December, 2001), Frank, Goldman, and McGuire put the problem very eloquently: “Insurers have an incentive to enroll people who are relatively healthy and therefore represent a low financial risk. This incentive distorts competition among health plans because they compete for people they consider to represent a low risk. It has long been argued that plans with good mental health benefits would attract people with mental disorders that are costly to treat (an adverse selection of enrollees), and insurers tend to provide poor mental health benefits in order to avoid such enrollees. *Competition by plans to avoid enrolling people who represent high risks, although good for the individual health plans, is wasteful and inefficient.*”

This is a crucial concept. I am mindful of the healthy concern for overregulation of the marketplace by this Congress, and particularly by members of the majority in this house of Congress. But what we have now is a marketplace that does not work. Insurance works by spreading the risk equally over the largest possible population. The lack of parity represents a significant market distortion that prevents “the market” from working properly. Because of this anti-competitive distortion, insurers are given an incentive not to compete, but instead to dive to the bottom, attempting to avoid risk and reduce their own costs and liability. This segments the market and shifts costs from insurers to employers, who are unable to take advantage of market competition. It is the antithesis of free market economics. Worse, it penalizes responsible employers who recognize the value of non-discriminatory mental health coverage and prevents them from moving employees where the work is, as those employees in need of mental health care are stuck where the benefits are good. In effect, insurers are subverting responsible employers by segmenting risk and costs and shifting the obligation of mental health coverage onto an already overburdened public sector.

As Frank, et al, put it: “Parity can improve the efficiency of insurance markets by eliminating wasteful forms of competition that are the result of adverse selection . . . Parity for mental health benefits establishes the same floor for mental health coverage and for other types of medical care.”

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 H.R. 4066 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.

I’m confident that if insurance companies proposed that Congress should sanction the exclusion of coverage of cancer or heart disease, or that Congress should permit insurers to charge diabetics more than twice as much out-of-pocket for seeing an endocrinologist than for seeing an internist, or that breast cancer patients should only be allowed to see an oncologist for 5 visits, every member of this Subcommittee would be outraged and rightly so. Yet that is more or less where we are with coverage of treatment of mental illness. This archaic and discriminatory practice of the private insurance industry limits mental health coverage in ways that it does not limit other medical treatment. The MHETA 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. COST OF PARITY

A major concern of employers and insurance companies from the mid 1970’s to the mid 1990’s was that better mental health benefits would result in use of more mental health services than were needed or were cost effective—the so-called *moral hazard risk*. After reviewing all available research on this issue, the National Advisory Mental Health Council came to the following conclusions:

- A. The Current baseline treatment costs for mental disorders, as a percent of total health care premium costs, appear to be lower than they were a decade ago.
 - The mental health benefits under the Federal Employees Health Benefits Program (FEHB) dropped from 8% of premium to 2% between 1988 and 1997.
 - For mid- to large-size corporations the premium cost for the mental health benefits was halved, dropping from 6% of premium to 3% during the same period.
 - The average annual growth rate for all mental health care rose at a 1% lower rate for each year between 1986-1996—a cumulative 10% lower level.
- B. In the context of expanding mental health benefits under several State and Private Insurance parity initiatives, the expected large increase in costs did not occur.
 - In Texas and North Carolina, where parity insurance coverage for State employees was introduced in 1992 with managed care, the costs dropped 30% to 50% while the percent of the population accessing some care increased 1 to 2%.
 - In Maryland, where managed behavioral health care had already penetrated the private insurance market before the 1994 comprehensive State Parity law, premiums had already dropped by about 50%. Introduction of parity resulted in a slight increase of total premiums of less than 1%. Most of this increase came from HMO programs that previously had the most restrictive mental health benefits.
 - Multiple case studies of private insurance companies with partial or full parity-level benefits, referenced in the Senate parity reports, have demonstrated a long-term capability of controlling costs while often increasing the number with access to some care.

In addition to the findings of the NAMHC, others report similar experiences. For example, in response to Energy and Commerce Committee staff queries for recent real-world data, you may wish to review testimony before the House Education and Workforce Committee, in which the representative for Magellan—the largest managed behavioral healthcare organization in the country, covering nearly 70 million individuals—reported 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.”

The Subcommittee would also find it helpful to know that 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, noting that FEHBP’s implementation of parity—not only for mental health, but also for substance abuse services—resulted in an average premium increase of 1.64 percent for fee-for-service plans, 0.3 percent for HMOs, and an aggregate program increase of 1.3 percent for 2001.

With respect to the leading parity legislation in Congress, your own 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%. CBO, under considerable pressure, continues to reaffirm its estimate of 0.9 percent. This is literally pennies per employee.

7. 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.” As a clinician who submits insurance claims for review, I would like to challenge the business and insurance witnesses here today to offer any objective evidence that they are paying for these peripheral conditions to any statistically significant degree. Since diagnostic codes must be accompanied by credible procedure or treatment codes, along with evidence of clinically significant impairment, no insurance company would retain their managing or reviewing staff if more than a miniscule proportion of such codes were paid.

The carefully crafted language in both the House and Senate parity bills fully protects the ability of health plans to make such the “clinically significant distress or disability” determinations required of all DSM-IV disorders. Thus, “malingering” is no more likely to be covered in a post-parity world than it is today. Quite frankly, it is remarkable that an insurance industry that has historically sought to avoid responsibility for treating severe mental disorders is today expressing concern that only severely mentally ill patients should be covered by parity legislation. Most likely, the DSM issue is a canard that is intended to distract the Congress from the real issue: blatant discrimination against a single group of patients who for no fault of their own happen to need treatment for mental illness.

8. TREATMENT GUIDELINES FOCUS ON EFFECTIVE CARE

Still 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 production of evidence-based 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.

9. 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 serotonin 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, both separately and in combination with psychotherapy treatments, offer very substantial symptomatic reductions.

It's worth noting that as recently as the past few weeks, our press has been full of news stories about two studies that have revised conventional medical thinking. In one instance, standard use of hormone treatments in menopausal women was fundamentally challenged. In another, surgical intervention as a treatment for arthritis was found to be of questionable utility. These findings underscore an important fact of medicine: Thankfully our standard of treatment is not a static measure but is being constantly updated and refined as our knowledge base increases. This is as true, if not more so, for our understanding and treatment of mental illness. Yet we commend the expansion of the knowledge base for medical treatments on the one hand, while criticizing treatment of mental illness for not being “set in concrete” on the other. This dual standard has, I believe, its foundation in ongoing stigma about mental illness.

Let me put this another way: 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.

10. 35 STATES 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." 35 states 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.

This is a crucial point. State legislators and Governors are certainly at least as cost conscious as the Congress, if not more so. Yet 35 states have enacted some form of parity law, and not one has repealed it. That should tell you a great deal about real-world experience with parity. Unfortunately, state parity laws vary in the scope of coverage and do not, of course, extend to ERISA plans, which is why we are here today.

11. TIME TO END LEGAL INSURANCE DISCRIMINATION

Mr. Chairman, the struggle over parity is a struggle for basic human rights. It is the story of 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 illnesses 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. Thank you.

Mr. BILIRAKIS. Thank you. Thank you, Doctor, and there will be questions.

Mr. Trautwein, please, sir.

STATEMENT OF E. NEIL TRAUTWEIN

Mr. TRAUTWEIN. Thank you, Mr. Chairman, and Mr. Brown, and members of the committee. My name is Neil Trautwein, and I am Director of Employment Policy for the National Association of Manufacturers.

I appreciate this opportunity to appear before you this morning to discuss this important issue. Manufacturers like Mr. Hackett here are strong supporters of employer-based health care. Ninety-seven percent of NAM members provide coverage to their workers, and most of those people provide coverage to dependents.

These health plans cover a wide array of benefits of medical/surgical and mental health and employee assistance plans. Employers support mental health care benefits, because mental health conditions affect management and workers alike. It is the compassionate thing to do to provide coverage—mental health coverage.

However, in the current cost environment, the ability of employers to provide good quality benefits is being compromised by increasing costs. A majority of NAM members are experiencing cost increases above the stated national rate of inflation. Thirteen percent of our smallest members are experiencing cost increases above 26 percent. This is particularly a tough time for employers to provide health coverage.

The NAM is opposed to the legislation currently under consideration by this committee and the Congress, Mrs. Roukema's bill, and the bill—comparable bill in the Senate, the Domenici-Wellstone bill.

The Congressional Budget Office recently issued a clarification of their prior estimate on the Roukema and Domenici-Wellstone bills that really bears out, really more than bears out, our previous cost concerns. CBO's July 12, 2002, memo—and I would ask permission to insert a copy of that in the record—

Mr. BILIRAKIS. Without objection.

Mr. TRAUTWEIN. Thank you, sir. Indicates that once you remove non-affected populations—that is, populations that would not be subject to the mandates of size or prior coverage or the employer doesn't offer mental health coverage—the effects are quite substantial. For affected firms, this could mean cost increases between 30 to 70 percent. So it is something that does have our great attention and our great concern.

As has been noted, CBO had previously indicated that premium increases so different from the cost increases would average .9 percent. We think a big part of this problem is the expansive approach taken by these bills. And, in particular, we are troubled by the use of the DSM in this process.

The DSM is a professional classification of mental health conditions maintained on a proprietary basis by the American Psychological Association. No other area of medical practice has such a blanket array of coverage.

This legislation doesn't mandate any coverage of any particular condition in the DSM, but if you cover one you better cover all or be subject to the discrimination provisions. There is no apparent distinction between the most recognized, the so-called brain-based disorders, and such celebrated conditions as the jet lag condition we have discussed, malingerer, and my kids' personal favorite, which is oppositional defiant disorder.

The Roukema bill allows plans to maintain medical necessity and utilization techniques, but though the science is advancing and progress is being made to getting more objective standards, it is still a very subjective area. Where there is subjectivity—and if you talk to practitioners in the area, there is often disagreement about treatment where there is disagreement, and these days there is often litigation.

Increased litigation is a very substantial deterrent for firms of any size to offer coverage, but particularly for the small to mid-sized firms who aren't affected by the size limitation in this legislation.

Maintaining different categories of treatment are very much a part of plan design today. Many of the most comprehensive plans maintain these distinctions, and I would note that no similar expansion of coverage is planned for in the Medicare area.

Mr. Chairman, our clear preference is that no expansion be made beyond the 1996 law. But if expansion is contemplated, we would urge that the example of the States be looked at, where a majority of the States, 30 States, have taken the tack of identifying the most serious disorders, still allowing employers to provide more than is mandated but limiting the effect of the mandate.

Mr. Chairman, I thank you, and I look forward to any questions you may have.

[The prepared statement of E. Neil Trautwein follows:]

PREPARED STATEMENT OF E. NEIL TRAUTWEIN, DIRECTOR OF EMPLOYMENT POLICY,
NATIONAL ASSOCIATION OF MANUFACTURERS

Mr. Chairman, my name is E. Neil Trautwein and I am director of employment policy for the National Association of Manufacturers. I am pleased to appear before you today on behalf of our more than 14,000 members (including 10,000 small and mid-sized companies) and 350 member associations serving manufacturers, employers and employees in every industrial sector and all 50 states. We commend you for holding this hearing to focus attention on the issue of insurance coverage of mental health benefits.

Manufacturers are strong supporters of employer-sponsored health care. Ninety-seven percent of NAM members voluntarily offer coverage to their workers. The median contribution level among NAM members is 80 percent; 25 percent of NAM members continue to cover 100 percent of premiums.

Our health plans cover a wide variety of benefits, including mental health benefits and employee assistance plans. We understand that mental illness can affect workers and management alike. Mental health benefits, like medical and surgical benefits, are important to the productivity of our members.

Nevertheless, we are greatly concerned by the *mandated expansion* of these benefits, particularly in the current cost environment. We are opposed to the mental health parity legislation currently under consideration by this committee and the Congress: the Roukema (H.R. 4066) and the Domenici-Wellstone (S. 543) bills. In our view, this legislation is too expansive and explosive in its potential to add to the already rapidly rising cost of coverage. We urge Congress to look to less expansive and less burdensome means to improving insurance coverage for mental health benefits. We stand ready to assist these efforts.

HEALTH CARE INFLATION HAS RETURNED

Employers, workers and dependents are experiencing severe pressure from rising health coverage premiums. Fifty-seven percent of NAM members are experiencing cost increases at or above the 13% average rate of inflation. Thirteen percent of our smaller members have experienced rate increases of more than 26 percent.

Employers are increasingly less able and less willing to absorb health cost increases in the current economy. Workers are already feeling the pinch in terms of a greater share of premiums, higher copayments and deductibles and reduced benefits. To a large extent, it is workers and dependents that will bear the brunt of future cost increases from mandated benefits or other factors.

This cost pressure is unlikely to abate in the foreseeable future. Though pharmaceutical costs have received the lion's share of recent attention, it is but one factor among many today—and not even the leading factor at that. Other factors include: health care spending by our aging and rather sedentary population; increased use of health care services by workers unaware of their true cost; the movement away from the most tightly controlled managed care networks; and advances in medical practice and technology that leads to increased spending at the very earliest days and at the end of our lives. Given the difficulty of addressing any one of these many factors, we employers tend to be resistant to the addition of any type of mandated benefit.

CBO CLARIFIES TRUE COST OF PARITY MANDATE FOR AFFECTED FIRMS

We have long believed that the Congressional Budget Office's (CBO) estimate of an average 0.9 percent premium increase greatly understates the potential impact of mental health parity legislation. A July 12, 2002 memorandum from Jennifer Bowman, Jeanne De Sa and Stuart Hagen from the CBO that clarifies their previous estimate demonstrates that, if anything, our cost concerns were greatly understated.

The CBO memorandum describes their 0.9 percent estimate to be:

“a weighted average of the effects across both affected and unaffected plans. Because the bill would exempt firms with 50 or fewer employees (about 30 percent of private sector employees) from the federal requirements, because a number of states already have laws with similar requirements, and because some firms do not offer mental health benefits, a number of firms would face little or no additional costs from complying with the federal law. On the other hand, many firms that currently use benefit design elements that would be prohibited under the bill, such as having different day or visit limits, deductibles, coinsurance or copayments for mental health benefits than they have for medical or surgical benefits, would have experience increases in premium costs higher than 0.9 percent.”

The memorandum goes on to estimate that “affected plans would experience an increase between 30 and 70 percent in their mental health costs.” These cost increases will be reflected in higher claims costs which in turn will lead to higher premium costs—on top of the already rapidly rising cost of health coverage.

As I noted earlier, employers have a limited array of options with which to respond to rising premium costs. Given these latest, explosive estimates on the effect of the proposed new mental health parity mandate, many employers who can, likely will, consider dropping mental health coverage entirely. Though some employers may seek to establish or expand employee assistance programs to help compensate for the loss of mental health coverage, workers and dependents may find themselves largely without mental health benefits. This is a result that would serve no one well.

ROUKEMA BILL TOO EXPANSIVE

The Roukema bill changes the definition of “mental health benefits” from those specified under the plan to “all categories of mental health conditions listed in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV).” No other area of medical specialty has similar blanket coverage, though I strongly suspect that other specialties will quickly beat a path to Congress’ door for equivalent protection. Maintaining different categories of treatments (e.g., rehabilitative or chiropractic services) and different cost-sharing structures is integral to benefit plan design. Many of the most comprehensive plan designs maintain differences between categories of mental health conditions. Employer-sponsored health plans need the flexibility to experiment with differing coverage, or, indeed, with full parity as some plans have done. Mandated coverages take this needed flexibility from employers.

In fact, we may well see litigation to determine which categories of medical and surgical services will be matched to mental health services to determine what parity coverage will be. No similar expansion is contemplated for the Medicare program (which imposes different cost-sharing and limits on treatment for mental health care than for medical or surgical benefits)—a wise precaution given Medicare’s precarious future finances.

The Roukema and Domenici-Wellstone bills state that plans are not required to offer any mental health benefits or any particular mental health benefits. Though plans are not required to offer services, if they offer one mental health benefit, they must offer all if to do so otherwise would amount to discrimination. The Roukema bill apparently allows no distinction to be drawn between serious disorders like major depression, schizophrenia and bipolar disorder and such celebrated conditions as Circadian Rhythm Sleep Disorder/Jet Lag (DSM-IV 307.45), Partner Relational Problem (V61.1), Malingering (V65.2) and Oppositional Defiant Disorder (313.81). Our purpose is not to make light of any of these conditions, but to emphasize the need to draw distinctions in the level of coverage. I enclose a partial compilation of additional DSM-IV conditions at the conclusion of my testimony and request that it be included therein.

The Roukema and Domenici-Wellstone bills also allow plans to maintain medical necessity and utilization management techniques. However, the subjectivity inherent in mental health care (researchers note a wide variance of views on what are and are not mental disorders) will make use of these techniques difficult. Too strict an interpretation of medical necessity will invite further legislation and greater litigation. Too loose an interpretation may lead to the kind of “anything goes” mentality that led to insurance fraud seen frequently in the 1970s through 1990s.

Increased litigation surrounding medical necessity determinations is a substantial deterrent to offer mental health coverage for small to mid-size employers who do not fall within the 50-employee carve-out. Indeed, as costs increase as a consequence of the parity mandate, these may be among the first employers to be priced out of coverage.

Many have pointed to the ability of managed care to tightly manage benefits for the proposition that expanded mental health parity can also be effectively managed. Employers and insurers jointly developed the concept of managed care to provide better and more cost-effective care. However, the era of tightly managed care has largely passed as a result of consumer demand and the much-debated Patients’ Bill of Rights proposals. Managed care is unlikely to be able to manage this expansive new benefit mandate.

We are troubled by the use of the DSM-IV, a professional classification of mental health conditions maintained on a proprietary basis by the American Psychiatric Association (APA). This exhaustive compilation—which is updated by vote of the members of the APA—is more suitable to professional practice than benefit administration. As the DSM-IV notes, “[m]oreover, although this manual provides a classifica-

tion of mental disorders, it must be admitted that no definition adequately specifies precise boundaries for the concept of 'mental disorder.'" Health plans are better more appropriately characterized by lists of defined benefits than by blanket coverages.

ROUKEMA BILL IS ALSO TOO RESTRICTIVE

The Mental Health Parity Act of 1996 prohibited group health plans from maintaining different annual or lifetime limits on mental health services than for medical or surgical benefits. The Roukema bill would also prohibit plans from maintaining different cost sharing or limits on days or visits. Plans would still be permitted to carve out mental health benefits.

Employer-sponsored health plans need the flexibility to manage health benefits, especially in today's cost environment. Though the trend—in response to employee and consumer demands—has been away from more restrictive management of benefits, this proposal takes almost every option employers have to manage the benefit—except for the litigation-prone determination of medical necessity on a case-by-case basis. Greater flexibility in the management of mental health benefits is required.

MAJORITY OF STATES TAKE DIFFERENT APPROACH

Our clear preference, given the current health care inflation, the CBO's latest clarification of the potential costs of this mandate, and the problems identified above with the Roukema bill, is that no expansion be made beyond the 1996 law. But, we also recognize the large body of support in Congress for mental health parity as well as President Bush's own commitment to the concept. Therefore, we encourage this committee and the Congress to consider the following if it is inclined to act in this area.

Some thirty states (including Florida and Texas, but not Ohio) have taken the approach of specifying which conditions are subject to the parity mandate. These conditions are, most often, the serious, so-called "brain-based" disorders like schizophrenia, major depressive disorder or bipolar disorder. This would certainly be preferable to adopting the whole of DSM-IV if our preferred position of allowing the plan to define the scope of parity coverage is not taken.

In addition, plans should be afforded some greater degree of flexibility in administering the benefit. If Congress is to move beyond the scope of the 1996 law, then it should do so more cautiously given the current cost environment and the greater projected cost impact of the Roukema bill.

CONCLUSION

Employers voluntarily offer a wide range of benefits to their employees, including mental health benefits and employee assistance plans. The NAM opposes mandated health benefits because of rising health care costs and the need for greater flexibility of benefit plan administration. We oppose the Roukema bill and its Senate counterpart, the Domenici bill, which, though well-intentioned, are flawed in their approach. We urge Congress and the Bush Administration not to take additional steps that will add to the existing cost of coverage and instead look to more limited measures taken by the states—if any expansion of the mental health parity mandate is undertaken.

Thank you, Mr. Chairman. I will look forward to any questions you may have.

**Selected Mental Disorders Included in the Diagnostic and Statistical
Manual of Mental Disorders, Fourth Edition (DSM-IV)**

The following table contains descriptions of selected mental disorders (from more than 277) included within the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV). The manual defines a mental disorder as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress or disability or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. This definition excludes expectable and culturally sanctioned responses to events, and mental disorders must be considered a manifestation of a behavioral, psychological, or biological dysfunction in the individual.

Diagnosis	Code	Description
Nightmare Disorder	307.47	Nightmare Disorder is the repeated occurrence of frightening dreams that lead to awakenings from sleep. Nightmare Disorder, because of frequent nocturnal awakenings, can cause excessive sleepiness, poor concentration, depression, anxiety, or irritability that can disrupt daytime functioning.
Sleep Terror Disorder	307.46	Sleep Terror Disorder involves the repeated occurrence of abrupt awakenings from sleep usually beginning with a panicky scream or cry. Typically, individuals abruptly sit up in bed screaming or crying, with a frightened expression and autonomic signs of intense anxiety. According to the DSM-IV, Embarrassment concerning the episodes can impair social relationships. Individuals may avoid situations in which others might become aware of the disturbance, such as going to camp, visiting friends overnight, or sleeping with bed-partners.
Sleepwalking Disorder	307.46	The DSM-IV states, The essential feature of Sleepwalking Disorder is repeated episodes of complex motor behavior initiated during sleep, including rising from bed and walking about. Sleepwalking episodes can include simply sitting up in bed, or, more typically, the individual actually gets out of bed and may walk into closets, out of the room, up and down stairs, and even out of buildings. Individuals may use the bathroom, eat, and talk during episodes.
Circadian Rhythm Sleep Disorder: Jet Lag Type	307.45	Circadian Rhythm Sleep Disorder is a persistent or recurrent pattern of sleep disruption that results from a mismatch between the individual's endogenous circadian sleep-wake system on one hand and the exogenous demands regarding timing and duration of sleep on the other. The Jet Lag Type is a disturbance in the circadian cycle due to a new time zone. The severity of the disruption is proportional to the number of time zones traveled through.

Diagnosis	Code	Description
Substance-Induced Sexual Dysfunction	291.8, 292.89	Substance-Induced Sexual Dysfunction is a dysfunction fully explained by the direct physiological effects of a substance that results in impaired desire, impaired arousal, impaired orgasm, or sexual pain. Specific Substance-Induced Sexual Dysfunctions include those caused by: - alcohol - amphetamine or amphetamine-like substance - cocaine - opioid - sedative, hypnotic, or anxiolytic
Oppositional Defiant Disorder	313.81	The DSM-IV states that The essential feature of Oppositional Defiant Disorder is a recurrent pattern of negativistic, defiant, disobedient, and hostile behavior toward authority figures that persists for at least 6 months. The disorder is characterized by at least four of the following behaviors: - losing temper; - arguing with adults; - actively defying or refusing to comply with the requests or rules of adults; - deliberately doing things that will annoy other people; - blaming other for his or her own mistakes or ; - being touchy or easily annoyed by others; - being angry or resentful; or, - being spitefully vindictive
Partner Relational Problem	V61.1	Partner Relational Problem is a pattern of interaction between spouses or partners characterized by negative communications (e.g., criticisms), distorted communication (e.g., unrealistic expectations), or non-communication (e.g., withdrawal) that is associated with clinically significant impairment in individual or family functioning or the development of symptoms in one or both partners.
Sibling Relational Problem	V.61.8	Sibling Relational Problem is a pattern of interaction among siblings that is associated with clinically significant impairment in individual or family functioning or the development of symptoms in one or more of the siblings.
Malingering	V65.2	Malingering is the intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives such as avoiding military duty, avoiding work, obtaining financial compensation, evading criminal prosecution, or obtaining drugs.

Diagnosis	Code	Description
Academic Problem	V.62.3	An Academic Problem is an academic problem that is not due to a mental disorder or, if due to a mental disorder, is sufficiently severe to warrant independent clinical attention. Examples provided include a pattern of failing grades or significant underachievement in a person with adequate intellectual capacity, without any other disorder or disability that would account for the problem.
Occupational Problem	V.62.2	An Occupational Problem is an occupational problem that is not due to a mental disorder or, if it is due to a mental disorder, is sufficiently severe to warrant independent clinical evaluation. Examples include job dissatisfaction and uncertainty about career choices.
Identity Problem	313.82	An Identity Problem occurs when an individual is uncertain about multiple issues relating to identity such as long-term goals, career choice, friendship patterns, sexual orientation and behavior, moral values, and group loyalties.
Religious or Spiritual Problem	V62.89	The DSM states, This category can be used when the focus of clinical attention a religious or spiritual problem. Examples include distressing experiences that involve loss or questioning of faith, problems associated with conversion to a new faith, or questioning of spiritual values that may not necessarily be related to an organized church or religious institution.
Phase of Life Problem	V.62.89	A Phase of Life Problem is a problem associated with a particular developmental phase or some other life circumstance. Examples include problems associated with: <ul style="list-style-type: none"> - entering school - leaving parental control - starting a new career - changes involved in marriage, divorce, and retirement

Mr. BILIRAKIS. Thank you very much, Mr. Trautwein.
Mr. Hackett?

STATEMENT OF JAMES T. HACKETT

Mr. HACKETT. Thank you, Mr. Chairman, and all of the other members of the subcommittee for holding this hearing and giving us an opportunity to speak to a very important issue that America faces.

In January of 2002, as Congressman Green mentioned, we implemented voluntary mental health parity for our employees. We have 1,100 employees. Our medical claims for mental health amount to about 3.7 percent of our overall claims, to give you some flavor for the amount of cost that this represents that we're speaking of. We estimated that our costs would go up by 1.3 percent based on this change to our benefits program.

So I can assure you that those of us—the other two companies who went out and did the same thing with us in Houston feel very strongly that the cost estimates that were previously quoted are very much on target with our experience in terms of actual practice as opposed to theoretical conjecturing.

We believe that the productivity gains, the fairness issue, and the compassion issue, far outweigh the costs involved in this particular change for our companies. We think it is good for our employees. We think it is good for the Houston community. We think it is absolutely essential for the American people to have mental health parity.

Why? Over 15 percent of the disease burdens, more than cancer, arise from mental health. We believe that in our own personal lives. It is not black magic anymore, which I suggest to you that most businessmen still believe it is. It is not a character flaw.

It is a physiological issue. It can be treated with, we believe, and it can be dealt with for Americans. And two-thirds of those that have it don't seek treatment because of the stigma and because of the cost issue, and I firmly, firmly believe in that.

We have personally experienced in our family life an inequity that applies to this particular rule. It is not what drove us to change our mental health plan, but it is an exact example of why it is a problem. If it were not, the resources of my personal family would have had huge problems with a daughter who suffered from sexual assault 3 years ago at the age of 16.

That daughter suffered post-traumatic syndrome disorder. That is not one of the causes that was mentioned by Dr. Ganske. Importantly, it is not one of the listed disorders that are claimed to be serious disorders. They mostly don't apply to young children.

She was—what that is described as medically is that you suffer from intense fear, helplessness, or horror. And horror is the right word, I promise you. She suffered panic attacks, was not able to attend school for over a year. In-patient treatment was required outside of the State of Texas, because no Texas facilities could handle a child of that age.

We had extensive treatment, and she was able to recover. And, fortunately, she is going to Villanova next year for college a year after she was supposed to, but it is a dream come true. I promise you that if she had not gotten treatment, she would not be recov-

ered. I promise you she would be a shadow of her former self if she had not gotten treatment. It is that powerful to have the right people dealing with this.

Second, I promise you she would not have recovered if it was up to our plan at Ocean Energy to help out a family to do it, if they didn't have the resources that we had. I promise you that is a fact, and now our plan actually helps poor people in our employ to actually help themselves and their families out of dire circumstances.

Existing plans like OEI's—Ocean Energy's plans—discriminate by duration of treatment, by co-payments, and by diagnosis. Uneven and inadequate coverage must end. Voluntary efforts like ours will continue, but I promise you they will be slow; they will be spotty. It will disadvantage people for decades if we don't make this change.

There is a lot of misinformation surrounding this issue, an unbelievable amount to me, when you actually experience it in your families, as many of us have and many of us don't want to admit that we have. And I think that the start of this is to take the wonderful and rare opportunity that we have as legislators in this country to actually make a meaningful impact on the welfare of those in our States, as well as the welfare of all Americans.

The cost is small, and I challenge anyone to dispute this. The benefit to America is enormous.

Thank you very much.

[The prepared statement of James T. Hackett follows:]

PREPARED STATEMENT OF JAMES T. HACKETT, CHAIRMAN, PRESIDENT AND CHIEF
EXECUTIVE OFFICER OF OCEAN ENERGY, INC.

Mr. Chairman and Members of the Subcommittee, thank you for holding this hearing and providing me the opportunity to offer my perspective on insurance coverage of mental health benefits. 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 people around the world.

At the beginning of 2002, Ocean Energy voluntarily established full parity in insurance coverage for our workforce for mental health services. We took this step along with two other Houston companies, Weingarten Realty Investors and *The Houston Chronicle*; an announcement that a fourth company is adopting parity for its workforce is imminent. Each of us has estimated that any increase in cost due to parity will be minor and more than offset by avoided costs of lost employee productivity.

In addition, the leaders of these organizations have recently banded together to conduct a letter-writing campaign to our peers in other Houston corporations to encourage them to review their own insurance coverage to ensure parity between mental health benefits and coverage for medical and surgical care. The reason we are taking this public action is very clear: our employees, the Houston community and the American people deserve access to mental health care equal to that of physical health care.

Why? Mental illness is the second leading cause of disability and premature mortality in the United States. Mental disorders collectively account for more than 15 percent of the overall burden of disease from all causes, and slightly more than the burden associated with all forms of cancer. With striking scientific advances over the last half century, mental disorders are now reliably diagnosed and for virtually every such disorder, there is a range of treatments and services that have been shown to be effective. Those treatments have efficacy rates comparable to or exceeding those for many medical and surgical conditions. Yet the Surgeon General's 1999 Report on Mental Health notes that nearly two-thirds of all people with diagnosable mental disorders do not seek treatment. "Concerns about the cost of care—concerns made worse by the disparity in insurance coverage for mental disorders in contrast to other illnesses—are among the foremost reasons why people do not seek needed mental health care," the Surgeon General reported.

Sadly, I learned about the inequities in the coverage of mental health services after my teen-age daughter was the victim of a sexual assault that led her to suffer from post-traumatic stress disorder. A diagnosis of PTSD means that an individual experienced an event that involved a threat to one's own or another's life or physical integrity and that this person responded with intense fear, helplessness, or horror. Her despair left her with severe panic attacks that were so intense that she could no longer attend her high school and had to be treated at an inpatient center. This facility was out of state because no such inpatient care for teenagers existed in Texas. After missing a full-year in school and undergoing very expensive psychiatric and psychological treatment, she was able to recover and is now looking forward to attending college, a dream we had forsaken three years ago. I cannot describe to you the agony that my family experienced as we sought first a diagnosis and then the appropriate treatment for this violent offense against a young woman. It was during this process that we became exposed to the often-overlooked and highly stigmatized mental health care system and the fact that in America—the land of the free and the plenty—many citizens, despite having so-called “good insurance coverage,” simply cannot afford to receive the care their condition requires.

Fortunately, we did have the financial resources to provide the medical care that my daughter needed and our family the support it needed to deal with the illness. If we had depended on our company-provided benefits for full payment our daughter would not have been able to receive the needed inpatient treatment nor avail herself of the needed followup psychiatric treatment. I am certain that she would be a shadow of her former self. Today, that daughter is a beautiful example of how access to the proper mental health treatment can literally mean the difference between life and death. She also exemplifies how the medical community is now learning to treat mental illness more successfully than heart disease. The treatment success rate is more than 80 and 60 percent for clinical depression and schizophrenia, respectively, while the treatment success rate for heart disease, for example, is considerably lower—between 40 and 50 percent.

