MHSACM

MHSACM, Inc.

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Vicker V. DiGravio III, *President / CEO* **Ellen Attaliades, MA,** *Chairman*

January 30, 2008

Senator Richard T. Moore, Chair
Joint Committee on Health Care Financing
State House, Room 111
Boston, MA 02133

Representative Patricia A. Walrath, Chair
Joint Committee on Health Care Financing
State House, Room 236
Boston, MA 02133

Re: H. 4423, *An Act Relative to Mental Health Parity*

Dear Chair Moore, Chair Walrath and Honorable Committee Members:

On behalf of the membership of Mental Health & Substance Abuse Corporations of Massachusetts (MHSACM), I thank you for the opportunity to submit comments in **strong support of H. 4423, *An Act Relative to Mental Health Parity.*** As you may know, MHSACM is a statewide association representing 87 mental health and substance abuse provider organizations. Our members are the primary providers of publicly-supported behavioral healthcare services in the Commonwealth, serving 117,000 individuals on any given day and employing approximately 22,000 people.

Build on the Foundation Laid in 2000

The Mental Health Parity law that was passed in 2000 was landmark legislation for the people of the Commonwealth in terms of insurance coverage of mental illness, but MHSACM members' experience with the law since then has proven that it falls short of the needs of many Massachusetts families. This bill expands the scope of the existing law to ensure that individuals with behavioral health needs get the treatment they need and deserve by eliminating archaic distinctions among mental disorders.

Non-Biologically-Based Disorders

As you know, the current law requires insurers to provide non-discriminatory coverage for the diagnosis and treatment of "biologically-based" mental disorders, but permits limitations on coverage for so-called "non-biologically-based" illnesses. As a result, insurers can limit coverage of the diagnosis and treatment of substance abuse, trauma, eating disorders and other illnesses more strictly than they can for general health conditions. This is unfair and discriminatory and the Legislature should abolish it.

MHSACM strongly supports the bill's elimination of the distinction between biologically-based disorders and other mental health and substance abuse disorders. The distinction is of dubious

value and its elimination will ensure all insured individuals would be covered for treatment of mental health and substance abuse disorders to the same extent that all other medical conditions are covered.

Substance Abuse Treatment

MHSACM also strongly supports the bill's expansion of the parity law to require coverage of the diagnosis and treatment of substance use disorders on par with physical illnesses. The medical efficacy of substance abuse treatment is unquestionable. In a 2004 report to the Joint Committee on Insurance, the Division of Health Care Finance and Policy (DHCFP) summarized the medical efficacy of substance abuse treatment: "[d]ecades of research have established that a variety of alcohol and drug abuse treatment methods are successful," provided that individuals are permitted to remain in treatment for adequate periods of time.[i]

Last amended in 1982, the current insurance law requires carriers to cover at least 30 days per year of inpatient care and up to $500 per year of outpatient benefits for "treatment of alcoholism".[ii] This is an outmoded approach, particularly for outpatient care, as insurers rely on managed care tools such as utilization management and review to a larger degree than arbitrary benefit limits defined by days or dollars. The bill does nothing to prevent utilization of managed care tools such as utilization review.

Under the current mental health parity law, the current limitations on inpatient and outpatient services do not apply when such care is provided "in conjunction with" treatment for a mental disorder, but the law is ambiguous about its application and does not extend far enough.[iii]

There are more than 570,000 Massachusetts residents in need of treatment for alcoholism or other substance use disorders, and of those 488,000 are not receiving treatment.[iv] For these individuals, the treatment gap can be explained due to: 1.) lack of health insurance; 2.) health insurance that does not cover substance use disorder treatment; and/or 3.) inability to pay for out-of-pocket treatment costs.

People denied treatment by insurers are faced with three choices:

- Paying out of their own earnings or savings, *even though they are paying health care premiums to their insurers*;
- Competing with uninsured patients for the limited taxpayer-funded Department of Public Health treatment beds; or,
- Forgoing treatment because they can not afford it.

Of those who *do* receive treatment, the single largest source of payment is individual earnings or savings.