Currently, Federal law allows health-insurance discrimination against people with mental disorders: discrimination in duration of needed treatment, discrimination in cost-sharing burdens, and discrimination by diagnosis (allowing insurers to cover some mental disorders but not others despite the need for treatment). As a result, millions of Americans who experience mental disorders 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. While I personally believe as a business leader that providing mental health benefits on par with physical health benefits makes not only economic but moral sense, there is a need for governmental intervention to end insurance discrimination against mental illness. That is why I implore you to support the Mental Health Equitable Treatment Act, H.R. 4066, which prohibits group health insurance policies providing mental health benefits from imposing treatment limitations or financial requirements on the coverage of mental health conditions unless comparable limits are imposed on medical and surgical benefits.

You have a rare opportunity here to make a difference in the lives of millions of Americans without creating a detriment to American business. A recent MIT study concluded that clinical depression alone costs U.S. businesses nearly \$30 billion a year in missed days and poor work performance. Business leaders should not overlook such information when reviewing their insurance coverage as it relates to mental health parity. But unfortunately they do. Too few businesses have really examined mental health parity—typically because of misunderstandings regarding mental illness, the erroneous belief that parity means additional cost, and misperceptions about the efficacy of treatment. I was one of those business leaders until my personal circumstances made me see what was going on in our own company. Today more than ever, managers of every business have the opportunity to support their employees while, at the same time, reducing the cost to their companies 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 medical and surgical care 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 H.R. 4066.

I thank the Subcommittee for holding this hearing and urge you to adopt H.R. 4066 as introduced. I would be pleased to answer any questions you may have.

Mr. BILIRAKIS. Thank you so much, Mr. Hackett.
Ms. Nystul?

STATEMENT OF KAY NYSTUL

Ms. NYSTUL. Thank you, Mr. Chairman, and members of the committee for—I truly appreciate this opportunity to speak before this panel in regards to 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.

Today I work for Wausau Benefits as a nurse case manager, and part of my job—my whole job, actually, is to ensure that people with mental illness get the care they need when they need it at the appropriate level of care that they need it.

I am also—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 plan benefit 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—how they must spend it create an incentive for employers to not offer the coverage at all.

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. Wausau Benefits provide employee benefit plan administrative services for 434 employer groups ranging in size from 200 employees to large national accounts. We do business with two-thirds of the health care providers in the United States.

I have experience working in hospital settings, eating disorder units, chemical dependency and substance abuse treatment 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 the same desired results. That is where case management can be very effective.

Levels of care can be high cost or low cost. Most patients prefer the least restrictive treatment setting, which is generally more low cost, if at all possible, which is certainly consistent with both case management and quality of care objectives.

In my role as a nurse case manager, my No. 1 job is to be an advocate for the patient. Case management does empower the patient to get to an independent state through education, assistance in assessing treatment options, and developing support systems. People need support and enough information about their illness to help them make informed decisions.

For some disorders, there are good alternative treatments that will provide the same quality of care at a more—as the more expensive clinical settings but at a fraction of the cost. If all the DSM conditions were to be eligible for coverage, there would 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 can wisely be spent.

Wausau Benefits has three concerns with this bill. First, the bill attempts to extend the concept of parity to all illnesses defined in the DSM-IV—a policy decision that was questioned in our appearance before the Education and Workforce Committee in March and repeated again today.

Second, the bill in its rules of construction purports to allow plans flexibility in the way they manage mental health cases, but, in fact, forces plans to use management tools only if they are designed and applied exactly as they are in medical/surgical cases.

We argue that this formula calls into question whether plans can manage serious mental illness differently from the way they manage less serious behavioral problems and leaves open to court interpretation whether a plan's use of management tools for mental health cases offers enough for management of medical/surgical cases to be considered in violation of the bill.

Finally, Wausau Benefits questions the overreliance of the bill on medical necessity as the only screen for inappropriate or even harmful treatment of mental health cases.

To highlight the problem presented by the overly broad scope of this bill, let me cite a few real cases that we have faced as an administrator of benefits for large companies across the country in recent years. We have had a request for treatment for a college-age student who was kicked out of school for drinking. His parents would not allow him back home, wanted him to suffer consequences, and put him in 24-hour treatment.

Costs of facilities like this can range anywhere from \$300 to \$1,650 a day. The patient could have safely and effectively been treated at an outpatient setting, but since there was nowhere for the patient to live the facility would not discharge him.

We have also had requests for a 16-year old girl who was oppositional defiant. She was often truant from school, impulsive, didn't follow rules at home, and caused chaos in the family. Her family requested in-patient treatment for 9 to 12 months at a facility at approximately \$300 per day.

If you do the math on that, that can be over \$100,000 for only 6 to 9 months of the treatment requested. And one case could certainly cause significant cost to that plan.

Another case where a parent insisted that a 13-year old child needed 12 months of intensive in-patient treatment and would not consider anything less. The bottom line was they didn't want the child at home because he was not following rules and not compliant with homework. There were absolutely no symptoms to justify confinement, yet this family wanted these services.

We have also had requests for 4-year olds to be admitted to acute psychiatric in-patient facilities, because they have had aggressive behaviors, and, in the particular case I am citing, because he had been kicked out of 4 day cares. His single mother had begun a new career, was unable to stay home with the child, and certainly needed and wanted the placement that 24-hour in-patient provided. She successfully persuaded a doctor to agree to admit the child at roughly \$1,600 a day per cost.

Mr. BILIRAKIS. Would you please summarize, Ms. Nystul?

Ms. NYSTUL. In summary, finding just the right policy answer is a complex task, yet the desired outcome is simple. There is clear

need for mental health resources to be carefully allocated to the right cases and right treatment options. As stated earlier, this bill would require parity to be applied to all mental health conditions listed in the American Psychiatric Association's Diagnostic Statistical Manual.

Federal mandated application of 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 serious mental illness and all of the other conditions listed in the DSM-IV, which I have mentioned in my testimony.

In conclusion, 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 do get it. Federal mandated 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 suffer from serious mental illness and receive care when they need it, everybody wins. Employers get—

Mr. BILIRAKIS. Ms. Nystul, I am sorry, but you are three and a half minutes over time, and I—can you finish up?

Ms. NYSTUL. One last sentence. The employees get their lives back, the employer gets their employees back, and no one faces financial devastation.

Mr. BILIRAKIS. Thank you.

Ms. NYSTUL. Thank you.

[The prepared statement of Kay Nystul follows:]

PREPARED STATEMENT OF KAY NYSTUL, WAUSAU BENEFITS

INTRODUCTION

Chairman Bilirakis, I truly appreciate the opportunity to appear before the Health Subcommittee and 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 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.

COMMENTS ON PENDING MENTAL HEALTH PARITY PROPOSALS

Wausau Benefits has three concerns with HR 4066. First, the bill attempts to extend the concept of parity to all illnesses defined in the DSM IV-TR, a policy decision we questioned in our appearance before the Education & Workforce Committee in March and repeat again today. Secondly, HR 4066, in its rules of construction, purports to allow plans flexibility in the way they manage mental illness cases, but in fact forces plans to use management tools for mental health cases only if they are designed and applied exactly as they are in medical-surgical cases. We argue that this formula calls into questions whether plans can manage serious mental illnesses differently from the way they manage less serious behavioral problems and leaves open to court interpretation whether a plan's use of management tools for mental health cases differs enough from its management of medical/surgical cases to be considered violative of HR 4066. Finally, Wausau Benefits questions the overreliance of HR 4066 on medical necessity as the only screen for inappropriate or even harmful treatment of mental health cases.

To highlight the problem presented by the overly broad scope of HR 4066, let me cite a few real cases Wausau Benefits has faced as an administrator of benefits for large companies across the country in recent years.

- A college age student was kicked out of school for drinking alcohol. His parents would not allow him to come home and instead put him in a 24-hour treatment facility at a cost of anywhere from \$300 to \$1650 a day. The patient could have been safely and effectively treated in an outpatient setting, but since there was nowhere for the patient to live, the facility would not discharge him.
- A 16-year old girl was diagnosed as an oppositional deviant. She was often truant from school, impulsive, did not follow rules at home and caused chaos in the family. The parents requested inpatient treatment for 9 to 12 months at a cost of approximately \$300 per day.
- A parent insisted that a 13-year old child needed 12 months of intensive inpatient treatment and would not consider anything less. The cost was approximately \$300 per day. The parent wanted the child out of the home. Not following rules at home and failing to complete homework were the symptoms used to justify confinement.
- A request was received for a 4-year old to be admitted to an acute psychiatric inpatient facility because he had been expelled from four different day care facilities due to "aggressive behaviors" including hitting other children. His single mother had recently begun a career as an attorney and was unable to stay

home with the child. She successfully persuaded the doctor to agree to admit the child into an inpatient care setting at roughly \$1600 per day.

Reading these cases, it is easy to focus on the high dollar costs which are associated with aggressive inpatient courses of treatment, but it is just as important to focus on the question of whether the treatment chosen is effective or possibly even harmful to the individuals involved. Wausau Benefits attempts to work as often as it can with physicians and patients to take full advantage of community health services and other sound alternatives to inpatient care. Application of HR 4066 to all illnesses listed in the DSM-IV, a large percentage of which have just been officially added to the list in the last two years, will not only waste precious health care dollars, but also facilitate the inappropriate treatment of some younger Americans.

Regarding the HR 4066 requirement that management tool design and use not vary between mental health cases and medical/surgical cases, I want to point out that health plans differentiate between the kinds of treatment and financial limits they impose on different types of cases within the medical/surgical field. There are financial and treatment limitations on in-patient stays, annual limits on various preventive health exams, durational limits on physical therapy—all presumably designed around the general concept there are limits to the therapeutic benefit of these services. Following this logic, it is reasonable to ask why plans should not be able to establish different treatment limits or financial requirements on different types of mental illness benefits. For example, Wausau Benefits would recommend that plans be allowed much more flexibility with regard to cases not involving biological-based illnesses. Unfortunately, the language of HR 4066 raises major questions about a plan's ability to treat different mental health matters differently. Since medical/surgical limits and requirements do differ, it is also difficult under HR 4066 to determine whether the general parity rule has been violated by a particular limit on mental health treatment. This situation invites litigation which is unacceptable in today's cost-constrained environment and will be even more so once a Patient Bill of Rights is approved.

Since plans are effectively prevented by HR 4066 from establishing defensible treatment limits or financial requirements and from effectively managing mental health benefits, the only method of screening appropriate treatment and payment allowed by the bill would be a "medical necessity" screen. As a clinical professional, I can assure members of the panel that using medical necessity as a last resort screening methodology for many of the less serious mental health illnesses is like not managing the benefit at all. Many cases in the behavioral health area are based on self-reported symptoms which, by themselves, do not justify clinical intervention. Another problem is the lack of proven courses of treatment for recently identified behavioral health problems. I do not believe Congress wants employers or TPA's to turn a blind eye to the kinds of cases I highlighted earlier in my testimony. I recommend that plans be allowed to retain control over their payment policies with regard to questionable requests for treatment without having to risk violating the law or consider eliminating mental health benefits for their employees.

BEHAVIORAL VERSUS BIOLOGICAL AND FEDERAL POLICY—ADDITIONAL DISCUSSION

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

As stated earlier, HR 4066 would require parity to be applied to all mental health conditions listed in the American Psychiatric Association's Diagnostic Statistical Manual. Federally mandated application of 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-IV.

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 the bulk of 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 critical, 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-IV include such things as unhappiness in their job (V62.2), a chaotic home life (V62.89), or difficult personal relationships (V61.20), 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, plans generally do not cover mental health conditions that do not cause significant functional impairment. Such impairments include learning disorders (315.9), pathological gambling (312.31), bereavement (V62.82), communication disorders (307.9), spirituality (V62.89), sexual and gender identity disorders (302.6;302.9), conduct disorders (312.8) and jet lag (307.45). 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. Utilizing high cost treatments for low-impact conditions is not a wise use of limited health plan dollars.

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.

Mr. BILIRAKIS. Thank you very much.

Ms. NYSTUL, let us see. In the case of the college-age student, the cost of \$300 to \$1,650 a day, the facility would not discharge him because there was nowhere for the patient to live, was that benefit paid?

Ms. NYSTUL. That benefit, as far as I know, was paid.

Mr. BILIRAKIS. It was paid. In the case of the 4-year old, where the mother was unable to stay home with the child, persuaded the doctor to admit the child into an in-patient care setting at roughly \$1,600 per day, was that paid?

Ms. NYSTUL. A few days of that admission—

Mr. BILIRAKIS. A few days was paid.

Ms. NYSTUL. [continuing] were covered.

Mr. BILIRAKIS. What happened after that few days?

Ms. NYSTUL. Then it went to independent review with an external—with external reviewers that we have that are Board certified psychiatrists. Because, clearly, at that point there were no symptoms for this child to be in there, other than he had been kicked out of every day care in his area.

Mr. BILIRAKIS. And there was a clear, independent review. The psychiatrists, were they employed by the—by Wausau?

Ms. NYSTUL. Not employed by us, but certainly paid for their services. Again, they are external from us.

Mr. BILIRAKIS. And they chose to turn down any additional payment?

Ms. NYSTUL. They don't—they make a recommendation as to whether the care meets criteria for medical necessity.

Mr. BILIRAKIS. And what was their recommendation?

Ms. NYSTUL. And in that case they felt it did not.

Mr. BILIRAKIS. It did not. All right.

I am going to read a very lengthy set of questions. It is really one question broken down into various areas. It is intended for Dr. Regier, but I would ask Dr. Cutler and Ms. Nystul also to comment on these points.

Dr. Regier, there won't be enough time for you to respond orally to these questions, but I want to get them in the record, and also ask you to respond in writing as I would ask Dr. Cutler and Ms. Nystul. And if Messrs. Hackett and Trautwein would also like to respond to them, feel free to do so.

Let us see. Dr. Regier, your testimony states that the controversy over whether to incorporate DSM-IV into statutory law is a red herring. Many States, as has been testified to, that have looked at this issue have chosen to limit any parity requirements to biologically based or serious mental illness as they define them. Those States do not require use of DSM-IV criteria.

Moreover—and I am going to furnish this in writing to you all, so you don't really have to worry about making notes on it. Moreover, what you are asking us to do is incorporate an 800-page manual by reference into a statute. That is the manual that I held up earlier. That would give that document legal standing in many ways and with many consequences.

If you are asking us to take such a step, then I would want to fully understand and resolve all the attendant controversies. I think it will take both questions at this hearing and many followup questions to begin to understand the use of such a complicated document into a new legal setting.

First, I want to ask a number of questions about how you think the reference to DSM-IV and H.R. 4066 works. In your opinion, does the inclusion of the DSM-IV reference require companies to use the diagnostic standards in that document as a matter of law? And I would ask, is that your objective?

Next, in your testimony, you refer to the categories of DSM-IV referred to as conditions for clinical focus. These include such items as sibling relational problem, occupational problem, academic problem, and religious or spiritual problem. Some of these terms would apparently apply even if they are not termed "mental disorders" under the manual.

Do you believe that H.R. 4066 incorporates these conditions, even where the manual states that they are conditions and not mental disorders?

C. Your written testimony mentions the term "clinically significant impairment." Do you believe such a term should be directly incorporated into legislation as a filter to eliminate less serious claims? Also, in your opinion, whose burden is it to show that there is a clinically significant impairment? Should it be the burden on the claimant, or on the plan manager?

Next, could you support language that says that the diagnosis of a disorder or its treatment must be well established and supported

by clear scientific evidence? And, of course, I would ask, as I said before, Dr. Cutler and Ms. Nystul to respond.

My time is up. I would just merely say that I know Mrs. Domenici is still in the audience. The Senator—I have worked a number of conferences, health care conferences, where the Senator was involved. And he is—he refers to me as Doctor. I am not sure really why. And he, of course, brought up this point. And he has had this personal experience. Mr. Hackett has had personal experience.

I would wager that probably every one of us, to some degree, not to the same degree, but every one of us has had similar—some sort of similar, or at least some sort of experience in this area.

And I would say that if we all really want to seriously do something about this problem, we should not be looking at it as an either/or. I keep using this argument with my wife all the time. She is either/or. Should we be looking at an either/or situation? Or should we be trying to do something at least maybe for the serious cases, if you will, or those that are very definitely supported by some sort of scientific evidence, that sort of thing.

And I would say—and I have already sort of mentioned this already to Mr. Brown—if we really seriously want to do this, not use it as an issue, but do this. I really think it is doable, but we can't necessarily be, just stubborn and say either my way or no way.

Having said that, I would yield to Mr. Brown.

Mr. BROWN. Thank you, Dr. Bilirakis.

Dr. Regier, a question for you. In Mr. Trautwein's testimony, he mentions what he calls an explosive estimate, that the Congressional Budget Office stated that the bill would cause mental health costs to increase from 30 to 70 percent, mental health costs to increase 30 to 70 percent for affected plans.

My understanding is that mental health costs are pretty clearly a very small part of health care costs overall. And that would say to me that a 30 to 70 percent increase in mental health costs would not be a particularly big increase overall in plans. I understand CBO's estimate of—about the bill's cost is still—I believe, still only .9 percent. Could you elaborate on that to make sure I understand it?

Mr. REGIER. Yes, I would be happy to. Actually, Mr. Trautwein is completely correct. It would be a 30 to 70 percent increase. And if you realize that the current percentage of premiums at the present time accorded to mental health and substance abuse is somewhere between 1 and 3 percent, if you multiply that times 30 percent or a 70 percent increase, you get .9 percent, which is exactly what the Congressional Budget Office, you know, estimated.

So I think there was a bit of a misleading inference in Mr. Trautwein's statement, that this was somehow explosive. This is no news. This is exactly the basis on which the CBO made their estimate, and it is simple arithmetic.

Mr. BROWN. So while it is narrow cost on that specific part of it, mental health may, in fact, be explosive. The cost overall to health care is minimal.

Mr. REGIER. That is correct. And that is basically because in the last 10 years, as the FEHBP found, mental health costs dropped from 8 percent in 1988 to something like 2 percent of the total mental health benefit for the Federal Employees Health Benefit

Program. And so you have this very low baseline from which we are now operating.

So the whole field has changed from when some of the earlier estimates of the cost of parity were made.

Mr. BROWN. Okay. Thank you. I have another set of questions for Dr. Regier and Mr. Hackett.

When Congress was considering the prescription drug benefit, common sense told us that giving seniors a good, solid prescription drug benefit would help keep them out of hospitals, would help keep them from getting sicker, and that would, in turn, decrease Medicare's total expenditures in the perhaps peculiar way or not that the Congressional Budget Office figures the cost of a new program. They didn't include this type of cost savings in their estimate of the cost of the prescription drug benefit.

Likewise, CBO's cost estimates for 4066, the legislation Mrs. Roukema and Mr. Kennedy have introduced, doesn't factor in savings that result from mental health parity. CBO's estimate, while only .9 percent, doesn't include the increase in—obviously, in productivity that Mr. Hackett talked about, lost time, decrease in disability, all of those kinds of things.

The first question, Dr. Regier, is: is it your belief that mental health parity would decrease health care expenditures for other conditions and bring additional cost savings outside the health care arena?

Mr. REGIER. I think there is ample evidence that that would occur. And, in fact, the best evidence we saw was a study that I mentioned to you that Dr. Rosenheck at Yale University did of a large company which showed what happened when you overly constricted mental health benefits. They constricted them by something like 40 percent, and what happened is there was this hydraulic experience in which, by constricting them, they shot up their cost of general medical primary care services, they shot up the level of absenteeism, and they also decreased the level of productivity in that company.

So I think there is ample evidence that with an appropriate mental health benefit that is managed in a sense that—to make sure that there is a medical necessity, you know, for the care—that, in fact, this is a very efficient way of doing business.

Mr. BROWN. Okay. Mr. Hackett, briefly—my last question, Mr. Chairman. Is the cost of mental health parity offset by other savings in your mind?

Mr. HACKETT. Very definitely. And I think, just to support the previous estimates on your cost issues, ours were almost exactly the same. We go from about 2.4 percent of our total cost to 3.7, with the additional benefits.

I do think that we don't even know what is out there, frankly. I don't know how many people in my company are distracted from dealing with family problems that might otherwise be treatable.

I know that the secretary right next to me told me she almost declared personal bankruptcy, which I had no idea, about a year ago, because of a mental health problem with her husband that was not being treated because our policies didn't cover it. So we don't even know how good it is going to get.

Mr. BILIRAKIS. If the gentleman would yield. Mr. Hackett, did your company make available all of these benefits prior to your personal experience?

Mr. HACKETT. We actually had made the decision to do that prior to our—

Mr. BILIRAKIS. Prior.

Mr. HACKETT. [continuing] experience with this in terms of the frustrations, but it clearly provided extra impetus to feel good about it.

Mr. BILIRAKIS. That is commendable.

Dr. Norwood?

Mr. NORWOOD. Thank you very much, Mr. Chairman. I would like to start by saying that my tendency here is to agree with your comments that there is somewhere in the middle, if we are actually going to change the law. And right now both sides are out as far as they can with their views.

And if no one is willing to yield in any way, then we are not going to be able to improve mental health to the degree that some of you want, and maybe a lesser degree than others of you want.

I am—this is an interesting hearing to me, because it reeks of patient protections. It reeks of HMO reform, and it goes right back to where the basic systematic problem is in our system of health care today, where sometimes we have an external review and sometimes we don't. And it is a system that one side wants everything and the other side wants to pay for nothing.

And there needs to be somewhere in the middle there, and the only way to get into that middle, I believe, is to have the Federal Government set some standards that are reasonable in health care insurance. And in today's hearing, it is about mental health and the standards that should occur there. And one side is trying to get standards into this debate, and the other side is doing everything it can to make sure that no one is in charge of that but them, so that they can manage the cost according to their bottom line, not necessarily according to the needs of our patients.

Dr. Cutter, can you give me some idea what you think the cost today in the health care system is for mental health? Do you have some percentage in mind, any of you? Is 5 percent of total health care spending somewhere in the neighborhood right?

Mr. CUTLER. I don't have a current percentage, Dr. Norwood, but I would be happy to get that for you.

Mr. NORWOOD. Well, do any of you know? Or am I right to think—yes, sir?

Mr. REGIER. It is actually less than 5 percent in most cases. It is, as I mentioned before, somewhere in the neighborhood of often 1 to 3 percent of the benefit. In some of the better plans it will go up to 4 percent, but there are actually fairly few that are up to 5 percent.

Mr. NORWOOD. So, on average, let us say for the sake of discussion, 3 percent. Yet Dr. Cutler tells me the insurance coverage in the Nation today is about 96 percent of mental health coverage; 96 percent of plans cover mental health.

Now that says to me one or two things. It says to me that there are not near as many people having problems with mental health as we think, or either you may be covering it but not very well.

And that needs to be—that is what this is all about is, are you covering it very well?

To say to us 96 percent of the plans have mental health coverage means totally nothing in my viewpoint. It just means some—either people aren't sick or you aren't covering it very well, or you are managing the costs so that you don't really spend any money on the mental health coverage.

You pointed out, Dr. Cutler, that the DSM was troubling to you, that we should codify that into law. And you pointed out, further, that your problem with that was that these were independent people setting up protocols that you then would have to follow because we have put it into law. Am I stating that correctly?

Mr. CUTLER. Dr. Norwood, I think I said something slightly different. First of all, with regard to the point about cost, obviously there is a spectrum of costs within health plans based on the kind of benefit package that an employer has purchased. So as Mr. Hackett knows, he purchased a benefit packet previously with a lower level of benefits. He has now decided to increase those benefits, so those costs have gone up.

So the cost, when you asked, what is the number for health plans, will vary based on the benefits that an employer has decided to purchase.

Mr. NORWOOD. And what you decide to cover of what they have decided to purchase.

Mr. CUTLER. Well, we cover what employers decide to purchase.

Mr. NORWOOD. No, no, you don't. Come on. We have been doing this too long. Now, that is not right. You determine what is medically necessary, and you cover that, which is why we have an external review from time to time to tell you you are wrong, you didn't cover that. And it is not new news that managed care's job is to manage costs. So you don't cover everything that is medically necessary, that you call a benefit. And I didn't mean to interrupt you, but I couldn't help it.

Go back to the—get me on the protocol—

Mr. CUTLER. The DSM—

Mr. NORWOOD. [continuing] what is your problem with the protocol?

Mr. CUTLER. Our issue with the DSM is not that it is developed by someone who is independent. Our issue with the DSM is that, first of all, it was never designed to be used as a catalog for payment. It was designed to be a catalog of mental diagnoses that could be used in a consistent way for a variety of other purposes, such as research, education, and so on. It was never designed for payment.

As Dr. Regier pointed out, there are already diagnoses or categories in the DSM about which there is controversy whether they are even mental conditions or not. So to mandate payment using that book, in our mind, is inappropriate.

There is no other similar book which is developed by other organizations, and the examples, as you know, would be the CPT, which the AMA develops, or the ICD-9 classification, where all of the entities in those compendia are mandated for coverage. Health plans don't cover every diagnosis in the ICD-9 code book, and don't cover every procedure in the CPT code book.

And the last point is, obviously, there is a built-in conflict of interest, because the DSM is a book which is developed by the people who would be paid for the services, so that one of the considerations going forward is, should they include items in the DSM in order to be paid for it.

Mr. NORWOOD. Well, I know my time is up. Could I have just 30 seconds, Mr. Chairman, to—

Mr. BILIRAKIS. Without objection, 30 seconds.

Mr. NORWOOD. The problem here is somebody develops your protocols. I don't know who that is, but someone sets those protocols, and they are, in effect, mandated by law under ERISA. Now, I think perhaps this DSM is something that wasn't set up for payment but might be very helpful in case you didn't get your protocols right, because it was developed by professionals in mental health.

I am not sure where your protocols come from, and don't forget about this. I will be back in a minute, Mr. Chairman.

Mr. BILIRAKIS. Mr. Green to inquire.

Mr. GREEN. Thank you, Mr. Chairman. In follow up to my colleague from Georgia, I can see the concern of some of our opposition on the fear of treatment for procedures that may not work.

I think it was just last week—I don't know if Mr. Regier mentioned it—but how successful arthroscopic surgery has been in treating patients, and yet it has been on the protocols for a number of years. And so even in the physical side of medicine, there is no guarantees.

Mr. Chairman, members, I think this is—I served 20 years in the Texas legislature, and it seemed like coming to Washington—it is interesting because so often in the States—States have to mandate benefits for coverage. And over the years that has been the complaint of the insurance industry. We have these laundry lists of mandated benefits that individual States do, so they come under Federal law, under ERISA, so they don't have to have these mandated benefits.

Times do change. My first term in the Texas legislature in 1973—the first mandated benefit I voted for was for insurance companies to carry newborn children on the insurance policies. It was not covered until after the legislature mandated benefits for newborns to be covered by group insurance.

Now, maybe if the insurance companies realize it, it will either be done by you working the system or the legislature, whether it is local, in our States, or on the Federal level, to provide this needed coverage. Again, in 1973, it was mandated benefits for newborns, which today is outrageous that it wasn't covered.

But maybe 20 years from now we will say, "I can't believe we didn't have really mandated benefits for mental health coverage, because there are so many illnesses that can be treated as well as physical."

Mr. Hackett, many opponents of the parity have trivialized mental disorders and have suggested that only the most severe so-called biologically based mental illnesses merit our concern. And I gather from your daughter's illness, and due to trauma, it might not be deemed biologically based. And would you help us under-

stand, in light of your daughter's symptoms, that a mental disorder can be very severe even if it is not biologically based?

Mr. HACKETT. Well, I think it is a very good question. If you had seen my daughter roll up into a ball and have her eyes roll backwards and start hyperventilating and have to go to emergency rooms, and lose her speech for 2 days at a time, you would be convinced that your mind controls a lot physiologically. And this was not a biological disorder; this was induced by the violent offense of a man.

And I just assure you that there are conditions you can't imagine that are out there that have nothing to do with serious biological disorders.

Mr. GREEN. And I think all of us on our committee want to congratulate you and thank you for your courage and your family's courage in willing to come forward, because so often, as you know, these illnesses are not something people want to talk about. But unless we talk about them, the policies will not change.

And so I thank you for that, and it is interesting when I go to my physical doctor and say I have a pain here, it may not be biological. He typically talks to me and observes my behavior, which is what a psychiatrist will do when they are doing the analysis of you for some type of mental illness. It is not always biological.

One of our frustrations—a sad experience we have with our Mental Health Parity Act of 1996—is that we in Congress left lots of loopholes in the law that insurers have exploited their enormous barriers to mental health care. The essence of your testimony, I understand, is not simply we should pass any other legislation and call it parity, but we should truly end insurance discrimination against people with mental disorders.

Is that what you are asking us today, and not just pass something that says parity but may leave lots of loopholes?

Mr. HACKETT. Yes, sir. Because that is where we are today. We have a lot of loopholes.

Mr. GREEN. Okay. Thank you.

Let me—one quick question, Dr. Regier. In Ms. Nystul's testimony, she mentioned a number of instances where patients requested a very expensive and not always appropriate course of treatment for their mental illness, and one case where a patient successfully persuaded the doctor to agree to admit the child in an in-patient setting at \$1,600 a day.

Are physicians normally swayed to make medically inappropriate or unnecessary diagnoses for treatments? Is it the role of physicians—again, with your experience as a psychiatrist, or even your knowledge of your—the physical side, are doctors really influenced, whether you are a psychiatrist or a neurosurgeon because—if a patient comes in and says, "I want something"?

Mr. REGIER. I think in this particular case, obviously, a physician was influenced. But I think what happens is that the checks and balances in the system work. And there is nothing in this bill that would preclude the type of management that worked in the system—in the particular examples that you provided.

Mr. GREEN. Again, I understand that even under current law physicians, physical physicians for lack of a better term, can make medically inappropriate or unnecessary diagnoses or treatments.

And that is not just limited to psychologists—or psychiatrists—excuse me.

Mr. REGIER. That is absolutely correct. And there probably will be a lot of questions about arthroscopic surgery in the near future, because of changes in medical technology and medical knowledge.

Mr. GREEN. Thank you, Mr. Chairman.

Mr. BILIRAKIS. Let us see who—Mr. Greenwood.

Mr. GREENWOOD. Thank you, Mr. Chairman.

Mr. Cutler, I am sorry that I wasn't here for your testimony. But I have been reading it, and you have a section you label "Concerns with Pending Legislation." And you say, "In light of the progress we have made in expanding access to mental health services, and the current environment of rising health care costs, it is important to seriously consider the substantive concerns we have with H.R. 4066."

But your bottom line seems to be in your conclusion, in which you say, "However, we respectfully oppose doing so"—that is, expanding access to mental health services—"through mandates." So would I be correct in assuming that your association's position is that you don't want any more mental health mandates from Congress at all?

Mr. CUTLER. Well, Mr. Greenwood, my first reference was to activities health plans have in place which have actively—

Mr. GREENWOOD. I understand all of that, but it just—I have very limited time, so just get right to my answer if you would. The question is: does your association oppose any Congressional mandates with regard to coverage of health care benefit—mental health benefits?

Mr. CUTLER. In general, we feel that these kinds of questions can best be worked out in the market between—

Mr. GREENWOOD. Very well. That gets me to my question. Because I prefer—I am Republican. I prefer to see the marketplace work in as many instances as possible. The difficulty that I have is if Mr. Hackett's daughter—if Mr. Hackett worked for a company that had a health plan, he would, as a consumer trying to impact the marketplace—first off, he has very little input into making the market work for him, because he may have the—be able to say to his employer, "I want to make sure I have a health plan. I want to work somewhere where there is health coverage."

But nobody walks in in a job interview and says, "Before I decide whether I want this job, could you explain to me the depth of your mental health coverage." And if that is not deep enough, walks away and says, "I will have to go find another job."

And no one—even if someone said, you know, "I want to work someplace that covers mental health benefits," probably that would harm his chances of getting the job to begin with. But nobody is going to anticipate the kind of horrific event that happened to Mr. Hackett's daughter.

So how does the market work? How do people—how do consumers impact the market and demand that their employers provide something that they never in their wildest imaginations would anticipate occurring to them? I mean, you could look—even if you were savvy enough to say, "I want to make sure I have mental health coverage that covers all my family," to get to the point

where you realize, oh, this is not covering—this is only covering biologically derived syndromes, and not environmentally derived syndromes, who demands that? How does the marketplace work in that regard?

Mr. CUTLER. Well, if I could expand a little bit about mandates, I think there are some alternative approaches. One is to have a mandate review panel which would evaluate both the economic and quality consequences of any mandate. So that is one alternative approach. With regard to the market, I would say—

Mr. GREENWOOD. Is that one that you would support in—what I am trying to get at here is I think you are probably right that the DSM, as a payment mechanism, is a little extreme, because it—as my memo here says, it includes things like jet lag and chaotic family life, and so forth, and it would be—if you covered everything in there, it may be cost prohibitive.

But the other extreme of severe and biologically derived also seems to be—seems, in fact, to be an extreme position. So will your association support a mandate that lies somewhere in between?

Mr. CUTLER. We are always happy to talk about alternatives that lie in between, yes.

Mr. GREENWOOD. Talk is cheap.

Mr. CUTLER. Well, of course, the devil is in the details, and it depends on—

Mr. GREENWOOD. If you rule out being able to support a mandate that we can work on that is cost effective and not overly burdensome and manageable, do you rule that out?

Mr. CUTLER. If all of those constraints are met, no, I wouldn't rule that out.

Mr. GREENWOOD. Very good. That is good to hear.

I yield back, Mr. Chairman.

Oh, actually, if I have got 30 seconds, I wanted to ask Mr. Hackett a question. You said in your testimony that it was not—that providing this coverage not only made moral sense but it made economic sense. Did you share with the committee—and if you have it—what this additional coverage costs you as an employer, and how it makes economic sense to do that?

Mr. HACKETT. I did. We estimate it will cost us another 1.3 percent of our medical costs in total.

Mr. GREENWOOD. Thank you.

Mr. BILIRAKIS. Thank you. Ms. Capps to inquire.

Ms. CAPPS. Thank you, Mr. Chairman. I want to thank you, all the panelists, for your expert testimony, and Mr. Hackett particularly for your courage, both in your personal story but also in the stake and stand that you have taken with your company. And you stand as a beacon, I think, for how we should proceed, even in this place.

As you know, employers are not required to provide health insurance coverage to their employees. They choose to if they want to attract good employees and take good care of the people who work for them. We heard from the National Association of Manufacturers who believe that since an employer's decision to provide health coverage is voluntary, the decision to provide mental health parity should be voluntary, which doesn't do much for the word "parity."

Do you have problems with this approach, and would you elaborate as to your personal experience with it?

Mr. TRAUTWEIN. Certainly.

Ms. CAPPS. Actually, I wanted to have Mr. Hackett talk about whether or not he believes what you said would follow, whether—I am sorry if I wasn't clear I have been directing it to you, Mr. Hackett. You have offered it, and so you have overcome this hurdle of the voluntary aspect of it.

Do you think it should be parity—in other words, if an employer chooses to cover health care, it should be both equally?

Mr. HACKETT. Very much so. And I—

Ms. CAPPS. And why?

Mr. HACKETT. The issues of economics about insurance coverage in general are ones that ought to remain in a different forum than I can address, because I don't know enough about the circumstances. But where companies can afford health insurance, I just don't see the difference. It escapes me. It escapes me why physiological disorders of one kind are treated differently than physiological disorders of another kind. It is that simple.

Ms. CAPPS. Okay. And the unfair benefit limitations on people who need treatment for mental illness, you would say it all falls in the same category. And so if you are going to have parity, you are going to have parity.

Mr. HACKETT. I do. But recognize, you know, I am—like all of us, we are human. I came upon this revelation approximately a year and a half ago. That is where we are at in society, and it is very directly related to Congressman Greenwood's comments, is that what do we really know about what we need to ask? Who is going to demand the service and the risk of telling their employer they have mental issues in their family?

The stigma, the inability to quantify what the cost will be, the inability to express it in a meaningful fashion is so imponderable for most of us that—you know, I sit at the top of a company. I didn't have a clue what our mental health benefits were. Not a clue.

Ms. CAPPS. Right. And so the stigma that exists in the society as a whole is compounded by the kind of layering on of that stigma that we give by the unequal treatment within health care coverage.

Mr. HACKETT. Absolutely.

Ms. CAPPS. And maybe that leads, then, to Dr. Regier, if you—if you could—you mentioned in your testimony that the lack of requirement for employers to provide mental health parity can cause an adverse selection problem in the insurance market. This was hinted at, and I think you might have a different take on this.

Mr. REGIER. Yes. The thing that happens with insurance is that they make money by insuring the healthiest populations.

Ms. CAPPS. Right.

Mr. REGIER. And in order to do that, you can offer a very poor mental health benefit, which, by definition, is going to repel people who might need that benefit.

Ms. CAPPS. Right.

Mr. REGIER. This was a similar kind of situation that occurred with HIPA. Insurance companies were able to make money by not insuring people who had previous existing health conditions. And

it was very obvious, certainly, to Mr. Trautwein's constituents, that they had to part company with Mr. Cutler's—or Dr. Cutler's constituents on the HIPA issue, because that was a mandate that people recognized that in order to have employees move from one company to another they couldn't move if their new company would not insure them because they had a preexisting health condition.

And, likewise, if you have a good mental health benefit in your company, you are stuck there if you have a mental health—or if your children have a mental health condition that requires treatment. So it is distorting the market. And, in fact, what happens—and this is the point that Dr. Frank made in his New England Journal article, that this is really an anticompetitive issue. It makes the market very inefficient.

So we all would prefer to have the marketplace work if there is—if there are the conditions that make that possible. Otherwise, some type of regulation is necessary to make it work.

Ms. CAPPS. So this hearing we are having today really does revert back to the HIPA debate.

Mr. REGIER. Very close. Absolutely.

Ms. CAPPS. Thank you. I yield back the balance of my time.

Mr. BILIRAKIS. Maybe you might yield that additional few seconds to me, if you would.

Ms. CAPPS. Please.

Mr. BILIRAKIS. Mr. Hackett, the bill at question refers to all categories of mental health conditions listed in the now famous DSM-IV that we have been talking about all along, or the more recent edition, etcetera, and it goes on to some qualifiers there.

Would the plan that your company has include all categories included in this book? Do you know?

Mr. HACKETT. It does include that in what we rely on. And I think businesses can rely on, with the properly crafted legislation, is the fact that we can still have managed programs within that overall umbrella where medical necessity becomes the real key. And I think Congressman Strickland or Brown mentioned that earlier—is we can't assume that just because it is described that that is actually impacting what you actually treat.

Mr. BILIRAKIS. Well, that is the qualifier—

Mr. HACKETT. It has to be diagnosed or—

Mr. BILIRAKIS. [continuing] that is the qualifier that is in the statute.

Mr. HACKETT. Right. And so I think the statute is properly drafted from my vantage point. I don't scrub through these things in the normal course of business in great detail. But our sense is that we are comfortable with the legislation crafted.

Mr. BILIRAKIS. All right. Thank you.

Let us see, Mr.—I have got to go to the committee, Marge, but I will give you an opportunity. Mr. Shadegg?

Mr. SHADEGG. Thank you, Mr. Chairman, and thank you for holding this hearing. I want to follow up with where Mr. Greenwood left off. I would suggest that the line of questioning he posed goes beyond this issue of mental health.

And, Dr. Cutler, I would like to ask you and Mr. Trautwein to kind of follow with me here. I think that Mr. Greenwood did a good job of pointing out that the average person going to work does not

have any bargaining power to say to their employer that on the day of hire that they want mental health coverage or that they want certain types of coverage to be included.

And he explained in his questioning that he was interested in a marketplace working, and I think, Dr. Cutler, you indicated that you would prefer that the marketplace function to fill this void and that if there was a demand for mental health coverage that is how we would solve this problem. Is that correct?

Mr. CUTLER. Yes.

Mr. SHADEGG. And I take it, Mr. Trautwein, you would agree with that.

Mr. TRAUTWEIN. Yes, I would.

Mr. SHADEGG. I guess I want to point out that I don't believe—and I challenge you on this point—that there is a market in health care right now. The reality is that people going to buy health care today don't have a chance to buy health care.

What they do is they get their health care through their employer because that is the only option the Tax Code gives you. And some of us—Dr. Norwood and I—2 years ago worked on this issue and said, “We really need a market for health care. We need to put people in a position where they have some choice.”

I would argue right now that because health care insurance is provided by your employer, you have no choice in health care whether it is mental health coverage or whether it is physical health coverage. If you go to work for a small employer, you get one plan. You are stuck with it. If it abuses you, as Dr. Norwood and I were concerned about when we were working on patient's rights legislation, you can't fire that plan because you didn't hire it.

If it doesn't treat you, you can't retaliate against it. And, unfortunately, under ERISA, if it injures you, you can't sue it and hold it accountable. I would like to ask the two of you—because I tend to agree with you. I think the market is the right place to solve this.

But when we proposed a solution, what we proposed was that businesses should be required to tell their employees that they would give their employee the amount of money they are currently spending on that employee's health care insurance and let the employee go buy the plan they wanted.

And that would enable those employees to go out and buy a plan that, for example, included mental health coverage. And yet I know that the American Association of Health Plans opposed that at the time. I think National Association of Manufacturers I met with in Los Angeles at the time—and I guess I see a dilemma here.

If you don't want mandated mental health care coverage—and I don't, I think benefit mandates have done great damage to the insurance industry—then are you willing to accept as an alternative freedom, so that employees of a business could go out and buy a policy that met their needs, including mental health coverage? Would you address that, Dr. Cutler?

Mr. CUTLER. Well, there is a market in the sense that employers make individual decisions about—

Mr. SHADEGG. Yes. Employers get to make the decision; I understand that. But I am talking about me as an employee. I have no choice.

Mr. CUTLER. And employers do, certainly, listen to their employees. We work with employers all the time, and the employers switch health plans or—

Mr. SHADEGG. Can you answer my question? Are you willing to at least look at the issue of allowing employees some degree of freedom to pick a plan that meets their needs, so long as it is not at an additional cost to the employer?

Mr. CUTLER. We are always willing to look at issues.

Mr. SHADEGG. Okay. Mr. Trautwein?

Mr. TRAUTWEIN. Congressman, the issue always is, where is the most affordable coverage?

Mr. SHADEGG. Right.

Mr. TRAUTWEIN. Can we afford to offer coverage? Can our workers afford to accept the coverage we offer? If there was a chance that you could maintain affordable coverage not only for the workers who want to stay inside the employer pool, but also the workers who want to opt out of that employer pool, then it would be worth looking at. But I think there are challenges in looking at that kind of opt-out scenario.

Mr. SHADEGG. I don't think there is any doubt that there are challenges. But, for example, you as—your members, members of NAM, don't offer as a condition of employment homeowner's insurance or auto insurance, do they?

Mr. TRAUTWEIN. That is correct.

Mr. SHADEGG. You let people go out and buy their own homeowner's insurance and their own auto insurance?

Mr. TRAUTWEIN. That is correct.

Mr. SHADEGG. But in health care insurance, I think largely because of the Tax Code, you offer them health care coverage.

Mr. TRAUTWEIN. Yes, sir. Ninety-seven percent of our members offer coverage.

Mr. SHADEGG. Offer health care coverage. Well, I applaud you for doing that, but I think it is important to understand the trap we are putting people in. Mr. Hackett, you tell a compelling story, and I am glad you are here as an advocate, and I certainly think that you are right. The devastation that can be caused by mental illness or by the kind of thing that happened to your daughter is incredible, and isn't often anticipated by us.

I guess my question of you is, you are in a lucky position because you were the CEO of the company. But I guess my question of you is: do you recognize that your employees who don't get to pick the health care plan that they want to use are not in as good a position, and that an alternative which at least gave them the choice of buying a plan with the coverage that they wanted would put them, say, in the same position you were able to be in as chairman of the company?

Mr. HACKETT. I think it is a very good point, and I don't know the ramifications of what you are speaking to. But I think it is an interesting thing to analyze.

Mr. SHADEGG. Well, we have many challenges in health care. There is no doubt about it. And getting from the system we have right now to a system where individuals at least had choice—and I would agree with Mr. Trautwein.

Many employees may stay with their employer's plan, but giving them that choice would at least not have them be trapped in what I see the current system, where they can't pick their health plan because their employer picks it, they can't pick their doctor, they can't fire their health plan when it abuses them, and, unfortunately, under ERISA, as Dr. Norwood and I have worked on, they can't even hold it accountable when it abuses them.

So with that, I yield back the balance of my time.

Mr. BILIRAKIS. That always strikes me as funny. "I yield back the balance of my time" when it has already expired.

Let us see. Mr. Strickland.

Mr. STRICKLAND. Thank you, Mr. Chairman. Mr. Chairman, you urged us not to be stubborn, but the fact is I look out there and I see Mrs. Domenici, and I see Representative Roukema over there, individuals who have worked for years to achieve parity. I think we must be stubborn.

We are on the verge of achieving a victory for the American people. We have the President saying this is the right thing to do, and I believe the opponents of true parity are going to try to get something that is called parity but is so weakened that it is not going to provide the kind of coverage that the American people deserve.

Dr. Cutler, has your association ever supported any kind of mandate for any purpose?

Mr. CUTLER. Yes, we have supported mandates for external review.

Mr. STRICKLAND. For external review. Have you ever supported a mandate for the coverage of an illness, physical—any kind of medical condition that would—that you or your plans would be required to cover?

Mr. CUTLER. Not that I know of.

Mr. STRICKLAND. So is it fair to say that you are opposed to mandates?

Mr. CUTLER. As I said to the previous question, in general, we—

Mr. STRICKLAND. You are willing to talk about it. I have a question here. You say in your testimony that 96 percent of plans reported covering mental health substance abuse services, and I want to get to Dr. Norwood's earlier interaction with you.

My question to you is: how many of that 96 percent offer parity, in terms of co-payments, deductibles, coinsurance, limitations on the frequency of treatment, number of visits, days covered, and the like?

Mr. CUTLER. I am sure there is a range across all of the health plans. We didn't ask that question specifically, and—

Mr. STRICKLAND. Don't you think that is a relevant question to ask if you are going to come here and tell us that 96 percent of the plans offer coverage? Because, as Dr. Norwood said, and as you said, sir, the devil is in the details. And unless we know those things, we have no idea if there is any true parity being offered out there at all. Isn't that true?

Mr. CUTLER. It is true that what we know is there is a lot of diversity among health plans today.

Mr. STRICKLAND. For those of you who have problems with the DSM-III or DSM-IV being used—you can tell how long it has been

since I have been in a treatment situation. I just want to share some information here. Those who are, I believe, misrepresenting the DSM are confusing the diagnosis of mental disorders with every health plan's right to determine what treatments are medically necessary according to their own criteria. That is explicitly protected in the bill.

The bills require for services under a DSM listed mental condition only—only when that service is included as a part of an authorized treatment plan, when that plan is in accord with standard protocols, when the service meet the plan or the insurer's medically necessary criteria, and the services meet such managed care practices as the plan employs.

Concurrent and retrospective utilization review is there. Utilization management practices are possible. Preauthorization—the application of medical necessity, the appropriateness criteria. It is all there.

So when you use these—what I think are strawmen arguments about jet lag, I think it is just simply disingenuous. And I just wanted to share that.

Ms. Nexler—

Ms. NYSTUL. Nystul.

Mr. STRICKLAND. —Nystul, you are a psychiatric nurse. You know, the people that I respect most, as professionals, are psychiatric nurses. But I can tell you, I am offended by your reference to the unhappy well. We have large numbers of young people in this country committing suicide, and their suicidal behavior often times is in no way connected to what is a diagnosable brain disorder as such.

You know, you talk about people who are kept in the hospital inappropriately. I can sit here and talk to you about suicides of young people who were put out of hospitals inappropriately. I can talk to you about a young man that the last time I saw was in a restaurant, and he had both ankles broken because he had become fearful of living alone, thought someone was coming in the door, jumped out a window and broke all of his legs.

He died eventually, because he was in the hospital, they thought that they should not keep him longer. They wanted to get him in a group home. No group home was available, so they arranged for him to go to a hotel room, and he hanged himself in the bathroom. I think there is a greater number of people who are being denied treatment turned out inappropriately, certainly, than are being treated as an in-patient when they don't need to be there.

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

Ms. NYSTUL. If I may address Mr. Strickland's comment.

Mr. BILIRAKIS. Very briefly.

Ms. NYSTUL. He is taking out of context what I am saying in regards to the unhappy well. Certainly, the people that you are describing are people who have significant psychiatric issues, symptoms, and functional impairments. My reference to the unhappy well would be people that are suffering from spiritual problems, gambling addictions, occupational problems, partner relationship problems, those kind of issues—life stressors that we all face in our daily life.

And, sir, if I may also read to you just briefly a cautionary statement that is in the DSM-IV. "The purpose of the DSM-IV is to provide clear descriptions of diagnostic categories in order to enable clinicians and investigators to diagnose, communicate about, study, and treat people with various mental disorders. It is to be understood that inclusion here, for clinical and research purposes, of a diagnostic category such as pathological gambling or pedophilia, does not imply that the condition meets legal or other non-medical criteria for what constitutes mental disease, mental disorder, or mental disability."

And I would argue—

Mr. STRICKLAND. Mr. Chairman, if I could just respond to that. I think what I have read to you concerning the protections in terms of the use of the DM-III certainly would handle those objections that you bring out here.

Thank you.

Mr. BILIRAKIS. Ms. Eshoo to inquire.

Ms. ESHOO. Thank you, Mr. Chairman, for having this hearing. It is an incredibly important issue for the people of our country. And I would also like to salute Congresswoman Marge Roukema.

For those of you that are at the table, maybe some of you don't know, she has announced that she will not be returning to the Congress, and I think as the—I believe the highest ranking woman in the House of Representatives, that the quality of her work is certainly embedded in this legislation. It would be not only a great tribute to her as a legislator with conscience, but a tribute to the people of our country, if we pass this legislation.

So I want to thank her for her work, not only in this bill but for the work that she has done in the Congress. She has done well by doing good for the American people, and I couldn't mean that more.

To all of our witnesses, thank you for being here today. I would like to ask those who I have had the benefit of listening to your testimony that are opposed to the legislation. Dr. Cutler, Mr. Trautwein, and Ms. Nystul, have any of you, yes or no, had any mental health issues in either your immediate family or your extended family? Dr. Cutler?

Mr. CUTLER. Yes.

Ms. ESHOO. You have. Ms. Nystul?

Ms. NYSTUL. Yes.

Ms. ESHOO. You have. Were they covered?

Mr. CUTLER. Yes.

Mr. TRAUTWEIN. Yes.

Ms. NYSTUL. Yes.

Ms. ESHOO. Were they termed biological?

Mr. CUTLER. No.

Ms. ESHOO. They weren't. What was it?

Mr. CUTLER. It was—

Ms. ESHOO. How did they get their coverage?

Mr. CUTLER. I am sorry?

Ms. ESHOO. What was it that they were covered for?

Mr. CUTLER. It was a significant disorder, but it wasn't—if you are talking about biological, is it on the short list of biological coverage, in some States, I would say no.

Mr. TRAUTWEIN. Mine was also covered. My situation in my family's case, it was not a biological condition but it was fully covered.

Ms. ESHOO. Ms. Nystul?

Ms. NYSTUL. The condition that my family member has was covered.

Ms. ESHOO. But what was it?

Ms. NYSTUL. For depression.

Ms. ESHOO. For depression. And that was considered biological? That is considered biological?

Ms. NYSTUL. It can be, yes. But in this case, there were certainly significant functional impairments and symptoms to support the need for care. And I believe that is what care was—

Ms. ESHOO. So was it considered an extraordinary policy that covered this, or was it standard in terms of biological?

Ms. NYSTUL. As far as I know, it was a standard plan. And, again, no diagnosis—

Ms. ESHOO. No. Just let us stick to that because I only have 5 minutes.

I would like to ask you, Ms. Nystul, in your nursing career, did you ever serve at a local level, say, at a—in a county health system?

Ms. NYSTUL. Yes. Actually, I did community support for the chronically mentally ill.

Ms. ESHOO. Is there anything that stands out relative to the disparity of coverage from those days that you did that compared to what you are doing now with—is it Wausau Insurance?

Ms. NYSTUL. Wausau Benefits.

Ms. ESHOO. Benefits. Well, it is an insurance. Yes, benefits come from insurance policies. Is there anything that stands out in your—from that part of your career?

Ms. NYSTUL. I think what I see differently in this job is that there are requests for—

Ms. ESHOO. Well, I understand that you have to see things differently in the job. Otherwise, you wouldn't be, you know—but your experience as a nurse on the ground in the community, is there anything that stands out from that experience to you?

Ms. NYSTUL. My experience in this job is that there are requests for treatment at high levels of care for low impact results. Again, often for containment and for convenience.

Ms. ESHOO. Well, you know what, Ms. Nystul. I have to tell you that a lot of the terminology you use—and I am not a nurse, but I have been around health care for a long time. I really don't know what it means. It sounds like what you get when you dial the 1-800 number to find out if you are covered. And it is—I don't understand it, but I will reread your testimony.

Mr. Trautwein, can you describe the average mental health benefit of an NAM member? Does it deal simply with those—well, it is not simply, but, I mean, it is—with the biological coverage? Are there any of your members that go beyond that?

Mr. TRAUTWEIN. I think most of our members who provide coverage go beyond that, and that was really the essence of the 1996 law, which allowed employers to determine—

Ms. ESHOO. You supported the 1996 law, the NAM?

Mr. TRAUTWEIN. Actually, no, we had—

Ms. ESHOO. You didn't.

Mr. TRAUTWEIN. [continuing] concerns on cost of—

Ms. ESHOO. These are ongoing concerns. Is there anyone that opposes the bill on the panel whose mind has been somewhat changed by the testimony of Mr. Hackett today?

Mr. BILIRAKIS. Brief responses. Time has expired.

Mr. TRAUTWEIN. From our standpoint, we are proud of our members like—

Ms. ESHOO. No, no, no, no, no. Just yes or no. You can just say yes or no.

Mr. TRAUTWEIN. No.

Ms. ESHOO. No. Dr. Cutler?

Mr. CUTLER. I think Mr. Hackett's case illustrates that there are alternatives already in place for employers.

Ms. ESHOO. That is not what he said.

Mr. CUTLER. Well, what he—

Ms. ESHOO. He said that he changed—as I understand it, they changed the coverage.

Mr. CUTLER. He did, and—

Ms. ESHOO. No, don't—just—you know, I will tell you, answer the question yes or no, because your evasions really give the answer. So for the record, even though it may be uncomfortable for you, which I understand—it must be because I don't think the stand is one that the American people that are tuned in to today, that you are for disparity.

We are trying to get things—move things into the equal column. And so this is all about mental health parity, with the physical health problems that people have today. And I think that you are testifying for disparity. But is there anything that he said that changes your mind?

Mr. BILIRAKIS. The gentlelady's time is—

Ms. ESHOO. Yes or no.

Mr. BILIRAKIS. [continuing] a couple minutes over.

Mr. CUTLER. We are certainly not for disparity, and we have problems, as we noted in the testimony, with the specific bill as—

Ms. ESHOO. I think you have given your answer.

Thank you, Mr. Chairman.

Mr. BILIRAKIS. The gentlelady from New Jersey, who is the author, as we already know, of the piece of legislation in question, has sat through the entire thing. Marge, I did mention that you were here, and if you had come back immediately after the vote, I was going to give you an opportunity for an opening statement.

But in any case, please take a couple of minutes, if you have anything you want to say, or inquire, or whatever the case may be.

Mrs. ROUKEMA. All right. Thank you. No, I wouldn't have taken time on the opening statements. I was very interested in hearing the panelists. I want to say that a lot of good points have been made here, and I guess I just want to reinforce them.

This parity debate is not an abstraction. It is about patients, and we are talking about discrimination. That is the point I wanted to make. This has also been pointed out by Ms. Capps and others here, and certainly even Charlie Norwood, who has said, "Are we

going to continue to treat mental health patients as second-class citizens?”

We are talking about the stigma of mental health. And I don't know, I just come here thinking, are we living in the last century, or are we living in the 1930's and 1940's? It seems to me that all of this should be just assumed, and the question is: how do we put this bill together, so that there is no continued stigma or discrimination against mental health patients?

So I do thank the panelists that have supported this. As for the others, I won't go into all of the details, but I will simply say that I don't understand Ms. Nystul. I don't understand her—particularly with her psychiatric background. You spoke about it as though anybody just called up, any patient's parents just called up, or family member just called up, and they would be entitled to services. You didn't at all acknowledge the requirements for medical referencing, and you totally misrepresented what the bill does. And I don't understand how you could have done that.

But the point is that I just hope that this Congress—and from all the positive statements I have heard on both sides of the panel here from Republicans and Democrats—we will end this discrimination and get this long overdue bill passed this year. And I do thank the chairman profusely.

Mr. BILIRAKIS. And the Chair thanks the gentlelady.

Mr. NORWOOD. Mr. Chairman, I ask unanimous consent to have just a couple of minutes of additional questions that I think will be helpful.

Mr. BILIRAKIS. All right. I am not inclined to go through a second round. But if unanimous consent has been asked for an additional 2 minutes, without objection.

Mr. NORWOOD. Okay. Guys, we are going to have to go fast. First of all, I agree with Mr. Strickland—I want it on the record—that people are being denied care and being kicked out of hospitals inappropriately. I also agree, though, with Ms. Nystul that there is some miscare, there are some things going on that basically shouldn't happen.

I agree with Mr. Strickland that probably the denial of care goes on a great deal more than miscare or people that are trying to game the system. But it is important to point out this system lends itself to that, because when you say a patient shouldn't be treated, or the wrong treatment is occurring, it is always done 3,000 miles away on the phone and never having examined the patient. That is the problem when you say people shouldn't be treated.

Second, the marketplace—don't hide behind the marketplace. The marketplace should be a sick patient and a willing provider of health care. But it is not. The marketplace is between the insurance company and between the employer.

I think, Dr. Cutter, you would agree with me that a patient who is denied care who doesn't believe that care—or believes that care should have been treated, actually can never see the contract that was negotiated between the insurance company and the employer. They never really can know.

Now, that is not a marketplace that I understand anything about. So don't hide behind the marketplace here. I would love for the market to work, but it is between a sick patient and a doctor.

Second, and last, Mr. Chairman—Mr. Trautwein, I have a couple of questions for you, which points out the problem of all of this, why we can't find some middle ground. Do you believe that mental illness exists?

Mr. TRAUTWEIN. I do.

Mr. NORWOOD. So if I had a copy up here of an e-mail you sent out to the mental health parity opponents, people who want to kill this bill, directing them to a website that argues that mental illness does not exist, and that the profession is a farce, you would tell me that probably this e-mail has been maliciously altered.

But that is exactly what you did. You encouraged people who want to kill this bill to read a website that says, hey, nobody is sick anyway. Why in the dickens do we want to pass this bill? I have your e-mail, so I am certain you wouldn't deny it.

Mr. TRAUTWEIN. That is an accurate representation in the way of my usual fashion of pointing folks to different sources of information.

Mr. NORWOOD. Well, is that NAM's position, that mental illness doesn't exist and this profession is a farce?

Mr. TRAUTWEIN. No. And I believe the particular e-mail reference, if you would read further along that paragraph, it urges readers to evaluate for themselves the information on that website.

Mr. NORWOOD. Well, I encourage everybody in here to read the website, because you can't miss what they are trying to say on the website, which is mental illness doesn't exist, and the profession is a farce. And for you, head of NAM, lobbying effort to kill this bill, to send that out to people, is a farce, in my opinion.

Now, I have a list of 10 State studies on mental health parity that shows that there is a nominal cost impact. I presume they are all wrong. CBO scores this bill at less than 1 percent. Now, I don't like CBO any better than the rest of you, but they—are they wrong, too? Is .9 percent really the cost here?

Mr. TRAUTWEIN. I think the point of the July 12 CBO memo, it indicated that the .9 percent in premium increase is accurate, but it is a diluted definition. It is a diluted estimate. When you strain out the dilution, and look only at the affected firms, there is forecasting a 30 to 70 percent increase in—

Mr. NORWOOD. Which is the .9.

Mr. TRAUTWEIN. [continuing] cost concern.

Mr. NORWOOD. Well, you have to assume CBO either wants to give us the wrong information, or they don't know what they are doing, or you know a heck of a lot more about it than they do. It is already explained how the 30 and 70 percent misleads this committee into thinking that it is more than .9 percent.

Mr. Chairman, I know my time is up.

Mr. BILIRAKIS. God knows your time is up.

Mr. Wynn to inquire.

Mr. WYNN. Thank you, Mr. Chairman. Thank you for calling the hearing.

Dr. Cutler, I think it is fair to say that you disagree with the Bush administration's position on providing mental health parity. Is that correct?

Mr. CUTLER. I disagree with this bill as it is currently written.

Mr. WYNN. Do you agree with the Bush administration's position on parity?

Mr. CUTLER. I understand that what President Bush suggested was to increase coverage for mental health and not this bill in particular.

Mr. WYNN. Do you agree with that? Do you agree we ought to increase the coverage?

Mr. CUTLER. Again, I will go back to what I said before with regard to mandates, that we prefer that there not be mandates, but—

Mr. WYNN. Okay. Well, thank you.

Mr. STRICKLAND. Would my friend yield?

Mr. WYNN. Yes, I would be happy to yield.

Mr. STRICKLAND. Dr. Cutler, I just think we want a simple answer. The President has said—and he said in Senator Domenici's presence—that he was in favor of parity. And the question is: do you disagree with the President?

Mr. CUTLER. Again, I have answered this question before. I—

Mr. WYNN. Reclaiming my time, you know, I always have the view that sometimes a witness' failure to respond to a question is very telling, and I am not going to belabor it. I think it is pretty obvious where you stand on that. And if you choose not to answer the question directly, you have that right. Let me move on.

Dr. Cutler, I believe you said that 96 percent of your members offer substance abuse coverage of some sort. Is that correct?

Mr. CUTLER. Mental health and substance abuse.

Mr. WYNN. Mental health and substance abuse. Is there a difference between the deductible for mental health versus the deductible for—I guess it is the other kinds of health insurance?

Mr. CUTLER. Obviously, there is a variety of health plans. But in some instances, yes.

Mr. WYNN. On average, is the deductible greater for mental health?

Mr. CUTLER. I don't know on average, but in many cases it is greater, yes.

Mr. WYNN. Okay. Thank you. Now, you seem to be saying that your biggest objection comes down to cost. Is that correct?

Mr. CUTLER. There are cost issues, certainly, yes.

Mr. WYNN. Okay. How do you explain that Magellan Health Services, the Nation's largest managed behavioral health care organization, covers nearly 70 million individuals, reported that they have yet to see a premium cost of more than 1 percent as a result of implementing State mental health parity requirements?

Mr. CUTLER. I know Magellan has said that, but one of the issues that Magellan didn't talk about is, in this particular bill, the construction of how medical management would work is problematic. It is not—

Mr. WYNN. What does that mean?

Mr. CUTLER. What that means is Magellan controls costs by various medical management techniques, the kinds of things that Ms. Nystul was talking about before. This bill says that you can only use those kinds of techniques if they are exactly the same as they are for medical and surgical illnesses.

The difficulty is that medical and surgical illnesses are different. There are clear milestones. There are clear timelines. There are clear outcome measures for medical and surgical illnesses than there are for mental health.

So it is likely that the kinds of interactions and interventions that would be necessary to keep the care affordable—

Mr. WYNN. If I could just interject something, because Mrs. Roukema is here, and I wanted to ask if she would comment on that just for accuracy's sake. Is that true, Mrs. Roukema, that you have to use the same procedures that he is describing?

Mrs. ROUKEMA. I am sorry. I didn't get to hear what he was saying about procedures.

Mr. WYNN. I am sorry. Maybe I cut him off too soon.

Mrs. ROUKEMA. No. Well, the procedure should be the way other medical procedures are, and have the medical professionals confer with the patients and with those who handle the program. But the question is, again, fundamentally, why are you discriminating against mental health patients as opposed to orthopaedic patients?