Too often, the burden of inadequate or unrealized coverage falls on individuals and their families. The existing mandates have not kept pace with current medical knowledge about substance use disorders, and it is time to end outdated, unfair discrimination by requiring insurers to treat substance use disorders like any other physical illness.

Despite fears that substance abuse parity could dramatically increase insurance premiums, the same 2004 DHCFP report showed that the average premium increase due to substance abuse parity would be only 0.27% (under $10 per member annually).[v] In addition, the study found that states with parity mandates have experienced decreased lengths of stay for costlier inpatient services and increased use of more cost-effective services.

Further, this bill should not increase costs to the Commonwealth in any way. The Group Insurance Commission and MassHealth Managed Care already incorporate substance abuse parity in their plans. In addition, the DHCFP report estimated that if substance abuse parity were adopted, the state would actually *save* $6 to $25 million annually.[vi] When insurers create barriers to treatment, not only do healthcare costs of their members increase, but the burden on the state increases by the increase in demand for free treatment provided by the Department of Public Health. We expect that parity will reduce this burden on Massachusetts taxpayers by reducing the demand for state-funded treatment by patients with private insurance.

In adopting the original parity law, the Legislature rectified an inherent unfairness in our healthcare system and sent a clear message that discrimination against individuals with mental illness will not be tolerated in the public or private sectors. By adopting substance abuse parity, we will reject the discrimination that causes people with substance abuse disorders to go without care because of the persistence of scientifically rejected notions about illness in our healthcare system. Substance abuse parity would end this outdated discrimination by ensuring that substance abuse disorders are treated like any other illness for insurance purposes.

Despite the tremendous advances of the parity law, too many insured individuals with mental illness and/or substance use disorders face limits on critical treatment services. Studies show that implementation of full parity increases premiums by less than 1% and it reduces treatment barriers. MHSACM strongly supports *An Act Relative to Mental Health Parity*, comprehensive parity legislation that guarantees full coverage for substance use disorders on the same terms and conditions as physical disorders, and we urge a favorable report for this bill.

Sincerely,

Vicker V. DiGravio III

Vicker V. DiGravio III
President and CEO

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[i] Division of Health Care Finance and Policy, Commonwealth of Massachusetts Mandated Benefit Review, Review and Evaluation of Proposed Legislation Entitled: An Act to Provide Equitable Coverage for Substance Abuse, Senate Bill 872, provided for the Joint Committee on Insurance.

[ii] G. L. c. 175, § 110(H); c. 176A, § 10; c. 176B, § 4A 1/2; c. 176G, § 4; c. 32A, §22(f).

[iii] For example, the precise meaning of "in conjunction" is unclear, and it is also unclear whether coverage for individuals with co-occurring disorders applies to all mental disorders in the DSM or only to those enumerated disorders entitled to full parity under the statute

[iv] Substance Abuse and Mental Health Services Administration, "National Survey on Drug Use and Health, 2002".

[v] Division of Health Care Finance and Policy, Commonwealth of Massachusetts Mandated Benefit Review, Review and Evaluation of Proposed Legislation Entitled: An Act to Provide Equitable Coverage for Substance Abuse, Senate Bill 872, provided for the Joint Committee on Insurance.

[vi] Division of Health Care Finance and Policy, Commonwealth of Massachusetts Mandated Benefit Review, Review and Evaluation of Proposed Legislation Entitled: An Act to Provide Equitable Coverage for Substance Abuse, Senate Bill 872, provided for the Joint Committee on Insurance.

Nurses United for Responsible Services
P.O. Box 920711
Needham, Massachusetts 02492

June 20, 2008

Honorable Salvatore DiMasi
Speaker of the House
State House – Room 356
Boston, MA 02133

Dear Speaker DiMasi:

Nurses United for Responsible Services (NURS) is a professional organization that represents Advanced Practice Psychiatric Nurses (Psychiatric Clinical Nurse Specialists and Psychiatric Nurse Practitioners). NURS supports House Bill 4423, "A BILL RELATIVE TO MENTAL HEALTH PARITY" and is heartened by the progress it has made so far with your leadership and that of Committee Chairs, Representatives Balser, Walrath, Donato and Scaccia, who have kept this legislation alive.