There is a profession here, and there are clear definitions of what is mental illness and what is not, and we are not talking about substance abuse. That is not included in this legislation.

But I think you have misrepresented—I am sorry. Go ahead.

Mr. WYNN. No.

Mrs. ROUKEMA. I will defer back to you.

Mr. WYNN. I am actually just trying to get back to the fundamental question of Magellan's findings, which was that the premium increase was no more than 1 percent as a result of implementing State mental health parity requirements. They were State requirements. Do you deny that that was the case? Do you contradict—are you going to contradict Magellan's findings? Or what is your response?

Because you are premising your argument against this bill primarily on cost, and there doesn't seem to be—particularly in light of other comments that we have heard here from Mr. Norwood—that there is a significant cost increase associated with this.

Mr. CUTLER. Well, there are two issues. I don't contradict what Magellan said from its own experience. But there is experience elsewhere—the California Public Employment Retiree System has projected a cost increase of 3.3 percent for their PPOs, for example. South Carolina, where there is a mandate, had a premium increase of 3.2 percent. And the Substance Abuse and Mental Health Services Association of the Federal Government predicted a 3.4 percent premium increase.

Mr. WYNN. Okay. Now, with those premium increases—

Mr. BILIRAKIS. Please finish up. Go ahead.

Mr. WYNN. Could I just finish one question, Mr. Chairman?

Mr. BILIRAKIS. Yes.

Mr. WYNN. Thank you. Now, where they have these increases, I think the maximum you cited was a 3 percent increase when you consider that the Federal Employees Health Benefit Plan increased 13 percent, that doesn't seem so great.

But my point is: isn't that a total pass-through to the customer, so it is the customer's option to pay that premium for that benefit?

So it is really not a burden on the company in terms of cost, because the costs are passed through. Isn't that true?

Mr. CUTLER. That is true. But what we are concerned about is whether employers will continue to offer coverage if the premiums continue to go up at the rate at which they are currently increasing. And this would add an additional 3 percent. So our—

Mr. WYNN. Well, it might add 3 percent or it might add 1 percent.

And I will relinquish the balance of my time, or the balance of time I don't have.

Mr. BILIRAKIS. Anyway, what I read from the panelists is that there is a willingness to try to work on this subject. I may be reading that incorrectly, but I see that. I mean, I look at it optimistically.

In any case, the hearing is now ended. We do ask that you be available to answer written questions—the one that I posed, which is a very complex one, but also additional written questions that will be afforded to you by the staffs. And without objection, the record will remain open for any extraneous material.

It has been a good hearing, and, of course, you have made it so. Again, getting back to my prior statement, that is, do we want progress, if you will, or some additional coverage—if I can put it that way—for mental health parity? Or do we want, basically, all or nothing? And if we can get away from the all or nothing, I really think it is something that we can work out.

Now, someone can raise the question, well, mental health parity is black and white. Mental health parity—well, I suppose that is one way of looking at it.

But anyhow, thank you so very much. Whatever progress we may have as far as this area is concerned will be in no small measure attributable to your testimony. Thank you very much.

The hearing is adjourned.

[Whereupon, at 12:38 p.m., the subcommittee was adjourned.]

[Additional material submitted for the record follows:]

RESPONSES FOR THE RECORD OF KAY NYSTUL, PSYCHIATRIC REGISTERED NURSE, CERTIFIED CASE MANAGER, CLINICAL MANAGEMENT COORDINATOR, WAUSAU BENEFITS, INC.

QUESTIONS REGARDING DSM IV

Dr. Regier's testimony states that the controversy over whether to incorporate DSM IV into statutory law is a red herring. Many states that have looked at this issue have chosen to limit any parity requirements to "biologically-based" or "serious" mental illness as they define them. Those states do not require use of DSM IV criteria. Dr. Regier is asking Congress to incorporate an 800-page manual by reference in a statute. That would give that document legal standing in many ways and with many potential consequences. In asking the Subcommittee to take such a step, we need to fully understand and resolve all of the attendant controversies. Below are some of the relevant questions.

Question 1. It would appear from Dr. Regier's testimony that some believe if a group health plan offers any mental health benefits, H.R. 4066 requires the plan to offer coverage for a comprehensive list of conditions set out in DSM IV. This reading is stated in the Views of the Senate Committee on Health Education Labor and Pensions on S. 543, the Senate analogue to H.R. 4066. This reading, however, is troubling and not supported by the text. Nothing in H.R. 4066 appears to require a plan to cover any category of mental health benefits, much less the long list of "conditions" in DSM IV. H.R. 4066 defines mental health benefits, in part, as:

benefits with respect to services, as defined under the terms and conditions of the plan or coverage (as the case may be), for all categories of mental health conditions listed in [DSM IV]

The reference to DSM IV helps define what is a mental health benefit. Nowhere in the text, however, does the bill state that group health plans must provide comprehensive mental health benefits or provide benefits as broad as the conditions listed in DSM IV. The Subcommittee's reading is that if a plan provides any given mental health benefit the parity rules of the bill apply to that category of benefits. Nothing in the parity rule in proposed section 712(a) states that a plan must provide coverage for all of the conditions listed in DSM IV. Indeed, the savings clause language in proposed 712(b)(1) and (3) state that no mental health benefits are ever required at all; and that no specific services are ever required, except to the extent required by the parity rule itself. It is difficult to see how the parity rule would require any category under DSM IV.

Are you arguing that H.R. 4066 requires mental health plans to provide coverage for all conditions in DSM IV? If so, please explain your reading and your reading of the savings clause language, with specific references to language in the bill. For those that do not support such a position what clarifications are necessary to assure the appropriate policy from your prospective?

Response: I cannot support a policy that diverts health care dollars away from treatment of truly ill individuals to fund questionable treatment plans for individuals with behavioral problems that call for more limited treatment.

Making a distinction between a "mental illness" and mental conditions is necessary. Mental illness should be defined to mean affirmatively diagnosed serious and/or biologically based mental illnesses as defined in the DSM IV-TR, or the most recent edition if different than the Fourth Edition.

Question 2. Is there any precedent in current federal statutes that says, in effect, that if you provide ANY given service, such as mental health services that you must cover ALL conditions listed in a manual prepared by one group of health care professionals? For example, is there a similar federal law that says that if you provide coverage for some pharmaceuticals or medical procedures that you must now cover ALL pharmaceuticals or medical procedures listed in a manual prepared by a trade association of pharmacists or medical care providers?

Response: There is no precedent of which I am aware stating that if you provide any given service that you must cover all conditions listed in a manual prepared by a group of health care professionals. The DSM-IV TR is not unlike the ICD-9-Code book that classifies diagnosis or a PDR (physician desk reference) which classifies drugs. These references are tools for clinicians—not coverage mandates that dictate what services must be covered under a benefit plan.

Question 3. Dr. Regier's testimony addresses the categories of DSM IV referred to as conditions for clinical focus. These include such items as: sibling relational problem; occupational problem; academic problem; and religious or spiritual problem. Some of these terms would apparently apply even if they are not termed "mental disorders" under the manual. For example, V. 62.2 "Occupational Problem" states that the condition need not be a mental disorder. The manual further states "[e]xamples include job dissatisfaction and uncertainty about career problems. The manual provides an example of V. 62.3 "Academic Problem" as "a pattern of failing grades or significant underachievement in a person with adequate intellectual capacity in the absence of a Learning or Communication Disorder or any other mental disorder that would account for this problem." Does H.R. 4066 incorporate these conditions even where the manual states that they are conditions and not mental disorders?

Response: Yes, H.R. 4066 incorporates all conditions, even when the manual states they are conditions and not mental disorders. The bill makes no distinction between conditions and disorders in the bill. There is reference to "mental illness" in 712(a) of the bill, however, the term "mental illness" is left undefined.

Inclusion of V-codes in the DSM-IV-TR does not imply that the condition meets legal or other nonmedical criteria that constitutes mental illness or disease, or true mental disorder as outlined in the DSM's cautionary statement. V-codes are used to categorize conditions. These conditions are not comparable to a serious mental illness in which there is significant functional impairment and symptoms. They are simply problems. By including these conditions/problems, H.R. 4066 clearly puts at risk already limited treatment dollars, and in the process, takes money away from the treatment of the psychiatric illness it proposes to benefit.

Question 4. DSM IV category 315.1 is called Mathematics disorder. One of the diagnostic criteria is that mathematical ability is substantially below that expected for the person's age and intelligence. Another criterion is that it significantly interferes

with academic achievement. Are you saying employers must have insurance to cover diagnosis and treatment for Mathematics disorder?

Response: If the health plan provides mental health coverage, it apparently must provide coverage for Mathematics Disorder. Mathematics Disorder is classified in the DSM-IV-TR as a learning disorder. The public school system is already required to finance and provide children the education and tools needed to remedy any such learning problems. A health plan would be just another source of funding for that particular problem in addition to funding serious mental illnesses that often do not have other resources available for support.

Question 5. The DSM IV manual also states criteria to describe mild, moderate, and severe disorders. Mild disorders or example are defined as “[f]ew if any symptoms in excess of those required to make the diagnosis are present, and symptoms result in no more than minor impairment in social or occupational functioning.”

Dr. Regier’s testimony mentions the term “clinically significant impairment.” Does the universe of clinically significant impairments include mild disorders and conditions? What specific evidence would be required to describe a mild version of the following conditions in DSM IV:

Parent-Child Relational Problem V61.20
 Sibling Relational Problem V61.8
 Relational Problem Not Otherwise Specified V62.81
 Noncompliance with Treatment V15.81
 Adult Antisocial Behavior V71.01
 Child or Adolescent Antisocial Behavior V71.02
 Borderline Intellectual Functioning V62.89
 Age-related Cognitive Decline 780.9
 Bereavement V62.82
 Academic Problem V62.3
 Occupational Problem V62.2
 Identify Problem 313.82
 Religious or Spiritual Problem V62.89
 Acculturation Problem V62.4
 Phase of Life Problem V62.89

Are all of these conditions to be considered “clinically significant impairments”? If so, how is clinical significance measured?

Also, where in DSM IV is there a discussion of the specific medical evidence supporting each category?

How would you propose to determine what meets a parity standard between these mental health conditions and medical conditions?

Response: As mentioned in my testimony, you cannot measure clinically significant impairments with the above V-coded conditions/problems because there is no significant psychiatric impairment. It would appear that the universe of clinically significant impairments in H.R. 4066 would include mild disorders and conditions. Trying to compare medical illness to psychiatric illness as the house bill proposes is simply not possible. There is no standard that can compare the two. In the medical arena, measurement is objective as compared to the psychiatric arena which is highly subjective, often without basis for true scientific measurement.

Question 6. Do you believe that the diagnostic criteria in DSM IV should have legal standing by virtue of its reference in H.R. 4066, and if so, for what legal purpose or purposes?

Response: The DSM-IV-TR was never intended to be a guide for benefit coverage. It is intended to be used as a physician’s reference. This manual should not have legal standing by virtue of reference in H.R. 4066. It is unreasonable to create a benefit entitlement by reference to this professional reference guide.

Question 7. Could you support language that says that the diagnosis of a disorder and its treatment must be well established and supported by substantial scientific evidence?

Response: Yes. It is also important to distinguish between those conditions that are serious mental illnesses and those conditions that are not. Parity for all conditions in the DSM-IV is an unwise allocation of limited health care dollars.

Question 8. Dr. Regier’s testimony says that DSM IV has “precise” criteria for diagnoses. Can you please explain category 313.81 called “oppositional defiant disorder”? The diagnostic criteria require four among the following:

- often loses temper
- often argues with adults
- often actively defies or refuses to comply with adults request or rules
- often deliberately annoys people
- often blames others for his or her mistakes or behavior

- is often touchy or easily annoyed by others
- is often angry and resentful
- is often spiteful or vindictive

As Dr. Regier notes criteria also requires “clinically significant” impairment. This all seems pretty subjective. Other than the phrase “clinically significant” a lot of teenagers may meet these other criteria for periods of time. This puts a lot of emphasis on the phrase “clinically significant.” Recognizing that the DSM discusses clinical significance and states that “assessing whether this criterion is met... is an inherently difficult clinical judgment”, is it realistic to establish any objective standards for purposes of determining what is not clinically significant?

If there is a disagreement with the group health plan over an individual case, does the beneficiary or provider have the burden to show a clinically significant impairment?

Response: The evidence for determining a clinically significant impairment is the functional impairment and the symptoms that the person is experiencing as determined and reported by the provider. Where no functional impairments and/or symptoms exist, it will become a matter of what is significant for any particular condition. Plans will have great difficulty determining what is significant with respect to parent-child relational problems, spiritual problems, learning disorders, etc.

The burden to disprove significance or medical appropriateness, as H.R. 4066 would have it, will fall squarely on the health plan. This kind of situation invites litigation, which is unacceptable in today’s cost-burdened environment and will be even more so once a Patient Bill of Rights is approved.

The unintended consequence of all this is that limited treatment dollars will be spent needlessly on low-impact conditions.

Question 9. Is it correct that the DSM IV is essentially based on a 1994 classification scheme that may require revisions now? If we incorporate DSM IV in a statute, how do we propose plans keep up with advances in the classification and diagnostic system? Do you believe it is appropriate to delegate this authority to a nongovernmental body? Since members of the American Psychiatric Association would appear to benefit financially from broad definitions of coverage, please comment on whether you believe such a delegation would represent a conflict of interest. If not, why not?

Response: The DSM-IV-TR was last revised in June of 2000, and reflects a consensus of current formulations in the evolving knowledge base of the psychiatric field. It will continue to change. The DSM was never intended to serve as a benefit mandate. Delegating this authority to a nongovernmental body is most certainly not appropriate and absolutely represents a conflict of interest.

QUESTIONS REGARDING THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

Question 10. Dr. Regier’s testimony correctly notes the Office of Personnel Management has issued guidance which refers to DSM IV as an objective for health plans contracting with the Federal Employee Health Benefits Program. An initial review of several health insurance plans under FEHBP showed no reference to DSM IV in the plans available in 2002. Several of the actual plans had a definition of mental health benefits that referred to certain categories in the International Classification of Diseases (ICD). Are you aware of plans in FEHBP that specify DSM IV? What is your opinion of the plans that specified certain categories of ICD? Please list the differences in the DSM IV categories and the following language:

“Conditions and diseases listed in the most recent edition of the [ICD] as psychoses, neurotic disorders, or personality disorders; other nonpsychotic mental disorders listed in the ICD, to be determined by us...”

Given that actual FEHBP contracts are not using DSM IV, why should we mandate a change in statute?

Response: A change is unwise and unnecessary. However, if a change is made, it should require parity for only serious mental illnesses.

Question 11. A survey of FEHBP plans also indicates a number of exclusions that are not specifically provided for in H.R. 4066. These include, but are not limited to:

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

- services, drugs or supplies related to sexual transformation, sexual dysfunction and sexual inadequacy
- experimental or investigational procedures, treatments, drugs or devices

First, would you support language making clear that all exclusions like these and others found among FEHBP carriers would be available? Second, if language were also to refer to the DSM IV, how would you resolve excluding sexual dysfunction when it is clearly identified in DSM IV? Finally, under the same circumstances, how would you resolve excluding marital, educational, and behavioral problems when the DSM IV includes conditions such as:

Partner Relational Problem V61.1

Academic Problem V62.3

Mathematics disorder 315.1

Attention Deficit Hyperactivity Disorder 314

Child or Adolescent Antisocial Behavior V71.02

Response: Health plans need flexibility in order to better manage the financial risk associated with offering benefits so that they may continue to pay the costs of health care. Unfortunately, the language of HR 4066 will prevent employers from establishing defensible treatment limits or financial requirements to effectively manage mental health benefits, and would appear to prohibit standard plan exclusions. I would support language making it clear that exclusions would be available.

Placing conditions like the V-coded disorders on equal footing with true psychiatric illness, such as Bipolar disorder, major depression and post-traumatic stress disorder, is unworkable. To illustrate, sexual and impulse control disorders are usually problems of environment, relationships, personal choice or dissatisfaction or relational dissatisfaction. For these disorders, there is no actual functional impairment and they are difficult to disentangle from poor parenting, criminality or personal values. Treatment is nebulous, lengthy, expensive and of questionable resolution.

Question 12. In a letter to carriers dated April 11, 2001, OPM emphasizes that managed care behavioral health care organizations (MBHO) can implement mental health benefits. Where plans do not choose to use such organizations, OPM recommends approaches such as gatekeeper referrals to network providers, authorized treatment plans, and pre-certification of inpatient services. OPM states that plans may limit parity benefits when patients do not substantially follow their treatment plans. Do you agree with these recommendations and allowances? How can compliance with treatment plans be proven?

Response: I disagree with these recommendations and allowances. As a clinical professional working in the field of mental health daily, I do not know how one would objectively prove that the treatment plan is not being “substantially” followed, especially for conditions such as occupational and/or identity problems for which HR 4066 proposes parity. What will constitute substantial and who will define it? Again, how can you possibly measure compliance for treatment that is elective, nebulous and not evidenced by any objective criteria?

QUESTIONS CONCERNING THE GENERAL PARITY RULE

Question 13. Even outside of mental health benefits, health plans do not treat all categories of health benefits equally. For example, outpatient physical therapy, emergency care, specialty care, speech therapy, occupational care, chiropractic care, and preventive care often have different limitations than other categories of items or services. Prescription drugs may also have different categories of co-payments based on the kind of financial arrangements a plan can arrange with pharmaceutical companies. Do you consider differences in approach among these categories to be discrimination against the particular patients who may use these services? For example, are we allowing discrimination against those who need dental coverage or chiropractic care?

Response: As stated in my testimony and based on this logic, it is reasonable to conclude that benefit plans should be able to establish different treatment limits or financial requirements between differing types of mental health conditions.

Question 14. On page seven of Dr. Regier’s written testimony he claims that the Subcommittee would be outraged if Congress permitted, among other things, insurers to charge more than twice as much out-of-pocket for seeing an endocrinologist than for seeing an internist. This statement is a little unclear. Congress does permit plans to do just that. There is no current Federal restriction on what a plan should charge for a visit to an internist versus a specialist. Indeed, plans often do have different rates and conditions for such things. Is it your understanding that Federal law prohibits different rates and categories on the non-mental health side?

Response: No, this is not my understanding. Federal law allows full flexibility on the non-mental health side.

Question 15. H.R. 4066 would replace the 1996 parity rule and change it in a variety of ways. For example, the 1996 language provides a rule in the case where a plan has different aggregate lifetime limits on different categories of medical and surgical benefits. The 1996 language also provides a clear option to have overall lifetime and annual limits that do not distinguish between mental and non-mental health benefits. These seem like important concepts. Why do proponents of H.R. 4066 seek to make these changes? Is there any problem with the current provisions on lifetime and annual limits? Won't these changes start a new round of reviews for equivalent state laws?

Response: The current provisions on lifetime and annual limits detract from benefit plan flexibility and can, in some cases, discourage plan sponsors from offering mental health benefits at all.

Question 16. Medical and surgical services have different reimbursement rates. For example, services required for hip replacement might include surgical fees, MRI fees, hospitalization, and rehabilitation, each of which may be reimbursed at a different level. A broken leg might require emergency room services and physical therapy in addition to physician fees, and again, each of these services might have still different reimbursement mechanisms.

If this legislation is enacted, health plans would be required to have the same cost sharing requirement for mental health services as to comparable non-mental health services covered by the same plan. What happens if a health plan has one deductible and coinsurance amount for physician office visits, another one for physical therapy and a third one for occupational therapy, and a fourth one for preventive services? How is the health plan supposed to comply in this case? Which one would apply for treatment of schizophrenia or treatment of sibling rivalry condition? Wouldn't parity requirements force a revaluation of the whole system and make billing issues extremely complicated?

Response: Parity requirements would force a revaluation of the whole system and make billing and benefit design issues extremely complicated. HR 4066 does not set forth how a health plan would compare coverage for mental health and physical health. I do not believe such a basis for comparison exists or could even be created. There are stark differences between the medical treatment of body and mind.

Question 17. Group health plan sometimes provide a tiered formulary to address drugs. Under such an approach there are different cost-sharing requirements because the plan was able to get certain discounts or because of different cost effectiveness. Would such a plan violate parity rules if the net effect of the plan made certain psychotherapy drugs to have a higher cost-share? If so, would the determination be made on a drug-by-drug basis?

Response: It would appear that a plan would violate parity rules if the plan proposed to vary cost-sharing arrangements, as there would be no conceivable parallel with physical conditions that would provide such an allowance.

Question 18. Could plans differentiate reimbursement based on qualifications? For example, a psychiatrist may have a different reimbursement rate than a psychologist. Could this in any way violate a parity requirement? Let's assume a group health plan creates outpatient categories based on whether or not the visit was to someone with a medical degree—not on whether it was mental illness related or not. Under H.R. 4066 could such an approach be viewed as discriminatory to psychologists and, thus, to mental health benefits? That is to say, could lawyers argue that there is a disparate impact test?

Response: Yes, lawyers could argue that there is a disparate impact test. HR 4066 removes all flexibility in the provision of mental health benefits, making this coverage mandate unprecedentedly broad.

Question 19. There is a savings clause on Page 8 of H.R. 4066 beginning line 11 under the title (3) NO REQUIREMENT OF SPECIFIC SERVICES. It states:

Nothing in this section shall be construed as requiring a group health plan (or health insurance coverage offered in connection with such a plan) to provide coverage for specific mental health services, except to the extent that the failure to cover such services would result in a disparity between the coverage of mental health and medical and surgical benefits.

This language seems circular. What is the point of the exceptions clause? Please provide some examples illustrating the intent of this provision.

Response: I agree. This language is circular and therefore, incredibly difficult to interpret and apply.

QUESTIONS CONCERNING MEDICAL MANAGEMENT PROVISIONS

Question 20. The scope of the general parity rule in proposed 712(a) and related provisions are quite confusing. In the section entitled medical management of mental health, what is meant by the lead phrase "consistent with subsection (a)?" Do you believe a parity rule should apply to how medical management techniques such as concurrent and retrospective utilization review or application of medical necessity and appropriateness criteria must have parity rules applied when evaluating mental health services? If so, would this mean that arguments could be made that the failure to find a mental health benefit necessary or appropriate is legally bound by a comparison to such a decision for non-mental health benefits? If not, what is the purpose of the phrase "consistent with subsection (a)?"

Response: The purpose of the phrase "consistent with subsection (a)" is debatable. It will encourage litigation. I do not believe that medical management techniques, such as concurrent review and retrospective utilization review or application of medical appropriateness, should have parity rules applied when evaluating mental health services. There is no basis for comparison between mental and physical health or the standards by which either are measured. In the field of mental health, functional impairment and symptoms of the individual are the appropriate applied medical criteria. These criteria are considerably less objective or scientific than are physical medical criteria.

Question 21. Under H.R. 4066, treatment limitations include "limits on the duration or scope of treatment under the plan or coverage." Do you believe this means that decisions to limit the duration or scope of treatment for therapeutic reasons must be held up to a parity test? If so, how would this work? If not, why are these included in the definition of treatment limitations subject to the parity requirements?

Response: It is probably the case that decisions to limit the duration or scope of treatment for therapeutic reasons must be held up to a parity test. How this would work is highly questionable and will be litigated. The practical effect will be to pay it all if mental health coverage even continues to be offered. Paying it all will deplete the funds available in the health plan to treat both physical and mental health conditions.

Question 22. Proponents of parity legislation state that plans will be able to minimize abuse through use of the standard "medically necessary and appropriate." During the patients' bill of rights debate it seemed like the emphasis was on getting away from the use of this standard by plans. In fact, patients' rights legislation all make clear that plans decide which categories to cover, what exclusions to have, and what cost-sharing to have. Would this new legislation drive more "medical necessity" determinations by plans? Also, patients' rights legislation, if enacted, would subject such decisions to lawsuits for damages. Do you favor such lawsuits and what would be the cost of such suits? In the 40 states that permit external review of denials such reviews can average more than \$600 a case. Wouldn't more qualitative decisions concerning medical necessity increase these expenditures?

Response: In my opinion, I do think this new legislation would drive more "medical necessity" determinations. I can assure members of the panel that using medical necessity as a last resort screening methodology for many of the lesser conditions (not serious mental illness) is like not managing the benefit at all. Many of these conditions are based solely on self-reported symptoms, which by themselves, do not justify significant, if any, clinical intervention.

QUESTIONS CONCERNING COSTS INCREASES AND POTENTIAL DECREASES IN INSURANCE
COVERAGE

Question 23. Dr. Cutler's testimony notes that the California Public Employees Retirement System has reported that mental health parity legislation would cause premiums for its two PPO options to increase by 3.3 and 2.7 percent, respectively, in 2003. Dr. Cutler also notes that a 1998 study commissioned by the Substance Abuse and Mental Health Services Administration estimated that a mental health parity law would increase premiums by an average of 3.4 percent. Has your organization reviewed these studies? Does your organization disagree with them, and if so, on what points?

Response: Our organization has not reviewed these studies. However, I would like to make a couple of comments on the point of using any study to predict what kind of cost impact this federal bill will have. First, I am not aware of any plans that currently cover mental health the way H.R. 4066 proposes to cover it. So caution is warranted when using studies on current health plan cost impact. Chances are that it will not be an apples-to-apples comparison. Secondly, cost predictions have as much to do with analyzing the increased scope of coverage as it has to do with

measurable changes in behavior on the part of both the patient and provider when a third party has been mandated to pay for unlimited services.

Question 2. CBO estimates that H.R. 4066, if enacted, would increase premiums for group health insurance by an *average* of 0.9 percent, before accounting for the responses of health plans, employers, and workers to the higher premiums under the bill. On July 12, 2002, CBO issued some clarifications of this estimate. CBO notes that the 0.9% premium increase is a weighted average of *both affected and unaffected plans*. According to CBO, affected plans would experience and increase of between 30 and 70 percent of their mental health costs. Do you consider these costs to be substantial and do you believe some employers may choose to not offer mental health benefits?

Response: I do believe that passing HR 4066 will cause many employers to not offer mental health benefits at all. Most employers currently provide coverage for mental health conditions that cause significant impairment and symptoms, but selective coverage for treatment of low-impact conditions. This flexibility should continue.

In one of the examples I cited in my testimony, a treatment facility was asking for 12 months of service at \$300.00/day that would total approximately \$108,000.00. These are very real requests. I cannot help but believe that these requests will increase dramatically, especially for adolescent treatment if this bill passes. It would just take one of these cases to financially burden a health plan.

There are a lot of troubled teens, but quite frankly, this does not equate with a mental illness. Rather than mental illness, many troubled teens just have a chaotic home life, poor role models, low self-esteem, impulsiveness and a tendency to make bad choices. When parents know they have the option for someone else to take care of the problem, and for someone else to pay for it, they often go that route. Once these kids are diagnosed with parental child issues/adolescent antisocial behavior, parents often demand to have them in 24-hour care for 9 to 12 months. This is not only fiscally irresponsible, but also, in my opinion, socially irresponsible.

Nevertheless, this is the kind situation mental health parity will create. Shouldn't mental health benefits be earmarked for kids that are depressed, symptomatic, functionally impaired or suicidal—or for significantly impaired kids with anxiety/panic attacks and PTSD symptoms like Mr. Hackett's daughter? This is the choice with which we're faced.

Question 25. CBO also assumes that responses to cost increases from affected firms might include reductions in the number of employers offering insurance to their employees and in the number of employees enrolling in employer-sponsored insurance, changes in the types of health plans that are offered, and reductions in the scope or generosity of health insurance benefits, such as increased deductibles or higher co-payments. Do you agree with these assumptions?

Response: I agree with this statement. Mandating parity treatment for the entire DSM-IV-TR is not the answer to addressing the issue of updating 1996 mental health parity. 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. I work daily in the mental health field and know what consumers are demanding for service. Passing HR 4066 will further increase demand and without having any way to limit utilization, costs will be driven upward significantly. The employer and ultimately, the employee (the patient) will feel the impact of this cost spike. Nobody wins.

Question 26. CBO estimates two categories that would need to be offset by the budget resolution. First, CBO estimates that the resulting reduction in taxable income would grow from \$1.0 billion in calendar year 2002 to \$2.3 billion in 2011. Those reductions in workers' taxable compensation would lead to lower federal tax revenues. CBO estimates that federal tax revenues would fall by \$230 million in 2002 and by \$5.4 billion over the 2002-2011 period if H.R. 4066 were enacted. Second, CBO also stated the cost of federal spending on Medicaid and S-CHIP to the cost of the bill. CBO estimates this bill will cost those programs about \$30 million in 2002 and \$600 million over the 2002-2011 period.

Have supporters of H.R. 4066 provided specific means of offsetting these figures—whether through increased taxes or reductions in other spending?

Response: I do not believe that H.R. 4066 is a fiscally sound policy. Offsets for the changes this bill would bring about will impose serious cost pressures from many angles.

Question 27. A study conducted by the UCLA/RAND Research Center on Managed Care found that techniques to intensively manage care, including the use of provider networks and case management, is critical to appropriate utilization and maintaining costs. Various estimates have found a different cost increase depending on the

amount of managed care involved. Costs are higher when a group health plan offers a non-managed health care plan to its employees. Is it not more likely that where a health plan is not a managed care plan that its mental health care costs are likely to be higher if this legislation is enacted? What are the potential dangers to the quality of care if health plans are unable to manage mental health benefits successfully as they are currently able to do? Is it possible to contract with all potential providers of mental health care?

Response: I believe that case management is vital to appropriate utilization of mental health services and maintaining costs. I think there is one primary potential danger to the quality of care if health plans are unable to manage their mental health benefits successfully. Employers may choose to simply not offer the coverage, which will undoubtedly have a serious impact on access to care, and hence, the level and quality of care available. Patients will be negatively impacted.

Furthermore, given the vast array of professionals that can provide services to those in need of mental health conditions, it is impossible to contract with all potential providers of mental health care. Not only are there many different professionals that can provide mental health services to treat the broadly defined mental health conditions of the DSM IV, but there are also no limits on the types of services that can be recommended by them. Because H.R. 4066 does not permit limits, it is possible that health plans could be required to pay those who provide tutoring, physical fitness, aroma therapy, massage therapy, art therapy, horseback-riding therapy, etc.

Question 28. I understand that an independent analysis was done a couple years ago by the Lewin Group that concluded that for every one percent increase in health care costs (beyond the normal rate of health inflation) an additional 300,000 Americans lose their health care coverage. I assume some of those lose their coverage because their employers simply stop offering health insurance at some point. Is it not also correct that many more lose their coverage, though, because they cannot afford it themselves as the price goes up and up? Is it possible that some employers may simply decide to drop mental health coverage entirely if this legislation is enacted? If so, what sorts of companies might be forced to make such a drastic decision in your opinion?

Response: In this nation, we have chosen to privately finance health care, largely through employers. And the system works—we have the premier health care system in the world. However, there are some very real threats to the system. Open-ended benefit mandates are one of the most significant threats to that system. If the cost pressures become too great for the primary funders of this system, greater numbers of individuals will clearly lose coverage.

Question 29. (a) On page six of Dr. Regier's testimony, he quotes someone who states "insurers tend to provide poor mental health benefits in order to avoid [enrollees with mental disorders]." It is difficult to understand this claim in the current context or in general. In the group market, insurers are not selling to individuals at all, but to groups. Under ERISA there is no ability to look at or discriminate based on the conditions of individuals. Is there any further basis for the above claim?

(b) Dr. Regier further notes that insurers shift costs from insurers to employers who are not able to take advantage of the market. This too is hard to comprehend. Employers purchase insurance, so, of course, the costs are shifted to the purchaser. Employers, however, can choose from among insurance products in a free market. Dr. Regier then states: "In effect, insurers are subverting responsible employers by segmenting risk and costs and shifting the obligation of mental health coverage onto an already overburdened public sector." Most employer groups that I am aware of oppose this parity legislation. Some employers provide broader insurance coverage, some provide less, and others not at all. Some employers who provide coverage now may be forced to drop this benefit if costs go up too much. Is there any further basis for the statement that employers are not able to take advantage of the market or that insurers are subverting responsible employers?

Response: Our experience does not suggest that this kind of activity is taking place, or could take place, therefore, I have no comment.

Question 30. Dr. Regier states there is no objective evidence that businesses are paying for peripheral conditions to any statistically significant degree. That is, of course, because there is no law compelling that they cover such conditions. On page ten of Dr. Regier's written testimony he states that "'malingering' is no more likely to be covered in a post parity world than it is today." Can you provide an example of clinically significant malingering, and reasons as to why employers should be forced to cover this condition? Dr. Regier also states "it is remarkable that an insurance industry that has historically sought to avoid responsibility for treating severe mental disorders is today expressing concern that only severely mentally ill patients

should be covered by parity legislation.” Please comment on the basis for this statement.

Response: Finding just the right policy answer is a complex task, yet the desired outcome is simple. People suffering from severe mental illness, either from a biological basis or significant/serious impairment, need treatment. And, this treatment needs to be paid for.

Health plan funds are not unlimited. It is imperative that health plan sponsors be able to continue to offer mental health coverage for these kinds of people who truly need it. There is a clear distinction between the need for treatment of biologically based and/or serious mental illness and the other conditions listed in the DSM-1V-TR.

QUESTION CONCERNING COMPLIANCE TIMES

Question 31. H.R. 4066 has an effective date of January 1, 2003. Does this date give employers enough time to make the needed, far-reaching changes in their health plans, especially if the Department of Health and Human Services does not have final regulations for at least several months? Should the effective date be tied to some period after the issuance of final regulations?

Response: One year after the date this bill is enacted, or 18 months after rules are promulgated, would be appropriate.

RESPONSE FOR THE RECORD OF E. NEIL TRAUTWEIN, DIRECTOR OF EMPLOYMENT POLICY, NATIONAL ASSOCIATION OF MANUFACTURERS

QUESTIONS REGARDING DSM IV

Dr. Regier’s testimony states that the controversy over whether to incorporate DSM IV into statutory law is a red herring. Many states that have looked at this issue have chosen to limit any parity requirements to “biologically-based” or “serious” mental illness as they define them. Those states do not require use of DSM IV criteria. Dr. Regier is asking Congress to incorporate an 800-page manual by reference in a statute. That would give that document legal standing in many ways and with many potential consequences. In asking the Subcommittee to take such a step, we need to fully understand and resolve all of the attendant controversies. Below are some of the relevant questions.

Question 1. It would appear from Dr. Regier’s testimony that some believe if a group health plan offers any mental health benefits, H.R. 4066 requires the plan to offer coverage for a comprehensive list of conditions set out in DSM IV. This reading is stated in the Views of the Senate Committee on Health Education Labor and Pensions on S. 543, the Senate analogue to H.R. 4066. This reading, however, is troubling and not supported by the text. Nothing in H.R. 4066 appears to require a plan to cover any category of mental health benefits, much less the long list of “conditions” in DSM IV. H.R. 4066 defines mental health benefits, in part, as:

benefits with respect to services, as defined under the terms and conditions of the plan or coverage (as the case may be), for all categories of mental health conditions listed in [DSM IV]

The reference to DSM IV helps define what is a mental health benefit. Nowhere in the text, however, does the bill state that group health plans must provide comprehensive mental health benefits or provide benefits as broad as the conditions listed in DSM IV. The Subcommittee’s reading is that if a plan provides any given mental health benefit the parity rules of the bill apply to that category of benefits. Nothing in the parity rule in proposed section 712(a) states that a plan must provide coverage for all of the conditions listed in DSM IV. Indeed, the savings clause language in proposed 712(b)(1) and (3) state that no mental health benefits are ever required at all; and that no specific services are ever required, except to the extent required by the parity rule itself. It is difficult to see how the parity rule would require any category under DSM IV.

Are you arguing that H.R. 4066 requires mental health plans to provide coverage for all conditions in DSM IV? If so, please explain your reading and your reading of the savings clause language, with specific references to language in the bill. For those that do not support such a position what clarifications are necessary to assure the appropriate policy from your perspective?

Response: The NAM agrees that HR 4066 does not require the provision of any mental health coverage [proposed 712(b)(1)] but creates a litigation-prone conflict between the savings clause language in 712(b)(3) and the definition of mental health benefits that leads us to the conclusion that an employer who offers some but not all mental health services will be subject to litigation on the basis that the failure

to provide a specific service would result in a disparity between mental health and medical and surgical benefits.

HR 4066 defines mental health benefits as “benefits with respect to services” as defined under the plan “for all categories of mental health conditions” listed in DSM-IV and later editions “if such services are included as part of authorized treatment plan.” Further, 712(b)(3) provides that a plan need not provide coverage for specific mental health services, “*except to the extent that the failure to cover such services would result in a disparity between the coverage of mental health and medical and surgical benefits.*”

Question 2. Is there any precedent in current federal statutes that says, in effect, that if you provide ANY given service, such as mental health services that you must cover ALL conditions listed in a manual prepared by one group of health care professionals? For example, is there a similar federal law that says that if you provide coverage for some pharmaceuticals or medical procedures that you must now cover ALL pharmaceuticals or medical procedures listed in a manual prepared by a trade association of pharmacists or medical care providers?*Response:* We know of no similar precedent or similar delegation of authority to a group of health care professionals with a proprietary interest in the development of such manual.

Question 3. Dr. Regier’s testimony addresses the categories of DSM IV referred to as conditions for clinical focus. These include such items as: sibling relational problem; occupational problem; academic problem; and religious or spiritual problem. Some of these terms would apparently apply even if they are not termed “mental disorders” under the manual. For example, V. 62.2 “Occupational Problem” states that the condition need not be a mental disorder. The manual further states “[e]xamples include job dissatisfaction and uncertainty about career problems. The manual provides an example of V. 62.3 “Academic Problem” as “a pattern of failing grades or significant underachievement in a person with adequate intellectual capacity in the absence of a Learning or Communication Disorder or any other mental disorder that would account for this problem.” Does H.R. 4066 incorporate these conditions even where the manual states that they are conditions and not mental disorders?

Response: “Mental Health Benefits” is defined by HR 4066 as meaning “benefits with respect to services . . . for all categories of mental health conditions listed” in the DSM-IV. No distinction is drawn under HR 4066 between conditions and mental disorders.

Question 4. DSM IV category 315.1 is called Mathematics disorder. One of the diagnostic criteria is that mathematical ability is substantially below that expected for the person’s age and intelligence. Another criterion is that it significantly interferes with academic achievement. Are you saying employers must have insurance to cover diagnosis and treatment for Mathematics disorder?

Response: This is but one example of some of the absurdities possible under HR 4066. Ironically, many employers sponsor Employee Assistance Plans (EAP) that can provide assistance to employees and their families, rendering the overly broad mandate of HR 4066 unnecessary.

Question 5. The DSM IV manual also states criteria to describe mild, moderate, and severe disorders. Mild disorders or example are defined as “[f]ew if any symptoms in excess of those required to make the diagnosis are present, and symptoms result in no more than minor impairment in social or occupational functioning.”

Dr. Regier’s testimony mentions the term “clinically significant impairment.” Does the universe of clinically significant impairments include mild disorders and conditions? What specific evidence would be required to describe a mild version of the following conditions in DSM IV:

Parent-Child Relational Problem V61.20
 Sibling Relational Problem V61.8
 Relational Problem Not Otherwise Specified V62.81
 Noncompliance with Treatment V15.81
 Adult Antisocial Behavior V71.01
 Child or Adolescent Antisocial Behavior V71.02
 Borderline Intellectual Functioning V62.89
 Age-related Cognitive Decline 780.9
 Bereavement V62.82
 Academic Problem V62.3
 Occupational Problem V62.2
 Identify Problem 313.82
 Religious or Spiritual Problem V62.89
 Acculturation Problem V62.4
 Phase of Life Problem V62.89

Are all of these conditions to be considered “clinically significant impairments”? If so, how is clinical significance measured?

Also, where in DSM IV is there a discussion of the specific medical evidence supporting each category?

How would you propose to determine what meets a parity standard between these mental health conditions and medical conditions?

Question 6. Do you believe that the diagnostic criteria in DSM IV should have legal standing by virtue of its reference in H.R. 4066, and if so, for what legal purpose or purposes?

Response: Doing so would set a dangerous precedent by granting health care professional the ability to change employers’ health care obligations without further intervention by Congress.

Question 7. Could you support language that says that the diagnosis of a disorder and its treatment must be well established and supported by substantial scientific evidence?

Question 8. Dr. Regier’s testimony says that DSM IV has “precise” criteria for diagnoses. Can you please explain category 313.81 called “oppositional defiant disorder”? The diagnostic criteria require four among the following:

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

As Dr. Regier notes criteria also requires “clinically significant” impairment. This all seems pretty subjective. Other than the phrase “clinically significant” a lot of teenagers may meet these other criteria for periods of time. This puts a lot of emphasis on the phrase “clinically significant.” Recognizing that the DSM discusses clinical significance and states that “assessing whether this criterion is met... is an inherently difficult clinical judgment”, is it realistic to establish any objective standards for purposes of determining what is not clinically significant?

If there is a disagreement with the group health plan over an individual case, does the beneficiary or provider have the burden to show a clinically significant impairment?

Question 9. Is it correct that the DSM IV is essentially based on a 1994 classification scheme that may require revisions now? If we incorporate DSM IV in a statute, how do we propose plans keep up with advances in the classification and diagnostic system? Do you believe it is appropriate to delegate this authority to a nongovernmental body? Since members of the American Psychiatric Association would appear to benefit financially from broad definitions of coverage, please comment on whether you believe such a delegation would represent a conflict of interest. If not, why not?

Response: As previously noted, we know of no similar precedent or similar delegation of authority to a group of health care professionals with a proprietary interest in the development of such manual. However well intentioned the members of the American Psychiatric Association may be, the inevitable result of this unwarranted delegation of authority would be an ever expanding definition of mental health conditions and an ever greater expenditure on mental health services under employer-sponsored health plans.

QUESTIONS REGARDING THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

Question 10. Dr. Regier’s testimony correctly notes the Office of Personnel Management has issued guidance which refers to DSM IV as an objective for health plans contracting with the Federal Employee Health Benefits Program. An initial review of several health insurance plans under FEHBP showed no reference to DSM IV in the plans available in 2002. Several of the actual plans had a definition of mental health benefits that referred to certain categories in the International Classification of Diseases (ICD). Are you aware of plans in FEHBP that specify DSM IV? What is your opinion of the plans that specified certain categories of ICD? Please list the differences in the DSM IV categories and the following language:

“Conditions and diseases listed in the most recent edition of the [ICD] as psychoses, neurotic disorders, or personality disorders; other nonpsychotic mental disorders listed in the ICD, to be determined by us...”

Given that actual FEHBP contracts are not using DSM IV, why should we mandate a change in statute?

Question 11. A survey of FEHBP plans also indicates a number of exclusions that are not specifically provided for in H.R. 4066. These include, but are not limited to:

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

First, would you support language making clear that all exclusions like these and others found among FEHBP carriers would be available? Second, if language were also to refer to the DSM IV, how would you resolve excluding sexual dysfunction when it is clearly identified in DSM IV? Finally, under the same circumstances, how would you resolve excluding marital, educational, and behavioral problems when the DSM IV includes conditions such as:

Partner Relational Problem V61.1

Academic Problem V62.3

Mathematics disorder 315.1

Attention Deficit Hyperactivity Disorder 314

Child or Adolescent Antisocial Behavior V71.02

Question 12. In a letter to carriers dated April 11, 2001, OPM emphasizes that managed care behavioral health care organizations (MBHO) can implement mental health benefits. Where plans do not choose to use such organizations, OPM recommends approaches such as gatekeeper referrals to network providers, authorized treatment plans, and pre-certification of inpatient services. OPM states that plans may limit parity benefits when patients do not substantially follow their treatment plans. Do you agree with these recommendations and allowances? How can compliance with treatment plans be proven?

QUESTIONS CONCERNING THE GENERAL PARITY RULE

Question 13. Even outside of mental health benefits, health plans do not treat all categories of health benefits equally. For example, outpatient physical therapy, emergency care, specialty care, speech therapy, occupational care, chiropractic care, and preventive care often have different limitations than other categories of items or services. Prescription drugs may also have different categories of co-payments based on the kind of financial arrangements a plan can arrange with pharmaceutical companies. Do you consider differences in approach among these categories to be discrimination against the particular patients who may use these services? For example, are we allowing discrimination against those who need dental coverage or chiropractic care?

Response: If Congress opens the door with HR 4066, then there will be no limiting principle to constrain other health professions from making similar demands. We know of no employer who would voluntarily sponsor health coverage under those circumstances.

Question 14. On page seven of Dr. Regier's written testimony he claims that the Subcommittee would be outraged if Congress permitted, among other things, insurers to charge more than twice as much out-of-pocket for seeing an endocrinologist than for seeing an internist. This statement is a little unclear. Congress does permit plans to do just that. There is no current Federal restriction on what a plan should charge for a visit to an internist versus a specialist. Indeed, plans often do have different rates and conditions for such things. Is it your understanding that Federal law prohibits different rates and categories on the non-mental health side?

Response: No, this is a novel proposal.

Question 15. H.R. 4066 would replace the 1996 parity rule and change it in a variety of ways. For example, the 1996 language provides a rule in the case where a plan has different aggregate lifetime limits on different categories of medical and surgical benefits. The 1996 language also provides a clear option to have overall lifetime and annual limits that do not distinguish between mental and non-mental health benefits. These seem like important concepts. Why do proponents of H.R. 4066 seek to make these changes? Is there any problem with the current provisions on lifetime and annual limits? Won't these changes start a new round of reviews for equivalent state laws?

Question 16. Medical and surgical services have different reimbursement rates. For example, services required for hip replacement might include surgical fees, MRI fees, hospitalization, and rehabilitation, each of which may be reimbursed at a different level. A broken leg might require emergency room services and physical therapy in addition to physician fees, and again, each of these services might have still different reimbursement mechanisms.

If this legislation is enacted, health plans would be required to have the same cost sharing requirement for mental health services as to comparable non-mental health services covered by the same plan. What happens if a health plan has one deductible and coinsurance amount for physician office visits, another one for physical therapy and a third one for occupational therapy, and a fourth one for preventive services? How is the health plan supposed to comply in this case? Which one would apply for treatment of schizophrenia or treatment of sibling rivalry condition? Wouldn't parity requirements force a reevaluation of the whole system and make billing issues extremely complicated?

Response: inevitably so. Complexity will arise as plans attempt to comply and as the effect of litigation is felt.

Question 17. Group health plans sometimes provide a tiered formulary to address drugs. Under such an approach there are different cost-sharing requirements because the plan was able to get certain discounts or because of different cost effectiveness. Would such a plan violate parity rules if the net effect of the plan made certain psychotherapy drugs to have a higher cost-share? If so, would the determination be made on a drug-by-drug basis?

Response: Tiered formularies are quite common today. Placement of psychotherapy pharmaceuticals within tiers might well be the subject of litigation.

Question 18. Could plans differentiate reimbursement based on qualifications? For example, a psychiatrist may have a different reimbursement rate than a psychologist. Could this in any way violate a parity requirement? Let's assume a group health plan creates outpatient categories based on whether or not the visit was to someone with a medical degree—not on whether it was mental illness related or not. Under H.R. 4066 could such an approach be viewed as discriminatory to psychologists and, thus, to mental health benefits? That is to say, could lawyers argue that there is a disparate impact test?

Response: We believe this is a plausible concern.

Question 19. There is a savings clause on Page 8 of H.R. 4066 beginning line 11 under the title (3) NO REQUIREMENT OF SPECIFIC SERVICES. It states:

Nothing in this section shall be construed as requiring a group health plan (or health insurance coverage offered in connection with such a plan) to provide coverage for specific mental health services, except to the extent that the failure to cover such services would result in a disparity between the coverage of mental health and medical and surgical benefits.

This language seems circular. What is the point of the exceptions clause? Please provide some examples illustrating the intent of this provision.

Response: We agree that this "exceptions clause" will actually require employers who provide some mental health benefits to cover all conditions under DSM-IV. It would appear to us that the "point" of this clause is to confuse the reader.

QUESTIONS CONCERNING MEDICAL MANAGEMENT PROVISIONS

Question 20. The scope of the general parity rule in proposed 712(a) and related provisions are quite confusing. In the section entitled medical management of mental health, what is meant by the lead phrase "consistent with subsection (a)?" Do you believe a parity rule should apply to how medical management techniques such as concurrent and retrospective utilization review or application of medical necessity and appropriateness criteria must have parity rules applied when evaluating mental health services? If so, would this mean that arguments could be made that the failure to find a mental health benefit necessary or appropriate is legally bound by a comparison to such a decision for non-mental health benefits? If not, what is the purpose of the phrase "consistent with subsection (a)?"

Response: This interplay is quite confusing but would seem to suggest that medical management techniques are subject to parity analysis.

Question 21. Under H.R. 4066, treatment limitations include "limits on the duration or scope of treatment under the plan or coverage." Do you believe this means that decisions to limit the duration or scope of treatment for therapeutic reasons must be held up to a parity test? If so, how would this work? If not, why are these included in the definition of treatment limitations subject to the parity requirements?

Question 22. Proponents of parity legislation state that plans will be able to minimize abuse through use of the standard “medically necessary and appropriate.” During the patients’ bill of rights debate it seemed like the emphasis was on getting away from the use of this standard by plans. In fact, patients’ rights legislation all make clear that plans decide which categories to cover, what exclusions to have, and what cost-sharing to have. Would this new legislation drive more “medical necessity” determinations by plans? Also, patients’ rights legislation, if enacted, would subject such decisions to lawsuits for damages. Do you favor such lawsuits and what would be the cost of such suits? In the 40 states that permit external review of denials such reviews can average more than \$600 a case. Wouldn’t more qualitative decisions concerning medical necessity increase these expenditures?

Response: We believe that this legislation would lead to more medical necessity determinations and consequent liability if a Patients’ Bill of Rights were enacted. The NAM has been one of the foremost opponents of the Patients’ Bill of Rights which—in our view—could lead to many employers dropping health coverage. We would certainly recommend that our members take that action if a Patients’ Bill of Rights were enacted.

QUESTIONS CONCERNING COSTS INCREASES AND POTENTIAL DECREASES IN INSURANCE COVERAGE

Question 23. Dr. Cutler’s testimony notes that the California Public Employees Retirement System has reported that mental health parity legislation would cause premiums for its two PPO options to increase by 3.3 and 2.7 percent, respectively, in 2003. Dr. Cutler also notes that a 1998 study commissioned by the Substance Abuse and Mental Health Services Administration estimated that a mental health parity law would increase premiums by an average of 3.4 percent. Has your organization reviewed these studies? Does your organization disagree with them, and if so, on what points?

Response: We believe the CALPERS and SAMSHA findings are borne out by CBO’s clarification of July 12, 2002.

Question 24. CBO estimates that H.R. 4066, if enacted, would increase premiums for group health insurance by an *average* of 0.9 percent, before accounting for the responses of health plans, employers, and workers to the higher premiums under the bill. On July 12, 2002, CBO issued some clarifications of this estimate. CBO notes that the 0.9% premium increase is a weighted average of *both affected and unaffected plans*. According to CBO, affected plans would experience an increase of between 30 and 70 percent of their mental health costs. Do you consider these costs to be substantial and do you believe some employers may choose to not offer mental health benefits?

Response: These cost increases are substantial and troubling in the current climate of rapidly increasing insurance premiums. An increase of 30-70% in mental health costs could easily lead to premium increases of 2-3% or more. While such an increase itself might not be determinative, both employers and employees are increasingly being priced out of coverage. We can afford no new mandates, much less as significant a mandate as is proposed by HR 4066.

Question 25. CBO also assumes that responses to cost increases from affected firms might include reductions in the number of employers offering insurance to their employees and in the number of employees enrolling in employer-sponsored insurance, changes in the types of health plans that are offered, and reductions in the scope or generosity of health insurance benefits, such as increased deductibles or higher co-payments. Do you agree with these assumptions?

Response: Without a doubt. Such reductions in benefits and increase in employee responsibility are already quite common in light of current cost increases.

Question 26. CBO estimates two categories that would need to be offset by the budget resolution. First, CBO estimates that the resulting reduction in taxable income would grow from \$1.0 billion in calendar year 2002 to \$2.3 billion in 2011. Those reductions in workers’ taxable compensation would lead to lower federal tax revenues. CBO estimates that federal tax revenues would fall by \$230 million in 2002 and by \$5.4 billion over the 2002-2011 period if H.R. 4066 were enacted. Second, CBO also stated the cost of federal spending on Medicaid and S-CHIP to be the cost of the bill. CBO estimates this bill will cost those programs about \$30 million in 2002 and \$600 million over the 2002-2011 period.

Have supporters of H.R. 4066 provided specific means of offsetting these figures—whether through increased taxes or reductions in other spending?

Response: They have not to our understanding.

Question 27. A study conducted by the UCLA/RAND Research Center on Managed Care found that techniques to intensively manage care, including the use of provider

networks and case management, is critical to appropriate utilization and maintaining costs. Various estimates have found a different cost increase depending on the amount of managed care involved. Costs are higher when a group health plan offers a non-managed health care plan to its employees. Is it not more likely that where a health plan is not a managed care plan that its mental health care costs are likely to be higher if this legislation is enacted? What are the potential dangers to the quality of care if health plans are unable to manage mental health benefits successfully as they are currently able to do? Is it possible to contract with all potential providers of mental health care?

Response: These are all legitimate concerns under HR 4066. The irony is that workers and dependents may find mental health services harder to come by if HR 4066 were enacted.

Question 28. I understand that an independent analysis was done a couple years ago by the Lewin Group that concluded that for every one percent increase in health care costs (beyond the normal rate of health inflation) an additional 300,000 Americans lose their health care coverage. I assume some of those lose their coverage because their employers simply stop offering health insurance at some point. Is it not also correct that many more lose their coverage, though, because they cannot afford it themselves as the price goes up and up? Is it possible that some employers may simply decide to drop mental health coverage entirely if this legislation is enacted? If so, what sorts of companies might be forced to make such a drastic decision in your opinion?

Response: Although the offer rate of employers to employees remains strong (indeed, 98% of NAM members offer coverage to their workers) the rate at which employees accepts coverage (take-up rate) is declining in light of rising costs and greater employee responsibility for coverage. Some employers might well drop mental health services rather than offer the gamut of conditions under DSM-IV. Employers of all sizes may face this choice, but smaller employers with more than 50 employees will be particularly apt to do so.

Question 29. (a) On page six of Dr. Regier's testimony, he quotes someone who states "insurers tend to provide poor mental health benefits in order to avoid [enrollees with mental disorders]." It is difficult to understand this claim in the current context or in general. In the group market, insurers are not selling to individuals at all, but to groups. Under ERISA there is no ability to look at or discriminate based on the conditions of individuals. Is there any further basis for the above claim?

Response: This assertion is highly implausible. Employers offer good quality health benefits (including mental health benefits) to attract workers and insurers and HMOs who wish to contract with employers must meet the needs of the employer-designed health plan. Insurers cannot selectively provide coverage to some but not all employees.

Question (b) Dr. Regier further notes that insurers shift costs from insurers to employers who are not able to take advantage of the market. This too is hard to comprehend. Employers purchase insurance, so, of course, the costs are shifted to the purchaser. Employers, however, can choose from among insurance products in a free market. Dr. Regier then states: "In effect, insurers are subverting responsible employers by segmenting risk and costs and shifting the obligation of mental health coverage onto an already overburdened public sector." Most employer groups that I am aware of oppose this parity legislation. Some employers provide broader insurance coverage, some provide less, and others not at all. Some employers who provide coverage now may be forced to drop this benefit if costs go up too much. Is there any further basis for the statement that employers are not able to take advantage of the market or that insurers are subverting responsible employers?

Response: There is absolutely no basis for Dr. Regier's assertion other than a baseless prejudice against the insurance industry. The NAM, most employer groups and most employers oppose this proposed mandate.

Question 30. Dr. Regier states there is no objective evidence that businesses are paying for peripheral conditions to any statistically significant degree. That is, of course, because there is no law compelling that they cover such conditions. On page ten of Dr. Regier's written testimony he states that "malingering" is no more likely to be covered in a post parity world than it is today." Can you provide an example of clinically significant malingering, and reasons as to why employers should be forced to cover this condition? Dr. Regier also states "it is remarkable that an insurance industry that has historically sought to avoid responsibility for treating severe mental disorders is today expressing concern that only severely mentally ill patients should be covered by parity legislation." Please comment on the basis for this statement.

QUESTION CONCERNING COMPLIANCE TIMES

Question 31. H.R. 4066 has an effective date of January 1, 2003. Does this date give employers enough time to make the needed, far-reaching changes in their health plans, especially if the Department of Health and Human Services does not have final regulations for at least several months? Should the effective date be tied to some period after the issuance of final regulations?

Response: This would not be a sufficient period to make changes in health plans, most of which were set during the preceding summer. A better approach would delay enforcement until final regulations are issued or in any case, in the following plan year.

RESPONSE FOR THE RECORD OF CHARLES M. CUTLER, CHIEF MEDICAL OFFICER,
AMERICAN ASSOCIATION OF HEALTH PLANS

QUESTIONS REGARDING DSM IV

Question 1. It would appear from Dr. Regier's testimony that some believe if a group health plan offers any mental health benefits, H.R. 4066 requires the plan to offer coverage for a comprehensive list of conditions set out in DSM IV. This reading is stated in the Views of the Senate Committee on Health Education Labor and Pensions on S. 543, the Senate analogue to H.R. 4066. This reading, however, is troubling and not supported by the text. Nothing in H.R. 4066 appears to require a plan to cover any category of mental health benefits, much less the long list of "conditions" in DSM IV. H.R. 4066 defines mental health benefits, in part, as:

benefits with respect to services, as defined under the terms and conditions of the plan or coverage (as the case may be), for all categories of mental health conditions listed in [DSM IV]

The reference to DSM IV helps define what is a mental health benefit. Nowhere in the text, however, does the bill state that group health plans must provide comprehensive mental health benefits or provide benefits as broad as the conditions listed in DSM IV. The Subcommittee's reading is that if a plan provides any given mental health benefit the parity rules of the bill apply to that category of benefits. Nothing in the parity rule in proposed section 712(a) states that a plan must provide coverage for all of the conditions listed in DSM IV. Indeed, the savings clause language in proposed 712(b)(1) and (3) state that no mental health benefits are ever required at all; and that no specific services are ever required, except to the extent required by the parity rule itself. It is difficult to see how the parity rule would require any category under DSM IV.

Are you arguing that H.R. 4066 requires mental health plans to provide coverage for all conditions in DSM IV? If so, please explain your reading and your reading of the savings clause language, with specific references to language in the bill. For those that do not support such a position what clarifications are necessary to assure the appropriate policy from your prospective?

ANSWER: Due to ambiguity in the bill's language, one interpretation of H.R. 4066 is that it could require parity for all conditions listed in the most recent edition of the DSM (except substance abuse). This would include biologically based and severe mental illnesses, as well as numerous conditions such as jet lag, and academic, occupational, and religious problems.

Because the bill specifically states that any exclusions of coverage of mental health services may not result in a "disparity" between coverage of mental health and medical surgical benefits, the bill could have the effect of requiring coverage for all disorders and conditions listed in the DSM since one could claim that any coverage exclusion of a mental health disorder or condition would result in a disparity.

Question 2. Is there any precedent in current federal statutes that says, in effect, that if you provide ANY given service, such as mental health services that you must cover ALL conditions listed in a manual prepared by one group of health care professionals? For example, is there a similar federal law that says that if you provide coverage for some pharmaceuticals or medical procedures that you must now cover ALL pharmaceuticals or medical procedures listed in a manual prepared by a trade association of pharmacists or medical care providers?

ANSWER: We are not aware of any examples of mandating the coverage of all services listed in a particular manual. HIPAA mandates the use of a standard code set such as the ICD9 (International Classification of Disease), CPT (Current Procedural Terminology), NDC (National Drug Codes) or HCPCS (Health Care Common Procedure Coding System). These code sets are used to describe the service provided and the diagnosis, but there is no mandate that all of the codes be covered. Pur-

chasers such as individuals, private employers and federal, state, and local governments purchase the level of benefits that best meet their needs.

Furthermore, in the case of the DSM-IV there also is an inherent conflict of interest in mandating its use as a determination of coverage. The American Psychiatric Association determines the content of the DSM and its members will benefit from any use of the DSM as a determinant of coverage.

Question 3. Dr. Regier's testimony addresses the categories of DSM IV referred to as conditions for clinical focus. These include such items as: sibling relational problem; occupational problem; academic problem; and religious or spiritual problem. Some of these terms would apparently apply even if they are not termed "mental disorders" under the manual. For example, V. 62.2 "Occupational Problem" states that the condition need not be a mental disorder. The manual further states "[e]xamples include job dissatisfaction and uncertainty about career problems. The manual provides an example of V. 62.3 "Academic Problem" as "a pattern of failing grades or significant underachievement in a person with adequate intellectual capacity in the absence of a Learning or Communication Disorder or any other mental disorder that would account for this problem." Does H.R. 4066 incorporate these conditions even where the manual states that they are conditions and not mental disorders?

ANSWER: We believe that because the bill defines mental health benefits as "all categories of mental health conditions" listed in the DSM (except substance abuse) the bill incorporates the conditions listed in the DSM, such as sibling relational problem, occupational problem, academic problem and religious or spiritual problem, in addition to all of the mental disorders listed in the DSM.

Question 4. DSM IV category 315.1 is called Mathematics disorder. One of the diagnostic criteria is that mathematical ability is substantially below that expected for the person's age and intelligence. Another criterion is that it significantly interferes with academic achievement. Are you saying employers must have insurance to cover diagnosis and treatment for Mathematics disorder?

ANSWER: See answer to questions #1 and #3. Because the bill could be interpreted as requiring parity for all conditions in the DSM and because the DSM includes Mathematics disorder, it could be construed that insurance coverage would be required to include coverage for the diagnosis and treatment of Mathematics disorder.

Question 5. The DSM IV manual also states criteria to describe mild, moderate, and severe disorders. Mild disorders or example are defined as "[f]ew if any symptoms in excess of those required to make the diagnosis are present, and symptoms result in no more than minor impairment in social or occupational functioning."

Dr. Regier's testimony mentions the term "clinically significant impairment." Does the universe of clinically significant impairments include mild disorders and conditions? What specific evidence would be required to describe a mild version of the following conditions in DSM IV:

- Parent-Child Relational Problem V61.20
- Sibling Relational Problem V61.8
- Relational Problem Not Otherwise Specified V62.81
- Noncompliance with Treatment V15.81
- Adult Antisocial Behavior V71.01
- Child or Adolescent Antisocial Behavior V71.02
- Borderline Intellectual Functioning V62.89
- Age-related Cognitive Decline 780.9
- Bereavement V62.82
- Academic Problem V62.3
- Occupational Problem V62.2
- Identify Problem 313.82
- Religious or Spiritual Problem V62.89
- Acculturation Problem V62.4
- Phase of Life Problem V62.89

Are all of these conditions to be considered "clinically significant impairments"? If so, how is clinical significance measured?

Also, where in DSM IV is there a discussion of the specific medical evidence supporting each category?

How would you propose to determine what meets a parity standard between these mental health conditions and medical conditions?

ANSWER: Many of the diagnoses in the DSM IV describe what for most people are normal, routine life situations, such as parent-child relationship problems, academic problems or occupational problems. Because there is no clear and consistent definition of "clinically significant," what constitutes something outside the norm and needing treatment is left up to the subjective interpretation of providers.

Furthermore, given that H.R. 4066 prohibits “disparity” between mental health and medical/surgical services and “disparity” is not defined in the bill, it would be difficult to determine what meets the parity standard and what does not. Arguably any differences in the administration of the mental health benefit versus the medical/surgical benefit could be construed as a disparity and therefore in violation of the parity requirement.

Question 6. Do you believe that the diagnostic criteria in DSM IV should have legal standing by virtue of its reference in H.R. 4066, and if so, for what legal purpose or purposes?

ANSWER: The DSM was designed to be used for clinical, research, administrative and educational purposes. By codifying the DSM, H.R. 4066 would create a tremendous conflict of interest with respect to the group of professionals responsible for developing this directory of conditions. Congress should be troubled by the prospect of codifying a manual developed by a non-governmental body that was never intended to be the standard for insurance coverage. The American Psychiatric Association determines the content of the DSM and its members will benefit from its codification.

Question 7. Could you support language that says that the diagnosis of a disorder and its treatment must be well established and supported by substantial scientific evidence?

ANSWER: Health plans have long supported the use of evidence-based medicine and have done so in the absence of legislative requirements. The Institute of Medicine recently articulated that it should be one of our nation’s goals to move towards a more evidence-based system of health care delivery.

Question 8. Dr. Regier’s testimony says that DSM IV has “precise” criteria for diagnoses. Can you please explain category 313.81 called “oppositional defiant disorder”? The diagnostic criteria require four among the following:

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

As Dr. Regier notes criteria also requires “clinically significant” impairment. This all seems pretty subjective. Other than the phrase “clinically significant” a lot of teenagers may meet these other criteria for periods of time. This puts a lot of emphasis on the phrase “clinically significant.” Recognizing that the DSM discusses clinical significance and states that “assessing whether this criterion is met... is an inherently difficult clinical judgment”, is it realistic to establish any objective standards for purposes of determining what is not clinically significant?

If there is a disagreement with the group health plan over an individual case, does the beneficiary or provider have the burden to show a clinically significant impairment?

ANSWER: As mentioned in our answer to question #5, we agree that trying to decide when the “clinically significant” criteria in the DSM are met would be difficult. The term is open to tremendous interpretation and will ultimately vary in any given situation, for each diagnosis and across providers. Given the disagreements that will undoubtedly occur among providers as to what a clinically significant impairment is, referring to health plans’ coverage policies which are designed to promote evidence-based medicine, is the most appropriate way of resolving any conflicting opinions with respect to medical necessity. Furthermore, it should be noted that if an enrollee is not satisfied with a health plan’s medical necessity determination, 41 states plus the District of Columbia allow for the independent medical review of such determinations.

Question 9. Is it correct that the DSM IV is essentially based on a 1994 classification scheme that may require revisions now? If we incorporate DSM IV in a statute, how do we propose plans keep up with advances in the classification and diagnostic system? Do you believe it is appropriate to delegate this authority to a nongovernmental body? Since members of the American Psychiatric Association would appear to benefit financially from broad definitions of coverage, please comment on whether you believe such a delegation would represent a conflict of interest. If not, why not?

ANSWER: H.R. 4066 requires coverage as outlined in the most recent DSM, therefore indicating that the fourth and most current version of the DSM is open to revision.

As previously stated, we believe that codifying the DSM would create a tremendous conflict of interest with respect to the group of professionals responsible for de-

veloping this directory of conditions. Not only was the DSM never intended to be the standard for insurance coverage, but the American Psychiatric Association determines the content of the DSM and its members will benefit from its codification.

QUESTIONS REGARDING THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

Question 10. Dr. Regier's testimony correctly notes the Office of Personnel Management has issued guidance which refers to DSM IV as an objective for health plans contracting with the Federal Employee Health Benefits Program. An initial review of several health insurance plans under FEHBP showed no reference to DSM IV in the plans available in 2002. Several of the actual plans had a definition of mental health benefits that referred to certain categories in the International Classification of Diseases (ICD). Are you aware of plans in FEHBP that specify DSM IV? What is your opinion of the plans that specified certain categories of ICD? Please list the differences in the DSM IV categories and the following language:

"Conditions and diseases listed in the most recent edition of the [ICD] as psychoses, neurotic disorders, or personality disorders; other nonpsychotic mental disorders listed in the ICD, to be determined by us..."

Given that actual FEHBP contracts are not using DSM IV, why should we mandate a change in statute?

ANSWER: Both the ICD and the DSM are code manuals. As mentioned previously, we are not aware of any examples of mandating the coverage of all services listed in a particular manual. Purchasers such as individuals, private employers and federal, state, and local governments purchase the level of benefits that best meets their needs.

Question 11. A survey of FEHBP plans also indicates a number of exclusions that are not specifically provided for in H.R. 4066. These include, but are not limited to:

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

First, would you support language making clear that all exclusions like these and others found among FEHBP carriers would be available? Second, if language were also to refer to the DSM IV, how would you resolve excluding sexual dysfunction when it is clearly identified in DSM IV? Finally, under the same circumstances, how would you resolve excluding marital, educational, and behavioral problems when the DSM IV includes conditions such as:

Partner Relational Problem V61.1
 Academic Problem V62.3
 Mathematics disorder 315.1
 Attention Deficit Hyperactivity Disorder 314
 Child or Adolescent Antisocial Behavior V71.02

ANSWER: Current law allows health plans and employers the flexibility to design a mental health benefits package that best meets the needs of their specific member or employee populations. Mandating coverage of all conditions in the DSM would undermine that flexibility. As a purchaser, FEHBP has designed a benefit package that excludes coverage of certain disorders. We believe that private plans and employers should retain maximum flexibility in benefit design.

Question 12. In a letter to carriers dated April 11, 2001, OPM emphasizes that managed care behavioral health care organizations (MBHO) can implement mental health benefits. Where plans do not choose to use such organizations, OPM recommends approaches such as gatekeeper referrals to network providers, authorized treatment plans, and pre-certification of inpatient services. OPM states that plans may limit parity benefits when patients do not substantially follow their treatment plans. Do you agree with these recommendations and allowances? How can compliance with treatment plans be proven?

ANSWER: As OPM and the private sector have realized, managed behavioral health benefits have enabled more Americans to receive affordable, quality mental health care. As evidenced by AAHP's 2002 Industry Survey results, patients with mental illnesses increasingly have direct access to mental health services and have

benefited from disease management, care managers, preventive screening, treatment plans, evidence-based guidelines, and quality measurement. H.R. 4066 would impede the very medical management tools that have made mental health services more affordable and enabled employers to expand mental health benefits.

We are concerned that H.R. 4066 could be construed to preclude the use of many of these tools unless comparable tools are used on the medical/surgical side. If Congress were to preclude the utilization of these tools with respect to mental health benefits, it would have a direct impact on employees and the choices that employers can offer.

QUESTIONS CONCERNING THE GENERAL PARITY RULE

Question 13. Even outside of mental health benefits, health plans do not treat all categories of health benefits equally. For example, outpatient physical therapy, emergency care, specialty care, speech therapy, occupational care, chiropractic care, and preventive care often have different limitations than other categories of items or services. Prescription drugs may also have different categories of co-payments based on the kind of financial arrangements a plan can arrange with pharmaceutical companies. Do you consider differences in approach among these categories to be discrimination against the particular patients who may use these services? For example, are we allowing discrimination against those who need dental coverage or chiropractic care?

ANSWER: It is true that employers and health plans oftentimes have different cost sharing and other requirements for different types of medical and surgical services. One of the difficulties in implementing the provisions of H.R. 4066 would be in determining what to apply the parity rule to. In other words, if a plan generally covers unlimited outpatient office visits, but limits rehabilitative therapy services to 50 visits, which standard would apply? If the plan charges a \$15 copayment for primary care office visits, \$30 for a specialty care office visit, but charges no copayment for preventive care, what would be the comparable copayment standards on the mental health side? Being able to maintain flexibility in constructing and managing medical/surgical and mental health benefits is critical to providing affordable benefits and promoting appropriate care.

Question 14. On page seven of Dr. Regier's written testimony he claims that the Subcommittee would be outraged if Congress permitted, among other things, insurers to charge more than twice as much out-of-pocket for seeing an endocrinologist than for seeing an internist. This statement is a little unclear. Congress does permit plans to do just that. There is no current Federal restriction on what a plan should charge for a visit to an internist versus a specialist. Indeed, plans often do have different rates and conditions for such things. Is it your understanding that Federal law prohibits different rates and categories on the non-mental health side?

ANSWER: Within certain parameters (e.g., HIPAA rules), federal law generally provides private employers and plans with flexibility to design their benefits and provider networks.

Question 15. H.R. 4066 would replace the 1996 parity rule and change it in a variety of ways. For example, the 1996 language provides a rule in the case where a plan has different aggregate lifetime limits on different categories of medical and surgical benefits. The 1996 language also provides a clear option to have overall lifetime and annual limits that do not distinguish between mental and non-mental health benefits. These seem like important concepts. Why do proponents of H.R. 4066 seek to make these changes? Is there any problem with the current provisions on lifetime and annual limits? Won't these changes start a new round of reviews for equivalent state laws?

ANSWER: The 1996 law provides health plans and employers greater flexibility than H.R. 4066 does to design mental health benefits that best meet the needs of their members and employees because it does not mandate coverage of specific conditions and allows medical management techniques to be used to help manage care and control costs. While proponents of H.R. 4066 have maintained that the bill does not require plans and employers to cover any specific mental health service and would, in fact, permit exclusions of mental health services from coverage, the reality is quite different.

First, as we have stated in previous answers, it is our interpretation that H.R. 4066 could require parity for all conditions listed in the most recent edition of the DSM. This would include biologically-based and severe mental illnesses, as well as numerous disorders and conditions of questionable evidence such as jet lag, and academic, occupational, and religious problems. The "clinically significant" standard the DSM sets out is tremendously broad and subject to variance in interpretation. Therefore, such criteria does not provide any clear standard by which to determine

coverage, thus, in effect, requiring plans to cover all conditions in the most recent version of the DSM.

Additionally, the bill clearly states that any exclusions of coverage of mental health services may not result in a “disparity” between coverage of mental health and medical surgical benefits. “Disparity” is not defined, leaving its meaning, and its implications, ambiguous and undermining any flexibility for plans and employers to design mental health benefits that best meet the needs of their enrollees and employees.

And finally, it is important to note that a number of states require plans to cover certain mental health conditions, but permit differences in cost-sharing and other limitations. In these instances, the plan would be mandated to cover mental health benefits under state law, but any allowance to use different financial and visit limitations would be overruled by the federal law to cover those mandated benefits on par with medical/surgical benefits.

Question 16. Medical and surgical services have different reimbursement rates. For example, services required for hip replacement might include surgical fees, MRI fees, hospitalization, and rehabilitation, each of which may be reimbursed at a different level. A broken leg might require emergency room services and physical therapy in addition to physician fees, and again, each of these services might have still different reimbursement mechanisms. If this legislation is enacted, health plans would be required to have the same cost sharing requirement for mental health services as to comparable non-mental health services covered by the same plan. What happens if a health plan has one deductible and coinsurance amount for physician office visits, another one for physical therapy and a third one for occupational therapy, and a fourth one for preventive services? How is the health plan supposed to comply in this case? Which one would apply for treatment of schizophrenia or treatment of sibling rivalry condition? Wouldn't parity requirements force a reevaluation of the whole system and make billing issues extremely complicated?

ANSWER: See answer to question #13.

Question 17. Group health plan sometimes provide a tiered formulary to address drugs. Under such an approach there are different cost-sharing requirements because the plan was able to get certain discounts or because of different cost effectiveness. Would such a plan violate parity rules if the net effect of the plan made certain psychotherapy drugs to have a higher cost-share? If so, would the determination be made on a drug-by-drug basis?

ANSWER: We believe different cost-sharing requirements, including those that are part of a tiered formulary, could indeed be construed to violate the parity rule. At the very least, this ambiguity would be the subject of costly litigation. See also answer to question #13.

Question 18. Could plans differentiate reimbursement based on qualifications? For example, a psychiatrist may have a different reimbursement rate than a psychologist. Could this in any way violate a parity requirement? Let's assume a group health plan creates outpatient categories based on whether or not the visit was to someone with a medical degree—not on whether it was mental illness related or not. Under H.R. 4066 could such an approach be viewed as discriminatory to psychologists and, thus, to mental health benefits? That is to say, could lawyers argue that there is a disparate impact test?

ANSWER: Our interpretation of H.R. 4066 is that any “disparity” could violate the parity requirement. The likely result of this bill will be a tremendous increase in litigation over what constitutes “disparity.”

Question 19. There is a savings clause on Page 8 of H.R. 4066 beginning line 11 under the title (3) NO REQUIREMENT OF SPECIFIC SERVICES. It states:

Nothing in this section shall be construed as requiring a group health plan (or health insurance coverage offered in connection with such a plan) to provide coverage for specific mental health services, except to the extent that the failure to cover such services would result in a disparity between the coverage of mental health and medical and surgical benefits.

This language seems circular. What is the point of the exceptions clause? Please provide some examples illustrating the intent of this provision.

ANSWER: The phrase “except to the extent that the failure to cover such services would result in a disparity between the coverage of mental health and medical and surgical benefits” undermines the entire rule of construction. This circular language could be read to, in effect, require plans to cover every condition and disorder listed in the DSM, since any exclusions could result in charges of disparity.

This language could also be construed to include differences in medical management techniques.

As mentioned previously, health plan medical management techniques have enabled more Americans to receive affordable, quality mental health care. H.R. 4066

could impede the very medical management tools that have enabled employers to expand mental health benefits by making them affordable. Including this circular language in legislation could ultimately preclude the utilization of these tools and will have a direct impact on employees and the choices that employers can offer.

QUESTIONS CONCERNING MEDICAL MANAGEMENT PROVISIONS

Question 20. The scope of the general parity rule in proposed 712(a) and related provisions are quite confusing. In the section entitled medical management of mental health, what is meant by the lead phrase “consistent with subsection (a)?” Do you believe a parity rule should apply to how medical management techniques such as concurrent and retrospective utilization review or application of medical necessity and appropriateness criteria must have parity rules applied when evaluating mental health services? If so, would this mean that arguments could be made that the failure to find a mental health benefit necessary or appropriate is legally bound by a comparison to such a decision for non-mental health benefits? If not, what is the purpose of the phrase “consistent with subsection (a)?”

ANSWER: We are concerned that H.R. 4066 would apply its parity rule to medical management techniques by requiring that medical management of mental health benefits be “comparable” to that used for medical/surgical benefits. While this sounds harmless enough, there are oftentimes differences in how the techniques are used for the management of medical/surgical and mental health benefits.

Medical/surgical care for many diseases have more clear and specific care plans, milestones and outcome measures. For example, most hospitals have specific care plans for bypass surgery based on the ideal clinical protocol, measures of the patient’s heart and lung functions, and the specific care needed to reach the best outcome. However, this is not the case for many mental health conditions. The timeline, steps in treatment, milestones and outcomes are much less well defined, more difficult to measure and more subjective than on the medical/surgical side. When an individual has heart surgery, we know when the heart is functioning well by using standard clinical and laboratory measures. Progress in treating mental health conditions is evaluated using more subjective physician and patient self-assessment or a patient’s ability to perform activities of daily living. Therefore, health plans need the flexibility to manage mental health benefits differently in order to ensure that the patient is receiving the most appropriate care possible. More frequent use of treatment plans, care managers, and other management techniques are often necessary to ensure that patients are getting the most appropriate care for the condition, yet it is not clear that this would continue to be permitted under H.R. 4066.

Question 21. Under H.R. 4066, treatment limitations include “limits on the duration or scope of treatment under the plan or coverage.” Do you believe this means that decisions to limit the duration or scope of treatment for therapeutic reasons must be held up to a parity test? If so, how would this work? If not, why are these included in the definition of treatment limitations subject to the parity requirements?

ANSWER: Our interpretation of the bill language is that treatment limitations, including limits on the duration or scope of treatment, must be held to the parity test set out in H.R. 4066. However, implementation of this provision could be quite difficult. For example, the phrase “or other similar treatment limits on the duration or scope of treatment” could conceivably include medical management activities, which would then be in conflict with the bill’s rule of construction purporting to permit medical management.

Question 22. Proponents of parity legislation state that plans will be able to minimize abuse through use of the standard “medically necessary and appropriate.” During the patients’ bill of rights debate it seemed like the emphasis was on getting away from the use of this standard by plans. In fact, patients’ rights legislation all make clear that plans decide which categories to cover, what exclusions to have, and what cost-sharing to have. Would this new legislation drive more “medical necessity” determinations by plans? Also, patients’ rights legislation, if enacted, would subject such decisions to lawsuits for damages. Do you favor such lawsuits and what would be the cost of such suits? In the 40 states that permit external review of denials such reviews can average more than \$600 a case. Wouldn’t more qualitative decisions concerning medical necessity increase these expenditures?

ANSWER: As mentioned previously, it is not clear whether H.R. 4066 would permit plans to use medical management techniques, including the application of medical necessity criteria, differently on the mental health side versus the medical/surgical side. One likely outcome of the ambiguity created in H.R. 4066 is an increase in lawsuits that would only be exacerbated if patient’s rights legislation that in-

cluded expanded liability were enacted. Expanded liability will only end up diminishing the quality of medical care and substantially add to health care costs. In fact, a 2001 AAHP survey found that physicians believe the current medical liability system is unfair, raises costs, leads to defensive medicine, hurts patient relationships, reduces reporting of medical errors and does not improve quality care. Given these effects of physician liability, enacting legislation that will lead to increased litigation is not in anyone's best interest.

QUESTIONS CONCERNING COSTS INCREASES AND POTENTIAL DECREASES IN INSURANCE COVERAGE

Question 23. Dr. Cutler's testimony notes that the California Public Employees Retirement System has reported that mental health parity legislation would cause premiums for its two PPO options to increase by 3.3 and 2.7 percent, respectively, in 2003. Dr. Cutler also notes that a 1998 study commissioned by the Substance Abuse and Mental Health Services Administration estimated that a mental health parity law would increase premiums by an average of 3.4 percent. Has your organization reviewed these studies? Does your organization disagree with them, and if so, on what points?

ANSWER: In addition to the cost estimates referenced above, there are other cost estimates that show these numbers are consistent with other state experiences with respect to mental health. For example:

- In 2000, a South Carolina fiscal note estimated an increase in premiums of 3.2% if S. 1041 were enacted. S. 1041 mandated mental health and substance abuse coverage and required parity of financial limitations between mental health and medical/surgical benefits.
- In 1997, the National Center for Policy Analysis estimated costs for mental health benefits would increase the cost of health insurance by 5-10%.

Question 24. CBO estimates that H.R. 4066, if enacted, would increase premiums for group health insurance by an *average* of 0.9 percent, before accounting for the responses of health plans, employers, and workers to the higher premiums under the bill. On July 12, 2002, CBO issued some clarifications of this estimate. CBO notes that the 0.9% premium increase is a weighted average of *both affected and unaffected plans*. According to CBO, affected plans would experience an increase of between 30 and 70 percent of their mental health costs. Do you consider these costs to be substantial and do you believe some employers may choose to not offer mental health benefits?

ANSWER: We believe that the CBO estimate does not reflect the true costs of the bill, in part because CBO relied on the experience in FEHBP, which had less than one year of experience with complying with mental health parity requirements at the time of the CBO estimate. Furthermore, as shown by the cost estimates provided in our testimony and in the answer to question #23, the CBO estimate does not fall in line with other estimates. However, even if the CBO estimate did reflect the true costs of the bill, it is important to point out that even this relatively small increase would result in nearly 300,000 additional Americans losing their health insurance. (The Lewin Group, 1999)

The CBO clarification is significant because it makes clear that affected plans would experience an increase of between 30 and 70 percent of their mental health costs.

It is important to note that in April of this year, PricewaterhouseCoopers (PwC) conducted a study of the factors fueling rising health care costs. The PwC study concluded that, of the 13.7% increase in health insurance premiums experienced by large employers between 2001 and 2002, government mandates, increased litigation, and fraud and abuse accounted for over a quarter of new spending. Given the significant mandate that would be imposed by H.R. 4066, not to mention the potential for increased litigation and fraud and abuse due to ambiguous bill language, we believe that H.R. 4066 could increase costs more than CBO estimates. While we cannot speak for employers, it is clear that with costs on the rise, employers will be forced to make tough decisions with respect to the health benefits they offer their employees.

Question 25. CBO also assumes that responses to cost increases from affected firms might include reductions in the number of employers offering insurance to their employees and in the number of employees enrolling in employer-sponsored insurance, changes in the types of health plans that are offered, and reductions in the scope or generosity of health insurance benefits, such as increased deductibles or higher co-payments. Do you agree with these assumptions?

ANSWER: Again, while we cannot speak for the employers, it is not unreasonable to assume or expect that rising health care costs will force employers to make some

tough decisions with respect to the health care benefits they offer their employees. These actions could come in the form of reductions in the number of employers offering health insurance, reductions in the types of health plans and benefits offered, and even elimination of some or all of the health benefits offered. Indeed, it is important to point out that the parity requirements only apply if an employer chooses to offer mental health benefits.

Question 26. CBO estimates two categories that would need to be offset by the budget resolution. First, CBO estimates that the resulting reduction in taxable income would grow from \$1.0 billion in calendar year 2002 to \$2.3 billion in 2011. Those reductions in workers' taxable compensation would lead to lower federal tax revenues. CBO estimates that federal tax revenues would fall by \$230 million in 2002 and by \$5.4 billion over the 2002-2011 period if H.R. 4066 were enacted. Second, CBO also stated the cost of federal spending on Medicaid and S-CHIP to the cost of the bill. CBO estimates this bill will cost those programs about \$30 million in 2002 and \$600 million over the 2002-2011 period.

Have supporters of H.R. 4066 provided specific means of offsetting these figures—whether through increased taxes or reductions in other spending?

ANSWER: We are not aware of any proposals to offset the costs that will ultimately be imposed should H.R. 4066 be enacted, however, this question would best be answered by supporters of H.R. 4066.

Question 27. A study conducted by the UCLA/RAND Research Center on Managed Care found that techniques to intensively manage care, including the use of provider networks and case management, is critical to appropriate utilization and maintaining costs. Various estimates have found a different cost increase depending on the amount of managed care involved. Costs are higher when a group health plan offers a non-managed health care plan to its employees. Is it not more likely that where a health plan is not a managed care plan that its mental health care costs are likely to be higher if this legislation is enacted? What are the potential dangers to the quality of care if health plans are unable to manage mental health benefits successfully as they are currently able to do? Is it possible to contract with all potential providers of mental health care?

ANSWER: Health plans work to ensure that patients receive the most appropriate and efficient care for their mental health conditions by using techniques such as case management, treatment plans, preauthorization practices, and utilization review and management; by negotiating separate reimbursement rates and sometimes separate service delivery systems for different benefits; and by applying specific behavioral health medical necessity and appropriateness criteria. Eliminating the ability of health plans to use such mechanisms can harm consumers by resulting in inappropriate treatment of patient mental health needs and inflation of the benefit's cost, resulting in escalating premiums. The Substance Abuse and Mental Health Services Administration (SAMHSA) estimated that a federal mental health parity mandate would cause expenditures on mental health services to increase by 111% for enrollees in PPO plans, by 63% for enrollees in point-of-service plans, and by 11% for enrollees in HMO plans. As you can see, health plans with less medical management will see a greater increase in mental health expenditures. By undermining medical management of mental health benefits, H.R. 4066 could result in reduced quality and increased costs.

Contracting with all providers of mental health care would require the American health care system to revert back to traditional indemnity insurance. If we were to revert back to such a model, the critical role health plans play in screening providers and contracting with only those who are most qualified to meet the needs of their members to avoid misuse and inappropriate use of health care services would be eliminated. Consumers have come to rely on this important function health plans serve and throwing consumers back into the days without medical management and provider credentialing would only increase misuse and inappropriate use of health care services.

Question 28. I understand that an independent analysis was done a couple years ago by the Lewin Group that concluded that for every one percent increase in health care costs (beyond the normal rate of health inflation) an additional 300,000 Americans lose their health care coverage. I assume some of those lose their coverage because their employers simply stop offering health insurance at some point. Is it not also correct that many more lose their coverage, though, because they cannot afford it themselves as the price goes up and up? Is it possible that some employers may simply decide to drop mental health coverage entirely if this legislation is enacted? If so, what sorts of companies might be forced to make such a drastic decision in your opinion?

ANSWER: See answers to questions #24 and #25.

Question 29. (a) On page six of Dr. Regier's testimony, he quotes someone who states "insurers tend to provide poor mental health benefits in order to avoid [enrollees with mental disorders]." It is difficult to understand this claim in the current context or in general. In the group market, insurers are not selling to individuals at all, but to groups. Under ERISA there is no ability to look at or discriminate based on the conditions of individuals. Is there any further basis for the above claim?

(b) Dr. Regier further notes that insurers shift costs from insurers to employers who are not able to take advantage of the market. This too is hard to comprehend. Employers purchase insurance, so, of course, the costs are shifted to the purchaser. Employers, however, can choose from among insurance products in a free market. Dr. Regier then states: "In effect, insurers are subverting responsible employers by segmenting risk and costs and shifting the obligation of mental health coverage onto an already overburdened public sector." Most employer groups that I am aware of oppose this parity legislation. Some employers provide broader insurance coverage, some provide less, and others not at all. Some employers who provide coverage now may be forced to drop this benefit if costs go up too much. Is there any further basis for the statement that employers are not able to take advantage of the market or that insurers are subverting responsible employers?

ANSWER: Dr. Regier's statements fail to acknowledge current health plan coverage as well as the basic nature of insurance. The vast majority of health plans already cover mental health and substance abuse services. In fact, in AAHP's 2002 Industry Survey, which surveyed plans representing nearly 40 million enrollees, 96% of plans reported covering mental health/ substance abuse services. In addition, health plans routinely cover pharmaceuticals used to treat those with mental illnesses. Indeed, many health plans report that drugs used to treat mental illnesses rank among the top three most frequently utilized classes of drugs, and nearly half of plans report spending more money on drugs to treat mental illness than on any other class of drugs.

Not only have health insurers not sought to avoid responsibility for covering mental disorders, but health plans have increased access to mental health services by providing affordable coverage. In fact, many health plans offer employers a range of different options of coverage for mental health to meet the needs of their workforce and premium levels they can afford. Many health plans have outreach programs, for example programs to identify patients with depression, and to assure timely outpatient follow up of patients who have been admitted to the hospital with serious psychiatric disorders.

Question 30. Dr. Regier states there is no objective evidence that businesses are paying for peripheral conditions to any statistically significant degree. That is, of course, because there is no law compelling that they cover such conditions. On page ten of Dr. Regier's written testimony he states that "'malingering' is no more likely to be covered in a post parity world than it is today." Can you provide an example of clinically significant malingering, and reasons as to why employers should be forced to cover this condition? Dr. Regier also states "it is remarkable that an insurance industry that has historically sought to avoid responsibility for treating severe mental disorders is today expressing concern that only severely mentally ill patients should be covered by parity legislation." Please comment on the basis for this statement.

ANSWER: As we have mentioned previously, the difficulty with using "clinically significant" as a tool for measurement is that there is no definition of the term and it will ultimately vary from situation to situation and provider to provider. Without a clear definition, numerous disorders and conditions with questionable scientific evidence such as sibling relationship problems and spiritual disorders, are subject to interpretation by providers as to what "clinically significant" means. Therefore it is difficult to predict what the specific demand or implications of such a standard would be. However, it is not unreasonable to assume that with the conflict of interest inherent in using the DSM-IV as a determinant of coverage, members of the APA will benefit from H.R. 4066 and the demand for treatment for mental health disorders and conditions will increase significantly.

As noted previously, the vast majority of health plans already cover mental health and substance abuse services. In AAHP's 2002 Industry Survey, which surveyed plans representing nearly 40 million enrollees, 96% of plans reported covering mental health/ substance abuse services. In addition, health plans routinely cover pharmaceuticals used to treat those with mental illnesses. Indeed, many health plans report that drugs used to treat mental illnesses rank among the top three most frequently utilized classes of drugs, and nearly half of plans report spending more money on drugs to treat mental illness than on any other class of drugs.

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QUESTION CONCERNING COMPLIANCE TIMES

Question 31. H.R. 4066 has an effective date of January 1, 2003. Does this date give employers enough time to make the needed, far-reaching changes in their health plans, especially if the Department of Health and Human Services does not have final regulations for at least several months? Should the effective date be tied to some period after the issuance of final regulations?

ANSWER: We cannot speak for employers, however, we do believe that affected entities must have enough time to come into compliance with any bill. From the health plan perspective, if H.R. 4066 were enacted, plans would need adequate time to rewrite contracts, medical policies and other plan documents in order to make sure they are compliant. Therefore, any compliance date should come at a reasonable time (such as 18 months) after final regulations are issued to ensure that necessary changes have a chance to be made and are consistent with a final regulation. It is important to note that plans participating in FEHBP were allowed approximately 18 months to comply with the administrative order to provide parity for mental health benefits.

AMERICAN PSYCHIATRIC ASSOCIATION
WASHINGTON, D.C. 20005
September 24, 2002

Honorable MICHAEL BILIRAKIS
Chairman
Subcommittee on Health
U.S. House of Representatives
Washington, D.C. 20515

DEAR MR. CHAIRMAN: This letter is in response to your additional questions for the record of the Health Subcommittee's July 23, 2002, hearing on mental health parity. As you know, I filed my initial response to the Subcommittee's questions by the original deadline of September 9. My response at that time noted that Question #29 imputed to me testimony that I did not deliver to the Subcommittee, and offered to respond to additional questions if requested. On September 20, I received an amended list of questions with instructions to respond to Question 29 as revised, and to amend my entire submission for the record. This letter is in response to the Subcommittee's amended request. I am pleased to be able to respond.

The introductory paragraph to Question 1 asserts that states which have chosen to limit parity requirements to "biologically-based or "serious" mental illness do not require use of criteria included in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV, hereafter). This is not correct. In fact, DSM-IV is the official code set for various federal agencies and for virtually all states. Indeed, there are over 650 federal and state statutes and regulations that rely on or directly incorporate DSM's diagnostic criteria. For example, the Department of Veterans Affairs disability program uses the diagnostic criteria in DSM-IV to assess whether an applicant qualifies for disability on the basis of a mental disorder [38 CFR § 4.125]. In a similar vein, state and federal courts rely heavily on DSM in making so-called *scienter* assessments in murder and other cases involving serious crimes. You may therefore wish to direct your staff to conduct a Lexis/Nexis search to identify those laws that have already incorporated the DSM-IV in statute.

The introductory paragraph also asserts that "Dr. Regier is asking Congress to incorporate an 800-page manual by reference in a statute." While I certainly support the reference to DSM-IV in H.R. 4066 and S. 543, it must be noted that the DSM reference was included in the legislation as introduced and now sponsored by more than two-thirds of the Senate and over half the House of Representatives. This is not simply an idea that originated with my testimony before your Subcommittee.

QUESTIONS REGARDING DSM IV

Question 1: Dr. Regier's testimony states that the controversy over whether to incorporate DSM IV into statutory law is a red herring. Many states that have looked

at this issue have chosen to limit any parity requirements to “biologically-based” or “serious” mental illness as they define them. Those states do not require use of DSM IV criteria. Dr. Regier is asking Congress to incorporate an 800-page manual by reference in a statute. That would give that document legal standing in many ways and with many potential consequences. In asking the Subcommittee to take such a step, we need to fully understand and resolve all of the attendant controversies. Below are some of the relevant questions.

1. It would appear from Dr. Regier’s testimony that some believe if a group health plan offers any mental health benefits, H.R. 4066 requires the plan to offer coverage for a comprehensive list of conditions set out in DSM IV. This reading is stated in the Views of the Senate Committee on Health Education Labor and Pensions of S. 543, the Senate analogue to H.R. 4066. This reading, however, is troubling and not supported by the text. Nothing in H.R. 4066 appears to require a plan to cover any category of mental health benefits, much less the long list of “conditions” in DSM IV. H.R. 4066 defines mental health benefits, in part, as:

Benefits with respect to services, as defined under the terms and conditions of the plan or coverage (as the case may be), for all categories of mental health conditions listed in [DSM IV]

The reference to DSM IV helps define what is a mental health benefit. Nowhere in the text, however, does the bill state that group health plans must provide comprehensive mental health benefits or provide benefits as broad as the conditions listed in DSM IV. Indeed, the savings clause language in proposed 712(b)(1) and (3) state that no mental health benefits are ever required at all; and that no specific services are ever required, except to the extent required by the parity rule itself. It is difficult to see how the parity rule would require any category under DSM IV.

Are you arguing that H.R. 4066 requires mental health plans to provide coverage for all conditions in DSM IV? If so, please explain your reading and your reading of the savings clause language, with specific references to language in the bill. For those that do not support such a position what clarifications are necessary to assure the appropriate policy from your perspective?

Answer: I appreciate the opportunity to clarify our understanding of the scope of the parity rule in HR 4066, as it relates to DSM-IV. I note that the question poses a very limited reading of the bill’s reference to DSM-IV as it relates to scope, namely “that if a plan provides any given mental health benefit the parity rules of the bill apply to that category of benefits.” This reading is simply a restatement of current law, under which health plans can, for example, elect to limit coverage of mental health benefits to only a handful of illnesses. It ignores the broad definition of the term “treatment limitations”, particularly the language, “or other similar limits on the duration or scope of treatment,” under which, I believe a plan cannot exclude coverage of treatment for any particular mental disorder. By retaining the structure and key terms of the current law’s definition of mental health benefits while at the same time substantially expanding that definition and employing the phrase “all categories of mental health conditions” and employing a very broad definition of the term “treatment limitations,” the bill’s authors make it clear that this bill is not simply a restatement of current law. Rather, as the legislative record amply reflects, the bill was designed to closely track the expansive policy adopted in the Federal Employee Health Benefits Program (with the exception of excluding substance abuse and chemical dependency).

Paragraph two of Question 1 confuses the concept of treatment *services* with *definitions of mental disorders* included in DSM-IV. I note that services are not the same as disorders. Services may best be understood as those treatment procedures defined by the American Medical Association’s Fourth edition of the Common Procedural Terminology (CPT-4) codes, which as you know consist of several thousand different medical services. That manual is the standard reference for Medicare, Medicaid, and all private insurance companies for defining services covered under defined benefit insurance plans. For example, outpatient medical management and psychotherapy for 25 minutes is a service designated as CPT-90805. Other procedure codes maintained by CMS include the HCPCS codes that are used most often by public sector programs to code services such as Programs of Assertive Case-Management Treatment (PACT), for severely ill homeless patients that are not usually covered by private insurance policies.

A review of the legislative record of S. 543 and H.R. 4066 clearly supports the view that the sponsors intend for the parity requirement to be extended broadly to all mental disorders and conditions in DSM-IV except for substance abuse disorders. I believe that the sponsors indeed envisioned an “all or nothing” requirement with respect to coverage of disorders and conditions referenced in DSM-IV (again exclusive of substance abuse disorders). Thus it seems clear that an insurance company could market a plan with no mental health benefits, just as they can market one

with no dental benefits. However, if a plan elects to provide mental health benefits it must provide in-network parity for all categories of mental health conditions in DSM-IV exclusive of substance abuse disorders.

While questions about the exceptions clause in the rule of construction should best be directed to its authors (in the Senate), it is my view that the purpose of the clause is to specify that comprehensive coverage of disorders does not axiomatically require that all possible services for the treatment of these disorders be offered by all health plans. By the same token, the exceptions clause appears to me to be intended to prevent the “no specific services” clause from becoming an unintended loophole under which health insurers could circumvent the broad coverage requirements in the bill as a whole.

Question 2: Is there any precedent in current federal statutes that says, in effect, that if you provide ANY given service, such as mental health services that you must cover ALL conditions listed in a manual prepared by one group of health care professionals? For example, is there a similar federal law that says that if you provide coverage for some pharmaceuticals or medical procedures that you must now cover ALL pharmaceuticals or medical procedures listed in a manual prepared by a trade association of pharmacists or medical care providers?

Answer: Question 2 continues to confuse the requirement for coverage of mental disorders as defined in DSM-IV with the provision of specific services. Again, H.R. 4066 references DSM-IV because it is, simply, the current internationally-recognized standard for the diagnosis of mental disorders. DSM was developed through an open process involving more than 1,000 national and international researchers and clinicians drawn from a wide range of mental and general health fields. It is based on a systematic, empirical study of evidence consisting of literature reviews, data analyses and extensive field trials funded by NIMH and other government entities. The bill does not require the provision of specific services, it simply requires that patients with a class of disorders not be automatically denied access to medically necessary procedures or benefits simply by virtue of the diagnosed disorder.

The question also implicitly questions the objectivity of DSM by comparing it to hypothetical manuals “prepared by a trade association of pharmacists or medical care providers.” I would be happy to brief the Subcommittee on the process by which DSM is revised. It is worth noting that Congress routinely includes in statute references to, for example, the AMA’s manual of Current Procedural Terminology, without questioning the objectivity of the CPT, presumably because the Congress recognizes that the CPT is a standard reference (see, for example, CPT statutory references in recent legislation expanding Medicare coverage of telemedical services).

Question 3: Dr. Regier’s testimony addresses the categories of DSM IV referred to as conditions for clinical focus. These include such items as: sibling relational problem; occupational problem; academic problem; and religious or spiritual problem. Some of these terms would apparently apply even if they are not termed “mental disorders” under the manual. For example, V. 62.2 “Occupational Problem” states that the condition need not be a mental disorder. The manual further states “[e]xamples include job dissatisfaction and uncertainty about career problems. The manual provides an example of V. 62.3 “Academic Problem” as “a pattern of failing grades or significant underachievement in a person with adequate intellectual capacity in the absence of a Learning or Communication Disorder or any other mental disorder that would account for this problem.” Does H.R. 4066 incorporate these conditions even where the manual states that they are conditions and not mental disorders?

Answer: This question focuses on a section of the DSM-IV that is called “Other Conditions That May be a Focus of Clinical Attention.” Only a general description of these conditions is provided because these conditions are not mental disorders per se and thus do not have specific criteria governing their inclusion or exclusion. These codes are present in the DSM because they are also found in the U.S. Clinical Modification of the Ninth Edition of the International Classification of Diseases (ICD-9-CM), which is the official diagnostic classification for all disorders and medical conditions in the United States, and is used by all general medical physicians and health care providers.

Hence, if a patient comes to a general physician complaining of an occupational problem, relational problem, or spiritual problem, inclusion of these so-called “V Codes” provides the physician with a means of recording them as an integral part of the patient’s overall medical record, and also for any future statistical analysis of the types of problems brought to various health care settings. Since mental health practitioners have used DSM as the standard reference for mental disorders for nearly 25 years, inclusion of the V Codes is provided as a courtesy to facilitate coding and crosswalking between ICD and DSM and allows clinicians an opportunity

to identify the types of “non-diagnostic” problems that are brought to their attention.

Again, it must be stated that diagnosis does not equate to treatment. If no mental disorders are diagnosed in such patient encounters, then it is highly unlikely that treatment would be authorized by the insurance plan. If, however, an individual patient manifests a clinically significant level of impairment associated with some of these conditions, insurance companies currently may authorize a time-limited treatment plan. Under H.R. 4066 there is no requirement for an insurance company to offer any particular service for any of these problems although they would not be prohibited from doing so if they considered the service to be medically necessary.

Question 4: DSM IV category 315.1 is called Mathematics disorder. One of the diagnostic criteria is that mathematical ability is substantially below that expected for the person’s age and intelligence. Another criterion is that it significantly interferes with academic achievement. Are you saying employers must have insurance to cover diagnosis and treatment for Mathematics disorder?

Answer: No. The difference between Learning Disorders, such as mathematics disorder, and the “V-codes” described in the previous question, is that evidence of a significant learning disorder is often cause for a neurological, psychological, or psychiatric evaluation to determine the presence of a neurological abnormality such as a brain malformation, a tumor, or a mental disorder that can be responsive to treatment. A determination of the appropriateness for the medical necessity of continuing treatment with insurance coverage is one made by the insurance company in conjunction with the treating clinician. If no such medical condition is found, the remedy is usually appropriately found in the educational system.

Question 5: The DSM IV manual also states criteria to describe mild, moderate, and severe disorders. Mild disorders or example are defined as “[f]ew if any symptoms in excess of those required to make the diagnosis are present, and symptoms result in no more than minor impairment in social or occupational functioning.”

Dr. Regier’s testimony mentions the term “clinically significant impairment.” Does the universe of clinically significant impairments include mild disorders and conditions? What evidence would be required to describe a mild version of the following conditions in DSM IV:

- Parent-Child Relational Problem V61.20
- Sibling Relational Problem V61.8
- Relational Problem Not Otherwise Specified V62.82
- Noncompliance with Treatment V15.81
- Adult Antisocial Behavior V71.01
- Child or Adolescent Antisocial Behavior V71.02
- Borderline Intellectual Functioning V62.89
- Age-related Cognitive Decline 780.9
- Bereavement V62.82
- Academic Problem V62.3
- Occupational Problem V62.2
- Identify Problem 313.82
- Religious or Spiritual Problem V62.89
- Acculturation Problem V62.4
- Phase of Life Problem V62.89

Are all of these conditions to be considered “clinically significant impairments”? If so, how is clinical significance measured?

Also, where in DSM IV is there a discussion of the specific medical evidence supporting each category?

How would you propose to determine what meets a parity standard between these mental health conditions and medical conditions?

Answer: As noted, V Codes are not mental disorders under DSM-IV, but rather are conditions for potential clinical focus included in DSM to maintain consistency with the ICD. For the diagnosis of a mental disorder there is a requirement for clinically significant distress or impairment in social, occupational, or other important areas of functioning. This criterion is used to establish a threshold for the diagnosis of a disorder in those situations in which some of the symptoms of a disorder may be present but of insufficient intensity to affect normal functioning. DSM has severity and course specifiers for disorders that include mild, moderate, severe, in partial remission, in full remission, and prior history of a condition. Specific criteria for defining Mild, Moderate, and Severe, have been provided for mental retardation, conduct disorder, manic episode, and major depressive episode. For example, mild mental retardation has an IQ range of 50-70 whereas severe is in the range of 20-40. Hence, none of the conditions listed in question 5 would have specific criteria for a mild version.

With regard to the specific relational and other problems referenced in Question 5, all of them do not need to have clinically significant impairments. In fact, the text of DSM-IV notes that such problems may exacerbate or complicate the management of a mental disorder or general medical condition in one or more members of the relational unit, they may be the result of such disorders, or they may be independent of other conditions. The major way in which clinical significance is measured in DSM-IV is by means of the Global Assessment of Function (GAF) Scale. In this scale of 1-100, with 100 being superior functioning, specific functional levels are identified in which mild functional impairment begins at 70, moderate at 60 and severe at 50. This scale is used by all mental health professionals and by all managed behavioral health organizations to assist in determining the medical necessity for treatment across the full range of disorders and conditions.

Question 5 also asks “where in DSM IV is there a discussion of the specific medical evidence supporting each category?” While it is true that no specific scientific evidence is provided in DSM-IV or ICD-9-CM for conditions that are the focus of clinical attention, the V-code conditions are simply lists that have been accumulated over the years to describe the reasons why patients might come to a physician or other health care provider’s office. They are coded and given a number so that statistical analyses can be made for research that is intended to improve the organization and effectiveness of meeting patient needs and requests. Insurance coverage for treatment services specifically for these conditions and all mental disorders is subject to medical necessity criteria decisions that are routinely made by insurance and managed care companies. The only parity issue involved here is that there is no reason why mental health professionals should be denied the opportunity to list these reasons for a visit when the same list is available to general medical physicians in the ICD-9-CM.

Question 6: Do you believe that the diagnostic criteria in DSM IV should have legal standing by virtue of its reference in H.R. 4066, and if so, for what legal purpose or purposes?

Answer: Yes. DSM provides the most comprehensive diagnostic framework for defining and describing mental disorders. The major legal reason why states and the Federal Government have used DSM-IV criteria, instead of ICD-9-CM criteria is to insist on a higher and more precise standard for defining a mental disorder. When a physician requests payment for a DSM-IV disorder of Major Depression (296.2), the physician is obligated to document in his chart that the patient meets at least 5 of 8 symptoms, has had a significant depressed mood every day, most of the day for over two weeks, and meets other exclusion criteria. In addition, in order to document medical necessity for treatment, the managed care organizations generally require documentation of the level of function on Axis V and indications of any psychosocial or environmental factors that are likely to affect the course of treatment. Hence, DSM-IV already has legal standing in over 650 State and Federal Statutes because it is useful for legal enforcement purposes.

Question 7: Could you support language that says that the diagnosis of a disorder and its treatment must be well established and supported by substantial scientific evidence?

Answer: Absent further discussion of “well established” and “supported by substantial scientific evidence” it is difficult to respond. What is meant by these terms? As defined by whom? As a general rule, we would be concerned that these vague standards would be used to undermine the general principles embodied in H.R. 4066 and S. 543. The intent of H.R. 4066 is to provide parity between mental disorders and other medical/surgical disorders and not to establish a different or higher standard for mental health treatment.

Question 8: Dr. Regier’s testimony says that DSM IV has “precise” criteria for diagnoses. Can you please explain category 313.81 called “oppositional defiant disorder”? The diagnostic criteria require four among the following:

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

As Dr. Regier notes criteria also requires “clinically significant” impairment. This all seems pretty subjective. Other than the phrase “clinically significant” a lot of teenagers may meet these other criteria for periods of time. This puts a lot of emphasis on the phrase “clinically significant.” Recognizing that the DSM discusses clinical significance and states that “assessing whether this criterion is met” is an

inherently difficult clinical judgment”, is it realistic to establish any objective standards for purposes of determining what is not clinically significant?

If there is a disagreement with the group health plan over an individual case, does the beneficiary or provider have the burden to show a clinically significant impairment?

Answer: Question 8 leaves out the essential feature of Opposition Defiant Disorder (ODD), namely a *recurrent pattern* of negativistic, defiant, disobedient, and hostile behavior toward authority figures that persists for *at least 6 months* (Criteria A). After meeting that specific duration criterion, it is necessary for the child to exhibit at least four out of the eight specified symptoms, to have “clinically significant impairment,” and to express such symptoms in the absence of a psychotic mood disorder. Since ODD is frequently a precursor to a more severe conduct disorder, where symptoms of violence, property destruction, and theft are required for the diagnosis, it is necessary to rule out these more severe symptoms in making the less severe diagnosis.

Clinical judgments about such disorders are made on a daily basis in determinations of medical necessity for treatment and insurance coverage. In addition, this is a diagnosis of inclusion in that there must be documentation of having four or more of these criteria for at least 6 months. Those who don’t meet these very explicit criteria may be considered to be in a normal range of functioning, even if they are somewhat troublesome.

If there is disagreement between a health plan and a patient or provider over the validity of the diagnosis and the need for treatment, the case would generally go to arbitration as would occur for any other disagreement about treatment need.

Question 9: Is it correct that the DSM IV is essentially based on a 1994 classification scheme that may require revisions now? If we incorporate DSM IV in a statute, how do we propose plans to keep up with advances in the classification and diagnostic system? Do you believe it is appropriate to delegate this authority to a non-governmental body? Since members of the American Psychiatric Association would appear to benefit financially from broad definitions of coverage, please comment on whether you believe such a delegation would represent a conflict of interest. If not, why not?

Answer: DSM-IV is embodied in over 650 state and Federal statutes and regulations because it is the internationally-recognized standard for the diagnosis of mental illness. It is not, and cannot be a static measure, any more than we should expect a textbook of general medicine to be static, since to be so would be to ignore major scientific advances in the diagnosis and treatment of medical illness. This has not proved to be any significant problem with successive revisions of other diagnostic codes such as the International Classification of Diseases (ICD-9) or the Common Procedural Terminology (CPT-4).

With respect to the question about delegation of authority to a non-governmental body, under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the classifications of all medical, surgical, and mental health procedure codes have already been delegated to the American Medical Association for CPT-4, and the dental procedure codes have been delegated to the American Dental Association. Both are non-governmental professional organizations.

Question 9 posits that criteria are written broadly so that psychiatrists can justify treatment for the widest range of patients and thus benefit financially. It should be noted that DSM, as the standard reference for the diagnosis of mental disorders, is used by virtually all mental health professionals, including psychologists, social workers, and others, as well as other non-psychiatric physicians. Thus, the inference that psychiatrists would uniquely benefit is not correct, nor is it correct that DSM is written too broadly. In fact, the successful objective of successive editions of DSM has been to *narrow* the standards by which a diagnosis is made. The DSM revision process is a collaborative effort involving literally hundreds of research investigators from multiple disciplines and in collaboration with the National Institutes of Health and international scientists and clinicians representing the World Health Organization. The more stringent criteria of DSM-IV are used by the Food and Drug Administration to specify treatment indications and by the National Institutes of Health to narrow the focus of research studies.

QUESTIONS REGARDING THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

The FEHBP questions appear to reflect some confusion about current parity requirements as based on FEHBP policy guidance versus specific plan summaries on the Office of Personnel Management website which may not be current. I would encourage Committee staff to seek clarification from pertinent Office of Personnel Management staff.

Question 10: Dr. Regier's testimony correctly notes the Office of Personnel Management has issued guidance which refers to DSM IV as an objective for health plans contracting with the Federal Employee Health Benefits Program. An initial review of several health insurance plans under FEHBP showed no reference to DSM IV in the plans available in 2002. Several of the actual plans had a definition of mental health benefits that referred to certain categories in the International Classification of Diseases (ICD). Are you aware of plans in FEHBP that specify DSM IV? What is your opinion of the plans that specified certain categories of ICD? Please list the differences in the DSM IV categories and the following language:

"Conditions and diseases listed in the most recent edition of the [ICD] as psychoses, neurotic disorders, or personality disorders; other nonpsychotic mental disorders listed in the ICD, to be determined by us..."

Given that actual FEHBP contracts are not using DSM IV, why should we mandate a change in statute?

Answer: The FEHBP does not require that a health plan specifically reference the DSM-IV but rather OPM requires parity coverage for all diagnostic categories of mental health and substance abuse conditions listed in DSM.

With over 250 plans participating in the FEHBP insurance market, it is not possible to review the written specifications used by all participating insurers and their managed behavioral health organization subcontractors. Some of the smaller insurance companies that have not had extensive experience with managed behavioral health care organizations (MBHOs) may simply use the ICD-9-CM categories of disorders which use the same ICD code numbers in Chapter 5 (Mental Disorders) as are used in an officially approved cross-walk to the more explicit criteria of DSM-IV. However, all of the MBHOs that manage a mental health benefit carve-out and all of the HMO's that manage their own benefit use the DSM-IV criteria rather than the archaic definitions of disorders contained in the glossary to ICD-9-CM. Following the requirement that participating insurers must offer coverage for all diagnostic categories of mental health and substance abuse conditions listed in the DSM-IV, referencing the ICD effectively complies with this directive. The referenced definition lists the individual subsections of the ICD chapter 5 (Mental Disorders). The referenced definition does not include mental retardation (parity coverage excluded by FEHBP) and V-codes.

Nothing in the legislative (H.R. 4066 and S. 543) language mandates that a plan must reference the DSM specifically in their plan's definition but only would require coverage for the diagnostic categories of mental health conditions listed in the DSM-IV. The purpose of specifying the more stringent DSM-IV criteria is to better assess the patient's eligibility under the medical necessity criteria geared to DSM-IV, and to limit payment of benefits to those who meet this higher standard of functional impairment than is found in the older ICD-9-CM definitions.

Question 11: A survey of FEHBP plans also indicates a number of exclusions that are not specifically provided for in H.R. 4066. These include, but are not limited to:

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

First, would you support language making clear that all exclusions like these and others found among FEHBP carriers would be available? Second, if language were also to refer to the DSM IV, how would you resolve excluding sexual dysfunction when it is clearly identified in DSM IV? Finally, under the same circumstances, how would you resolve excluding marital, educational and behavioral problems when the DSM IV includes conditions such as:

Partner Relational Problem V61.1
 Academic Problem V62.3
 Mathematics disorder 315.1
 Attention Deficit Hyperactivity Disorder 314
 Child or Adolescent Antisocial Behavior V71.02

Answer: Federal (OPM) policy regarding parity under FEHB requires that coverage be made available for services to treat all DSM IV diagnoses to the extent that the services: are included in authorized treatment plans; delivered in accord-

ance with standard protocols; and meet medical necessity determination criteria. (OPM FEHB Program Carrier Letter, April 11, 2000). S. 543 incorporates that same FEHB policy (with the exception of substance abuse and chemical dependency). While we take note of the apparent existence of isolated exclusions employed by some particular plans, and are dismayed by some which appear to be at odds with FEHBP policy, we do not believe these illustrations warrant the addition of any language to HR 4066. We note that in some instances those exclusions may well be consistent with the “no requirement of specific services” provision of the bill, and a foundation for the exclusion already exists in the bill. In our view, however, H.R. 4066 (and S. 543) already provide employers and insurers substantial flexibility, through the many compromise provisions forged in crafting S. 543, as amended. The flexibility already provided in the bill makes it unnecessary for a plan to rely only on exclusions of coverage as a mechanism to limit their exposure.

With regard to the list of exclusions noted in Question 11, it is important to note that most of these are specific types of *services* (e.g. services by pastoral, marital, or drug counselors, biofeedback, and services for sexual dysfunction). Some of the referenced services (i.e., those related to substance abuse) would presumably be excluded under the terms of H.R. 4066 and S. 543. The decision to exclude certain types of services can be made by the insurance companies, although it is interesting to note that support for the use of Viagra for certain forms of sexual dysfunction is generally covered by FEHBP and most insurance companies. The treatment of V-codes and mathematics disorder has been discussed in previous answers. The addition, however, of Attention Deficit Hyperactivity Disorder (ADHD) is unexpected. I note that ADHD is defined as a severe mental disorder in Texas and Virginia parity laws and has a well-defined set of criteria and treatment guidelines for both primary care physicians and mental health specialists. Hence, there should be no question about the inclusion of this disorder under the legislation.

Question 12: In a letter to carriers dated April 11, 2001, OPM emphasizes that managed care behavioral health care organizations (MBHO) can implement mental health benefits. Where plans do not choose to use such organizations, OPM recommends approaches such as gatekeepers, referrals to network providers, authorized treatment plans, and pre-certification of inpatient services. OPM states that plans may limit parity benefits when patients do not substantially follow their treatment plans. Do you agree with these recommendations and allowances? How can compliance with treatment plans be proven?

Answer: The FEHBP’s original policy guidance accepted a provision that allowed plans to limit parity benefits when patients did not substantially follow their treatment plans. The exclusion was counterintuitive and problematic. For example, if a patient with Schizophrenia fails to take his medication because of a partially treated psychotic delusion that the pills are poison, it makes absolutely no sense to cut off his treatment. In addition, since the FEHBP plan includes substance abuse services, concern was expressed that substance abuse relapses, which are a common occurrence with these disorders, could be used as a reason to cut off all future insured treatment.

The OPM quickly realized the potential negative consequences of such a policy and the inability of insurance companies to police compliance with treatment plans. In testimony on July 11, 2001 before the Senate Committee on Health, Education, Labor and Pensions Committee, William E. Flynn, Associate Director for Retirement and Insurance, of the Office of Personnel Management stated that “Our intent was to provide an incentive for people to get the services they need. However, some stakeholder groups expressed concern that the provision could be misused to cut off critical services to people in need. *Therefore, in our recent policy guidance, we affirmed our original intent that all members will receive medically necessary services.*”

The American Psychiatric Association concurs with this decision to ensure that all patients receive all medically necessary services.

QUESTIONS CONCERNING THE GENERAL PARITY RULE

Question 13: Even outside of mental health benefits, health plans do not treat all categories of health benefits equally. For example, outpatient physical therapy, emergency care, specialty care, speech therapy, occupational care, chiropractic care, and preventive care often have different limitations than other categories of items or services. Prescription drugs may also have different categories of co-payments based on the kind of financial arrangements a plan can arrange with pharmaceutical companies. Do you consider differences in approach among these categories to be discrimination against the particular patients who use these services? For example, are we allowing discrimination against those who need dental coverage or chiropractic care?

Answer: Question 13 again confuses services with diagnosis, and juxtaposes limits impacting a particular category of health professional with those impacting patients. Nowhere else are entire categories of diagnosis systematically excluded because of their etiology. We consider the pervasive discrimination in health insurance plans against people with mental disorders to be unique in nature and in the magnitude of the damage such discrimination does to individuals, families, and to society at large. The establishment and maintenance of arbitrary barriers to needed treatment targeted globally at mental disorders is altogether different from the examples cited in this question.

Question 14: On page seven of Dr. Regier's written testimony he claims that the Subcommittee would be outraged if Congress permitted, among other things, insurers to charge more than twice as much out-of-pocket for seeing an endocrinologist than for seeing an internist. This statement is a little unclear. Congress does permit plans to do just that. There is no current Federal restriction on what a plan should charge for a visit to an internist versus a specialist. Indeed, plans often do have different rates and conditions for such things. It is your understanding that Federal law prohibits different rates and categories on the mental health side.

Answer: I do not believe that Federal law prohibits different rates and categories on the non-mental health side. However, to date, few if any plans have chosen to have different rates for the treatment of specific categories of general illnesses. Different rates, if imposed, are usually imposed on entire general categories of providers (i.e. primary care providers versus specialists). The bill allows for this type of general distinction to continue both in general health care and in mental health care. What the bill does not permit is categorical exclusion of mental disorders and discriminatory cost sharing that impact patients, such as charging a \$50 copayment for mental health providers when the in-network copayment for all other specialists is \$25.

Question 15: H.R. 4066 would replace the 1996 parity rule and change it in a variety of ways. For example, the 1996 language provides a rule in the case where a plan has different aggregate lifetime limits on different categories of medical and surgical benefits. The 1996 language also provides a clear option to have overall lifetime and annual limits that do not distinguish between mental and non-mental health benefits. These seem like important concepts. Why do proponents of H.R. 4066 seek to make these changes? Is there any problem with the current provisions on lifetime and annual limits? Won't these changes start a new round of reviews for equivalent state laws?

Answer: In the view of the American Psychiatric Association, H.R. 4066 would mark a vast improvement over the very modest protections contained in the 1996 Mental Health Parity Act (MHPA). While a notable achievement in federal law, the promise of protection from discrimination in insurance benefit design embodied in the 1996 law has been elusive. When Congress passed the MHPA it provided only partial parity, banning the use of arbitrary *dollar* limits on mental health services on an annual or lifetime basis. Left untouched were other important and potentially costly parts of a policy like limits on inpatient days and outpatient visits and other out of pocket expenses. Those limits result in continued discrimination against millions of Americans, who are denied needed treatment or must incur substantial out-of-pocket costs not required for treatment of other medical illness. The U.S. General Accounting Office found in a May 2000 report that 87% of the employers complying with the Act merely substituted another limit for dollar limits. It is widely recognized that many employers simply "squeezed the balloon" and used, most typically, tighter day and visit limits instead. This was certainly violating the spirit of the MHPA and it has had the effect, found the GAO, of placing parity protections out of reach of many consumers.

Would passage of H.R. 4066 set off a new round of reviews of state equivalency laws? It is likely that state enabling legislation or regulatory action would be required, and that appropriate federal regulatory guidelines and oversight would also be required, as was the case with the 1996 law. I am unaware of any reports of significant problems with state implementation of enabling laws and regulation. In a similar vein, the 1990 amendments to the Medicare supplemental insurance (Medigap) plans enacted on a bipartisan basis by Congress required enactment or implementation through regulation of fairly extensive changes in applicable state legislative and regulatory standards. This was accomplished with little difficulty.

Question 16: Medical and surgical services have different reimbursement rates. For example, services required for hip replacement might include surgical fees, MRI fees, hospitalization, and rehabilitation, each of which may be reimbursed at a different level. A broken leg might require emergency room services and physical therapy in addition to physician fees, and again, each of these services might have still different reimbursement mechanisms.

If this legislation is enacted, health plans would be required to have the same cost sharing requirement for mental health services as to comparable non-mental health services covered by the same plan. What happens if a health has one deductible and coinsurance amount for physician office visits, another one for physical therapy and a third one for occupational therapy, and a fourth one for preventive services? How is the health plan supposed to comply in this case? Which one would apply for treatment of schizophrenia or treatment of sibling rivalry condition? Wouldn't parity requirements force a reevaluation of the whole system and make billing issues extremely complicated?

Answer: I would respectfully suggest that questions related to the operationalization of the definition of parity are best resolved by questioning the sponsors of the parity legislation. Nevertheless, I appreciate that enactment of parity legislation will raise operational questions which will ultimately require resolution through the development of an implementing regulation, as was the case with the Mental Health Parity Act of 1996. With respect to cost-sharing, I see no reason to believe that federal regulators will be incapable of establishing reasonable rules, and no reason whatsoever to believe that anything in this legislation will force health plans to reevaluate their billing systems or face "extreme complication". It should be noted that OPM implemented an extensive parity requirement, including coverage of treatment for substance abuse disorders, impacting millions of covered lives, without major difficulty.

Question 17: Group health plan (sic) sometimes provide a tiered formulary to address drugs. Under such an approach there are different cost-sharing requirements because the plan was able to get certain discounts or because of different cost effectiveness. Would such a plan violate parity rules if the net effect of the plan made certain psychotherapy drugs to have a higher cost-share? If so, would the determination be made on a drug-by-drug basis?

Answer: If a group health plan applied the same criteria to establishing cost-sharing requirements for psychotropic medications as are applied to other medications, there would appear to be no conflict with the provisions of H.R. 4066 and S. 5431. For example, if there is a different copayment for generic medications in comparison to brand-name medications, there would be no problem. However, if psychotropic medications were specifically singled out for higher copayments because they are used for patients with mental disorders, I believe this would be a violation of the intent of the bill. At the present time, I am unaware of any systematic exclusion of pharmacy benefits by diagnosis.

Question 18: Could plans differentiate reimbursement based on qualifications? For example, a psychiatrist may have a different reimbursement rate than a psychologist. Could this in any way violate a parity requirement? Let's assume a group health plan creates outpatient categories based on whether or not the visit was to someone with a medical degree—not on whether it was mental illness related or not. Under H.R. 4066 could such an approach be viewed as discriminatory to psychologists and, thus, to mental health benefits? That is to say, could lawyers argue that there is a disparate impact test?

Answer: Yes, plans could differentiate reimbursement based on qualifications unless there was an applicable state law preventing this. The Mental Health Equitable Treatment Act is designed to protect patients from discriminatory, exclusionary, and predatory practices by insurers, not to enrich health professionals. The MHETA has nothing to do with reimbursement. Plans would remain free to establish their provider networks and design reimbursement levels consistent with applicable laws.

Question 19: There is a savings clause on Page 8 of H.R. 4066 beginning line 11 under the title (3) NO REQUIREMENT OF SPECIFIC SERVICES. It states:

Nothing in this section shall be construed as requiring a group health plan (or health insurance coverage offered in connection with such a plan) to provide coverage for specific mental health services, except to the extent that the failure to cover such services would result in disparity between the coverage of mental health and medical and surgical benefits.

This language seems circular. What is the point of the exceptions clause? Please provide some examples illustrating the intent of this provision.

Answer: The term "disparity" appears in the portion of the Rule of Construction that deals with "specific services." This language was added to S. 543 during markup in the Senate Committee on Health, Education, Labor, and Pensions (HELP) at the request of minority members of the HELP Committee, including Senator Gregg. I respectfully suggest that questions about the intent of this language are best directed to those HELP Committee members who drafted the language and pressed for its inclusion.

That said, I believe the Committee's stated intent is quite clear. The "disparity" issue is the subject of discussions on pages 15-16 of the HELP Committee report

(Senate Report 107-61, September 6, 2001). The report states that “the bill reflects an understanding that there may be circumstances under which a health plan would not provide specific mental health services. The principle that guides the establishment of such exclusions must, however, be the principle which provides the underpinning for the reported bill.” The report then goes on to refer to the FEHBP, noting that the parity carrier letter of 2000 states that “(w)e also expect you to develop benefit packages that will make effective use of available treatment methods. Since much successful treatment for mental health...is now being delivered through alternative modalities...we encourage a flexible approach to covering a continuum of care from a comprehensive group of facilities and providers.” The report then notes that “As with medical and surgical benefits, the committee expects that the selection of services will vary over time in response to clinical trials of effectiveness and improved standards of care.” This seems straightforward.

QUESTIONS CONCERNING MEDICAL MANAGEMENT PROVISIONS

Question 20: The scope of the general parity rule in proposed 712(a) and related provisions are quite confusing. In the section entitled medical management of mental health, what is meant by the lead phrase “consistent with subsection (a)?” Do you believe a parity rule should apply to how medical management techniques such as concurrent and retrospective utilization review or application of medical necessity and appropriateness criteria must have parity rules applied when evaluating mental health services? If so, would this mean that arguments could be made that the failure to find a mental health benefit necessary or appropriate is legally bound by a comparison to such a decision for non-mental health benefits? If not, what is the purpose of the phrase “consistent with subsection (a)?”

Answer: The parity requirement in section 712(a) applies to arbitrary treatment limitations and financial requirements, terms defined in the legislation. I do not read that requirement in H.R. 4066 (or S. 543) to dictate or apply to the manner in which medical management techniques or medical necessity and appropriateness criteria are used in evaluating mental health services. I express no view as to how best to interpret the phrase “consistent with subsection (a)”, but would note that the Senate Report on S. 543 (Senate Report 107-61), discusses the “importance of recognizing [the] impact of managed care” and does not suggest that a parity rule is intended to apply to “the explicit language recognizing the ability of group health plans to utilize preauthorization, networks of behavioral health providers, and other means of managing the mental health benefits required by the legislation.”

Question 21: Under H.R. 4066, treatment limitations include “limits on the duration or scope of treatment under the plan or coverage.” Do you believe this means that decisions to limit the duration or scope of treatment for therapeutic reasons must be held up to a parity test? If so, how would this work? If not, why are these included in the definition of treatment limitations subject to the parity requirements?

Answer: I believe H.R. 4066 makes a very clear distinction between impermissible arbitrary limitations (on duration or scope of treatment) **in** a health plan and the clearly permissible exercise of clinical judgment regarding the duration or scope of treatment needed by an individual patient. I do not believe the bill is ambiguous on this point.

With respect to specific phrasing, as the General Accounting Office found in its review of the implementation of the 1996 parity law, employers and insurers evaded the spirit of that law and, by exploiting gaps in its provisions, erected new barriers to mental health treatment. It is my understanding that in light of the disappointing experience with implementation of parity under the 1996 Act, the authors of the Mental Health Equitable Treatment Act defined the term “treatment limitations” to include the phrase “or other similar limits on the duration or scope of treatment under the plan or coverage” to ensure that this legislation did not create new loopholes or avenues (as the 1996 act did) to erect new arbitrary mechanisms to limit access to needed mental health treatment.

Question 22: Proponents of parity legislation state that plans will be able to minimize abuse through use of the standard “medically necessary and appropriate.” During the patients’ bill of rights debate it seemed like the emphasis was on getting away from the use of this standard by plans. In fact, patients’ rights legislation all make clear that plans decide which categories to cover, what exclusions to have, and what cost-sharing to have. Would this new legislation drive more “medical necessity” determinations by plans? Also, patients’ rights legislation, if enacted, would subject such decisions to lawsuits for damages. Do you favor such lawsuits and what would be the cost of such suits? In the 40 states that permit external review of deni-

als such reviews can average more than \$600 a case. Wouldn't more qualitative decisions concerning medical necessity increase these expenditures?

Answer: No. The Congressional Budget office estimates that the Mental Health Equitable Treatment Act (S. 543) will result in an increase in premiums of just 0.9 percent. In a CBO memorandum dated March 26, 2002, CBO analysts Jennifer Bowman, Stuart Hagen, and Alexis Ahlstrom addressed the potential cost implications of the Bipartisan Patient Protection Act (S. 1052) on their cost estimates for S. 543. Rather than a "skyrocketing" of mental health costs, they concluded that if S. 1052 preceded consideration of S. 543, the increase in premiums for group health insurance would be an average of just 0.2 percentage points more than the current 0.9 percent increase estimate of S. 543 alone, for an aggregate combined premium impact of 1.1 percent.

The assumption of the employers and insurers mentioned is that a Patient Bill of Rights (PBR) would expose them to additional scrutiny and challenges to their management decisions. However, their vulnerability to additional costs would be directly related to a company's current conformity to professional standards of care in making decisions about "medical necessity." Since most companies have provisions for an independent review of contested claims and perform in a responsible manner, there should be a minimal impact of PBR on costs. On the other hand, if the company performs its management role in a clearly discriminatory manner, as the Minnesota BlueCross/BlueShield did prior to the suit against them by the Minnesota Attorney General, inappropriate profits for the insurance company will be decreased. (see Josephine Marcotty, "Hatch, Blue Cross settle mental-health lawsuit," *Minnesota Star Tribune*, 19 June 2001). In summary, those insurers most likely to be impacted are "bad actors" who should rightly be viewed as outliers.

QUESTIONS CONCERNING COSTS INCREASES AND POTENTIAL DECREASES IN INSURANCE
COVERAGE

Question 23: Dr. Cutler's testimony notes that the California Public Employees Retirement System has reported that mental health parity legislation would cause premiums for its two PPO options to increase by 3.3 and 2.7 percent, respectively, in 2003. Dr. Cutler also notes that a 1998 study commissioned by the Substance Abuse and Mental Health Services Administration estimated that a mental health parity law would increase premiums by an average of 3.4 percent. Has your organization reviewed these studies? Does your organization disagree with them, and if so, on what points?

Answer: The cited CalPERS premium increases are for self-funded PPO plans only, and are thus misleading in the context in which the data is presented. CalPERS states that members pay a higher premium for these plans. In fact, only 26 percent of CalPERS enrollees are in PPOs. CalPERS also states that the PPO parity rate increase will allow enrollees and employers to continue to have sound coverage and good value. CalPERS has not released a cost increase attributable to mental health parity for the 74 percent of CalPERS members that are in HMOs. While I am not yet prepared to dispute the cited CalPERS premium increases, I do not believe that the CalPERS self-funded PPO experience of approximately 300,000 covered lives can be generalized to the entire country. It must also be noted that the limited information that is available from Mathematica Policy Research, Inc. on implementation of the California mental health parity law states that "*the law does not appear to have had any adverse consequences on the health insurance market to date, such as large increases in premiums or decreases in health insurance offerings by employers.*"

The 1998 SAMHSA report is four years old and does not reflect the fact that enrollment in managed behavioral healthcare has grown by over 30 percent in that time period. The report recognized that health maintenance organizations would have only a 0.6 percent premium increase. Therefore, the increase in managed care enrollment over the last several years will lower the cost estimate. The HayGroup Mental Health Benefit Value Comparison (MHBVC) actuarial model used to generate the 3.4 percent estimate is described on page 29 of the SAMHSA report (DHHS Publication No. (SMA) 98-3205), and was developed in 1997 under contract with NIMH. An earlier model had been used by the Congressional Budget Office and Congressional Research Service to estimate the predicted costs of the Mental Health Parity Act of 1996.

In June 2000, the HayGroup updated their model with more recent data from the Medical Expenditure Panel Survey (MEPS) data of the Federal Agency for Healthcare Research and Quality (AHRQ), the FEHB, and multiple private insurance company claims data. The result of this update was released by the National Advisory Mental Health Council Report to the Senate Appropriations Committee,

which estimated that the national cost of implementing mental health parity nationwide would be an average premium increase of 1.4 percent, including the cost of coverage for substance abuse services. More recent and accurate cost estimates have been made by the Congressional Budget Office (.9%) and PricewaterhouseCoopers (1%). It should also be noted that CBO estimated that the actual increase in costs to employers would be closer to a 0.4% increase because of changes in management that were likely to occur.

Question 24: CBO estimates that H.R.4066, if enacted, would increase premiums for group health insurance by an *average* of 0.9 percent, before accounting for the responses of health plans, employers, and workers to the higher premiums under the bill. On July 12, 2002, CBO issued some clarifications of this estimate. CBO notes that the 0.9% premium increase is a weighted average of *both affected and unaffected plans*. According to CBO, affected plans would experience and increase of between 30 and 70 percent of their mental health costs. Do you consider these costs to be substantial and do you believe some employers may choose to not offer mental health benefits?

Answer: Parity opponents who testified before your subcommittee promoted the statistic that H.R. 4066 and S. 543 would result in an increase of 30 percent to 70 percent in mental health benefits, apparently without realizing the base-rate for these projected increases. This is one half of the equation, and the statistic is meaningless in a vacuum. The increase of 30 percent to 70 percent occurs on a base that mental health costs currently represent only 2 percent to 3 percent of total health premium cost. If one does the math, the projected 30 percent to 70 percent increase on this base yields a weighted premium increase of 0.9 percent. This, of course, is the essential finding of the Congressional Budget Office and parenthetically speaks directly to the minimal attention paid to mental health care under most insurance plans. There is no controversy here.

Question 25: CBO also assumes that responses to cost increases from affected firms might include reductions in the number of employers offering insurance to their employees and in the number of employees enrolling in employers-sponsored insurance, changes in the types of health plans that are offered, and reductions in the scope or generosity of health insurance benefits, such as increased deductibles or higher co-payments. Do you agree with these assumptions?

Answer: We are aware that CBO modeling expects various possible responses to cost increases on the employer and employee sides. In its analysis of S. 543, CBO explains that it is the combination of behavioral responses to a cost increase due to parity that results in only a 0.4% premium increase, which employers will pass through to employees. There are studies that suggest that employers and employees are more willing to pay higher premiums when they receive a new benefit rather than pay more for the same.

Question 26: CBO estimates two categories that would need to be offset by the budget resolution. First, CBO estimates that the resulting reduction in taxable income would grow from \$1.0 billion in calendar year 2002 to \$2.3 billion in 2011. Those reductions in workers' taxable compensation would lead to lower federal tax revenues. CBO estimates that federal tax revenues would fall by \$230 million in 2002 and by \$5.4 billion over the 2002-2011 period, if H.R. 4066 were enacted. Second, CBO also stated the cost of federal spending on Medicaid and S-CHIP to the cost of the bill. CBO estimates this bill will cost those programs about \$30 million in 2002 and \$600 million over the 2002-2011 period.

Have supporters of H.R. 4066 provided specific means of offsetting these figures—whether through increased taxes or reductions in other spending?

Answer: The CBO estimate of the reduction in taxable income and the corresponding reduction in national federal tax revenues of \$230 million in 2002, is a testament to the minimal cost of less than \$1 /person/year for over 260 million citizens, that is actually involved in removing this longstanding policy of discrimination against persons with mental disorders. Although CBO is required by law to make such estimates before any market response is accounted for, this small amount in a trillion dollar health care budget and in a multi-trillion dollar economy could be considered a rounding error. As the CBO stated, it is likely that even this amount would be cut in half or there could be no increase depending on the effect of management on the actual costs of the mental health benefit.

Question 27: A study conducted by the UCLA/RAND Research Center on Managed Care found that techniques to intensively manage care, including the use of provider networks and case management, is critical to appropriate utilization and maintaining costs. Various estimates have found a different cost increase depending on the amount of managed care involved. Costs are higher when a group health plan offers a non-managed health care plan to its employees. Is it not more likely that where a health plan is not a managed care plan that its mental health care costs are likely

to be higher if this legislation is enacted? What are the potential dangers to the quality of care if health plans are unable to manage mental health benefits successfully as they are currently able to do? Is it possible to contract with all potential providers of mental health care?

Answer: At the present time, it is probable that less than 5 percent of health plans have no supply-side management of mental health costs and rely completely on demand-side controls of higher co-payments, visit-limits, and bed-day limits for controlling costs. Patients covered under these plans have no protection against catastrophic costs of medically necessary treatment for severe mental disorders. Despite the enactment of the 1996 Mental Health Parity Act, the lifting of annual and life-time dollar caps for mental disorder treatment was undercut by the imposition of other treatment restrictions or higher cost sharing. It is likely that in order to meet the requirements of a "full parity" law, those few insurance companies that do not manage their mental health benefits themselves (carve-ins) or contract out with a managed behavioral healthcare organization (MBHO) to manage the benefit, will probably make such arrangements. At the present time, there appears to be adequate capacity in the MBHO industry or in the insurance and HMO plans to provide such management services for both public Medicaid services and for private health plans. The committee is referred to the American Managed Behavioral Health Association (AMBHA) and to the independent consultant group Open Minds for additional information on the capacity of this industry.

Question 28: I understand that an independent analysis was done a couple years ago by the Lewin Group that concluded that for every one percent increase in health care costs (beyond the normal rate of health inflation) an additional 300,000 Americans lose their health care coverage. I assume some of those lose their coverage because their employers simply stop offering health insurance at some point. Is it not also correct that many more lose their coverage, though, because they cannot afford it themselves as the price goes up and up? Is it possible that some employers may simply decide to drop mental health coverage entirely if this legislation is enacted? If so, what sorts of companies might be forced to make such a drastic decision in your opinion?

Answer: I am not an expert on employee price sensitivity to the cost of health insurance but I am aware of disagreement in the health economics field over a formula predicting how many individuals lose health insurance for every one percent of premium increase. It must be noted clearly that there appears to be little or no evidence of any significant dislocations attributable to mental health parity in the many states that have implemented some form of parity law. Real-world analyses of the actual impact of the 1996 Act (i.e., GAO and Hay Group) show no significant dislocations occurring as a result of the 1996 law.

The General Accounting Office has criticized Lewin Group estimates suggesting ratios of 1% = 400,000 loss and of 1% = 300,000 loss, calling these questionable in a July 7, 1998 letter to Senator Jeffords signed by William J. Scanlon, noting that "Insufficient information is currently available to predict accurately the coverage loss that may result from health insurance premium increases associated with new federal mandates." GAO also noted that rising premiums do not always translate into coverage loss, commenting that "Between 1988 and 1996, health insurance premiums increased, on average, by approximately 8 percent per year. During roughly the same period, 1987 to 1996, the proportion of workers who were offered insurance by their employers rose from 72.4 percent to 75.4 percent, according to one study."

Further, the Congressional Budget Office disavowed use of a formula of 1% = 200,000 coverage loss for any purpose other than the original legislation to which that CBO analysis applied, the Domenici amendment to S. 1028, the Health Insurance Reform Act in April 1996. As CBO Director June O'Neill said in a November 20, 1997 letter to Representative Charles Norwood, "Consequently, the mental health parity estimate cannot be used as a general rule of thumb for the impact of health insurance mandates on health insurance coverage."

You asked if it is possible that some employers may simply drop mental health coverage. MHETA does not require employers to offer mental health benefits. However, I am unaware of any state where passage of a mental health parity law led to a noticeable loss of coverage, nor was there such an adverse effect after 2001 implementation of a more expansive parity benefit in the Federal Employee Health Benefit Program. The CBO's estimate is that the employer's share of the cost increase would be only 0.4%—less than half of the average 0.9% cost increase. This suggests that MHETA compliance will not be a large cost item necessitating dropping of mental health benefits that are valuable to protecting the productivity of one's workforce.

Question 29: (a) On page six of Dr. Regier's testimony, he quotes someone who states "insurers tend to provide poor mental health benefits in order to avoid [enroll-

ees with mental disorders].” It is difficult to understand this claim in the current context or in general. In the group market, insurers are not selling to individuals at all, but to groups. Under ERISA there is no ability to look at or discriminate based on the conditions of individuals. Is there any further basis for the above claim?

(b) Dr. Regier further notes that insurers shift costs from insurers to employers who are not able to take advantage of the market. This too is hard to comprehend. Employers purchase insurance, so, of course, the costs are shifted to the purchaser. Employers, however, can choose from among insurance products in a free market. Dr. Regier then states: “In effect, insurers are subverting responsible employers by segmenting risk and costs and shifting the obligation of mental health coverage onto an already overburdened public sector.” Most employer groups that I am aware of oppose this parity legislation. Some employers provide broader insurance coverage, some provide less, and others not at all. Some employers who provide coverage now may be forced to drop this benefit if costs go up too much. Is there any further basis for the statement that employers are not able to take advantage of the market or that insurers are subverting responsible employers?

Answer: The referenced quote on page 6 of my written statement is by Richard G. Frank, Ph.D., Margaret T. Morris Professor of Health Economics at Harvard Medical School. The quotation is from an article by Dr. Frank (“Will Parity in Coverage Result in Better Mental Health Care?”) published in the December 6, 2001 issue of the *New England Journal of Medicine*.

Dr. Frank and his co-authors were fully cognizant of the fact that insurers sell to groups and not to individuals, and that ERISA prohibits explicit discrimination against employees with specific disorders. However, the insurance industry understands that individual insurance companies make the most money by seeking to minimize costs by insuring the healthiest populations who have the least risk of needing—potentially expensive health services. If, for example, a large corporation or the Federal Government offer multiple insurance plans to employees, a plan that promised very good mental health benefits, cardiac care, or AIDS treatment would attract enrollees who considered it likely that they would use such benefits. This would most likely result in a self-selected group of enrollees who use more services and decrease profits for the insurance company, a phenomenon known as adverse selection.

Hence, if there is not a level playing field where coverage of treatment for illnesses (such as mental illness) are equivalent, plans that offer better mental health benefits will tend to attract and accumulate higher cost enrollees while those that offer poor benefits will attract low-cost and more profitable patients. For example, when Aetna offered a superior mental health benefit in the early 1980’s, its costs increased in comparison to other insurers offering less comprehensive coverage in a fee-for-service market. In the current managed care market, costs have dropped, but there is still significant variation in the scope of mental health benefits that are offered by private insurers.

The need for comprehensive coverage of treatment for mental illness tends to be underestimated because of stigma and ignorance of risk. Insurance companies have thus been able to offer poor coverage as one means of improving their competitive position in the insurance market. Poor insurance coverage in turn shifts the cost of treatment onto employees, via higher out-of-pocket expenses coupled with their underlying premium payments for inadequate coverage. Under our current discriminatory system, an employer offering very good mental health coverage may attract employees with higher personal or family need—for—such coverage. In effect, insurance coverage rather than job opportunities may become the driving employment decision for these employees. The failure to provide parity coverage of treatment for mental illness remains an unaddressed objective of the Health Insurance Portability and Accountability Act (HIPAA) of 1996. As you know, HIPAA was intended in—large part to prevent insurance driven “job lock” for workers who otherwise would have taken advantage of the economy and moved to new jobs but could not do so because insurers refused to cover those new employees who had pre-existing health conditions.

With respect to mental health benefits, state insurance commissioners have long recognized that insurance companies can increase profits by refusing to cover certain mental health benefits, resulting in “safety-net” cost-shifting from insurers to state mental hospitals and publicly-funded community mental health centers. To limit this cost shifting to state budgets, most states have long required the provision of minimal mental health benefits before insurance plans are licensed to do business in the state. More recently, 35 states have required all insurance companies to provide some defined form of parity mental health benefits to prevent such cost shifting. As you know, however, ERISA exempts self-insured plans from such state regu-

lation. As a result, as few as 20-30 percent of the residents of individual states may currently benefit from state parity laws.

Since HIPAA has made it impossible for insurance companies to use strict limits on pre-existing conditions for competitive advantage, insurers may seek advantages by offering poor mental health coverage. Just as Congress acted to remove the incentives for offering strict limits on pre-existing conditions, Congress clearly should act to correct the failure of the market itself to eliminate discriminatory coverage of treatment of mental illness. Leveling the playing field by enacting broad mental health parity legislation is an appropriate remedy that will ultimately prevent the shifting of costs to the public sector and to responsible employers who, like Mr. Hackett, have recognized the need for parity in mental health coverage.

With respect to the question about efforts by insurers or others to subvert the market, Health Maintenance Organizations (HMOs) in particular have sought to limit their responsibility for providing broad mental health coverage. For example, the Public Health Service Act lays out general requirements at Title XIII for Health Maintenance Organizations (initially enacted in 1972), whereby the only "basic mental health service" listed in Section 1302[300e-1](D) were "short-term (not to exceed twenty visits), outpatient evaluative and crisis intervention mental health services." This is hardly—broad based non-discriminatory coverage of treatment, and underscores the ability of many HMOs and private plans to shift costs by forcing individuals with more severe and/or chronic mental disorders into the public sector.

As late as 1998, the Federal Employee Health Benefits (FEHB) plan benefits descriptions for Aetna/US HealthCare, Cigna, and Kaiser Health Plans excluded "Care for psychiatric conditions which in the professional judgment of Plan doctors are not subject to significant improvement through relatively short-term treatment." Notably,—per Executive Order, FEHB plans have effectively rescinded that provision and are now offering parity coverage of treatment for mental and substance abuse disorders to 9 million federal employees and their families. The FEHB requirements provide the framework for H.R. 4066 and S. 543. Surely employees in the rest of the country deserve what federal employees and their families now have? Enactment of a national mental illness treatment parity insurance coverage requirement is the appropriate remedy for continued discriminatory and cost-shifting strategy.

Question 30: Dr. Regier states there is no objective evidence that businesses are paying for peripheral conditions to any statistically significant degree. That is, of course, because there is no law compelling that they cover such conditions. On page ten of Dr. Regier's written testimony he states that "malingering" is no more likely to be covered in a post parity world than it is today." Can you provide an example of clinically significant malingering, and reasons as to why employers should be forced to cover this condition? Dr. Regier also states "it is remarkable that an insurance industry that has historically sought to avoid responsibility for treating severe mental disorders is today expressing concern that only severely mentally ill patients should be covered by parity legislation." Please comment on the basis for this statement.

Answer: Much has been made of peripheral conditions included in the DSM-IV, such as the "V-codes." It is important to understand that because the DSM-IV is used by clinicians to apply ICD-9-CM codes to insurance claims, the DSM-IV also contains many "Conditions That May Be a Focus of Clinical Attention" that include the V-codes. These conditions, as distinct from *disorders*, include malingering (V65.2), Academic (V62.3), Occupational (V62.2) and Religious (V62.89) Problems that may be an additional focus of clinical attention in any primary care or specialty care medical practice. The multi-disciplinary and international American Psychiatric Association DSM-IV workgroups never developed any diagnostic criteria for these conditions. Thus, these codes are included as a courtesy to the ICD-9-CM committee in order to have comparable reporting of these reasons for seeking care with other areas of medicine. Generally, these codes are not used as a primary diagnosis to request payment for any mental health service—with the exception of an evaluation to determine if a client's poor functioning is the result of a true mental disorder or the result of malingering. Insurance companies rarely if ever reimburse for V codes and this will not change with parity. They are not mental disorders, have no treatment guidelines, and cannot meet even the most lax medical necessity criteria. The arguments about V-codes ignore these facts and are intended to mislead Congress and the public.

If the Congress wishes to make it explicit that only mental disorders and not these reasons for seeking care are to be covered in the legislation, they can certainly do so. However, it must be stated clearly that neither these "Conditions" nor any "Diagnosis" in the DSM or the ICD-9-CM constitutes entitlement to treatment. In comparison with the approximately 250 diagnoses in DSM-IV, ICD-9-CM has over 12,000 diagnoses and conditions that include diaper rash and premature baldness

that insurance companies do not have an obligation to treat. Although having a diagnosis in the DSM-IV means that an important threshold of severity has been passed (beyond what would be required by the official ICD-9-CM), the level of severity and the availability of effective treatments are other requirements of “medical necessity” that are used in determining an entitlement to treatment.

There is no shred of credible evidence that states or plans are paying for treatment of the above-mentioned conditions or that they are receiving requests for such payment in more than a miniscule percentage of claims. The American Managed Behavioral Health Association (AMBHA) just completed an analysis of claims data for 2001. The data represents 45 million covered lives and 11.5 million mental health claims totaling \$3 billion. The data shows that, for “jet lag, a total of 12 claims per million claims were actually filed, totaling \$8 billed per \$1 million billed, or 0.001 percent of total claims filed, and 0.0008 percent of total mental health dollars billed.

QUESTIONS CONCERNING COMPLIANCE TIMES

Question 31: H.R. 4066 has an effective date of January 1, 2003. Does this date give employers enough time to make the needed, far-reaching changes in their health plans, especially if the Department of Health and Human Services does not have final regulations for at least several months? Should the effective date be tied to some period after the issuance of final regulations?

Answer: The effective date of legislation is inevitably the domain of legislators. I note that health insurers routinely alter their plans on a calendar year, and I believe that the effective date embodied in the proposed legislation offers incentives to Congress to conclude deliberations, and our regulatory agencies to promulgate implementing regulations, in a timely fashion.

Thank you for the opportunity to respond to these important questions. I will be happy to further address your concerns at any time as Congress continues to correct this discriminatory practice towards the mentally ill insured.

Sincerely,

DARREL A. REGIER, *M.D., M.P.H.*
Director, Division of Research and Executive Director,
American Psychiatric Institute for Research and Education



226 Organizations Supporting the Mental Health Equitable Treatment Act
 Domenici/Wellstone (S. 543) and Roukema/Kennedy (H.R. 4066)
 July 22, 2002

Advocates for Youth
Alliance for Aging Research
Alliance for Children and Families
Alzheimer's Association
American Academy of Child and Adolescent Psychiatry
American Academy of Family Physicians
American Academy of Neurology
American Academy of Pediatrics
American Academy of Physical Medicine and Rehabilitation
American Academy of Physician Assistants
American Association for Geriatric Psychiatry
American Association for Marriage and Family Therapy
American Association for Psychosocial Rehabilitation
American Association of Children's Residential Centers
American Association of Pastoral Counselors
American Association of School Administrators
American Association of Suicidology
American Association on Mental Retardation
American Board of Examiners in Clinical Social Work
American College of Medical Genetics
American College of Nurse-Midwives
American College of Physicians – American Society of Internal Medicine
American Congress of Community Supports and Employment Services (ACCSES)
American Counseling Association
American Diabetes Association
American Family Foundation
American Federation of State, County and Municipal Employees
American Federation of Teachers
American Foundation for Suicide Prevention
American Group Psychotherapy Association
American Heart Association
American Hospice Foundation
American Hospital Association
American Humane Association
American Jail Association
American Managed Behavioral Healthcare Association (AMBHA)
American Medical Association
American Medical Rehabilitation Providers Association
American Mental Health Counselors Association
American Music Therapy Association
American Network of Community Options and Resources
American Nurses Association
American Occupational Therapy Association
American Orthopsychiatric Association
American Osteopathic Association
American Political Science Association
American Psychiatric Association

American Psychiatric Nurses Association
 American Psychoanalytic Association
 American Psychological Association
 American Psychotherapy Association
 American Public Health Association
 American School Counselor Association
 American School Health Association
 American Society of Clinical Pharmacology
 American Therapeutic Recreation Association
 American Thoracic Society
 America's Health Together
 Anorexia Nervosa and Related Eating Disorders, Inc.
 Anxiety Disorders Association of America
 Association for the Advancement of Psychology
 Association for Ambulatory Behavioral Healthcare
 Association for Clinical Pastoral Education, Inc.
 Association for Science in Autism Treatment
 Association of Jewish Aging Services
 Association of Jewish Family & Children's Agencies
 Association of Maternal and Child Health Programs
 Association of University Centers on Disabilities
 Attention Deficit Disorders Association.
 Autism Society of America
 Bazelon Center for Mental Health Law
 Brain Injury Association of America, Inc.
 Camp Fire USA
 The Carter Center
 Catholic Charities USA
 Center for the Advancement of Health
 Center for Women Policy Studies
 Center on Disability and Health
 Center on Juvenile and Criminal Justice
 Central Conference of American Rabbis
 Chicago Public Schools
 Child & Adolescent Bipolar Foundation
 Children and Adults with Attention-Deficit/Hyperactivity Disorder
 Children's Defense Fund
 Children's Healthcare Is a Legal Duty
 Child Welfare League of America
 Christopher Reeve Paralysis Foundation
 Clinical Social Work Federation
 Coalition for Juvenile Justice
 Commission on Social Action of Reform Judaism
 Corporation for the Advancement of Psychiatry
 Council for Exceptional Children
 Council of State Administrators of Vocational Rehabilitation
 Council on Social Work Education
 Cure Autism Now
 Dads and Daughters
 Disability Rights Education and Defense Fund, Inc.

Disability Service Providers of America
 Division for Learning Disabilities (DLI) of the Council for Exceptional Children
 Easter Seals
 Eating Disorders Coalition for Research, Policy & Action
 Employee Assistance Professionals Association
 Epilepsy Foundation
 Families For Depression Awareness
 Families USA
 Family Violence Prevention Fund
 Family Voices
 Federation of American Hospitals
 Federation of Behavioral, Psychological & Cognitive Sciences
 Federation of Families for Children's Mental Health
 Freedom From Fear
 Friends Committee on National Legislation (Quaker)
 Human Rights Campaign
 Inclusion Research Institute
 Institute for the Advancement of Social Work Research
 International Association of Jewish Vocational Services
 International Association of Psychosocial Rehabilitation Services
 International Community Corrections Association
 International Dyslexia Association
 International Society of Psychiatric-Mental Health Nurses
 Iris Alliance Fund
 Jewish Federation of Metropolitan Chicago
 Johnson Institute
 Kids Project
 Kristen Watt Foundation for Eating Disorder Awareness
 Learning Disabilities Association of America
 Legal Action Center
 Lutheran Ofc. for Governmental Affairs, Evangelical Lutheran Church in America
 MentalHealth AMERICA, Inc.
 NAADAC, The Association for Addiction Professionals
 National Alliance for Autism Research
 National Alliance for the Mentally Ill
 National Alliance for Research on Schizophrenia and Affective Disorders
 National Alliance to End Homelessness
 National Asian American Pacific Islander Mental Health Association
 National Asian Women's Health Organization
 National Association for the Advancement of Colored People (NAACP)
 National Association for the Advancement of Orthotics & Prosthetics
 National Association for Children's Behavioral Health
 National Association for the Dually Diagnosed
 National Association for Rural Mental Health
 National Association of Anorexia Nervosa and Associated Disorders -- ANAD
 National Association of Children's Hospitals
 National Association of Counties
 National Association of County Behavioral Health Directors
 National Association of Developmental Disabilities Councils
 National Association of Mental Health Planning & Advisory Councils
 National Association of Protection and Advocacy Systems

National Association of Psychiatric Health Systems
National Association of School Nurses
National Association of School Psychologists
National Association of Social Workers
National Association of State Directors of Special Education
National Association of State Mental Health Program Directors
National Center on Institutions and Alternatives
National Coalition Against Domestic Violence
National Coalition for the Homeless
National Coalition of Mental Health Consumers and Professionals
National Committee to Preserve Social Security and Medicare
National Council for Community Behavioral Healthcare
National Council of Jewish Women
National Council of La Raza
National Council on the Aging
National Council on Alcoholism and Drug Dependence
National Council on Problem Gambling
National Council on Suicide Prevention
National Depressive and Manic-Depressive Association
National Down Syndrome Congress
National Down Syndrome Society
National Eating Disorders Association
National Educational Alliance for Borderline Personality Disorder
National Education Association
National Exchange Club Foundation
National Foundation for Depressive Illness
National Health Council
National Hopeline Network
National Housing Conference
National Law Center on Homelessness & Poverty
National Mental Health Association
National Mental Health Awareness Campaign
National Multiple Sclerosis Society
National Network for Youth
National Organization for Rare Disorders
National Organization of People of Color Against Suicide
National Osteoporosis Foundation
National Partnership for Women and Families
National PTA
National Rural Health Association
National Schizophrenia Foundation
National Senior Citizen Law Center
National Therapeutic Recreation Society
National Treatment and Research Advancements Association for Personality Disorder
National Eating Disorders Association
NISH (National Industries for the Severely Handicapped)
Obsessive Compulsive Foundation
Office & Professional Employees International Union
Older Adult Consumer Mental Health Alliance
Partnership for Recovery
Presbyterian Church (USA), Washington Office

Prevent Child Abuse America
Rebecca Project for Human Rights
Samaritans Suicide Prevention Center
School Social Work Association of America
Service Employees International Union
Shaken Baby Alliance
Sjogren's Syndrome Foundation
Society for Personality Assessment
Society for Public Health Education
Society for Social Work and Research
Society for Women's Health Research
STOP IT NOW!
Suicide Awareness Voice of Education
Suicide Prevention Advocacy Network
The Arc of the United States
Title II Community AIDS National Network
Tourette Syndrome Association
Union of American Hebrew Congregations
Unitarian Universalist Association of Congregations
United Cerebral Palsy Association
United Church of Christ, Justice and Witness Ministry
United Jewish Communities
Volunteers of America
Working Assets
Women of Reform Judaism
Yellow Ribbon Suicide Prevention Program
Youth Law Center