It is unfortunate that many DSM diagnoses are not covered or are only minimally covered by insurance carriers. This discrimination in mental health and substance abuse coverage, based on an artificial distinction between biologically based and non-biologically based illnesses, limits access to medically necessary treatment and increases the risk of a patient's further deterioration. Of note, this type of discrimination does not exist in primary care medicine. Examples of current non-parity behavioral health diagnoses are posttraumatic stress disorder, eating disorders and substance abuse disorders. Patients carrying these diagnoses often experience severe symptoms which are highly disruptive to their mental and emotional wellbeing and may, in fact, actually threaten life itself. Of course, members of NURS understand that medical necessity would still guide treatment and that insurance carriers would not be responsible for services that are required to be covered by school systems, the Department of Mental Health, the Department of Corrections and other state agencies.

Untreated mental illness and substance abuse problems cause a great burden to the Commonwealth in terms of time lost from work, medical problems, crime, disrupted home lives and the perpetuation of dysfunctional behavior from generation to generation. Advanced Practice Psychiatric Nurses are in a position to provide affordable psychotherapy and psychopharmacological services. All too often, our patients are denied access to these services if their diagnoses are not on an "approved" list, arbitrarily determined by health care plans that were created to provide these services.

Please support House Bill 4423 so that discrimination by behavioral health diagnosis is eliminated and the citizens of the Commonwealth have access to the treatment they deserve for all mental health and substance abuse conditions which impact on their health and quality of life. Thank you.

Respectfully submitted,

Tedi Hughes
NURS Co-Chair

Sharon Reynolds
NURS Legislative Committee Chair

Cc: Hon. Ruth Balser, House Chair, Joint Committee on Mental Health and Substance Abuse
Hon. Robert DeLeo, Chair, House Committee on Ways and Means
Hon. Patricia Walrath, House Chair, Joint Committee on Health Care Financing
Hon. Angelo Scaccia, Chair, House Rules Committee
Hon. Kay Khan, Chair, Mental Health Caucus
Christie Hager, Speaker DiMasi's Office

The Commonwealth of Massachusetts
MENTAL HEALTH LEGAL ADVISORS COMMITTEE

FRANK LASKI
EXECUTIVE DIRECTOR

399 WASHINGTON ST., 4TH FLOOR
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June 18, 2008

The Honorable Speaker of the House Salvatore DiMasi
The State House, Room 356
Boston, MA 02133

RE: H. 4423, An Act Relative to Mental Health Parity

Dear Speaker DiMasi,

Mental Health Legal Advisors Committee, an agency that represents persons with mental illness throughout the Commonwealth, supports the passage of H. 4423 and respectfully requests favorable action on this critical health care issue.

The bill amends the Massachusetts Mental Health Parity bill, Chapter 80 of the Acts of 2000, to provide full insurance parity for treatment of mental disorders. The list of "biologically based" disorders under the current law is overly restrictive and omits significantly disabling disorders that can have both biological and non-biological components, such as post traumatic stress disorder and eating disorders. Such an artificial distinction in the law between "biologically based" versus "non biologically based" disorders is not based on medical science.

While mental illness is treatable, often individuals with mental illness do not seek treatment due to stigma. Parity both eliminates discrimination in insurance coverage and dispels pervasive societal stigma. Without mental health insurance parity, myths that mental illness is a personality flaw and that symptoms are untreatable are only perpetuated. Full mental health parity will fight this stigma and help ensure access to treatment for those who need it.

H. 4423 aligns the Commonwealth's parity law with other states that have found significant advantages and minimal cost impact in covering the full range of mental disorders. The U.S. Substance Abuse and Mental Health Services Administration reported that after the passage of Vermont's comprehensive mental health parity law, spending for mental health and substance abuse declined while the likelihood of obtaining mental services increased. Fears that full mental health parity will increase the financial burden for health insurance providers are not supported by the experience of

other states with comprehensive parity laws. Furthermore, insurance plans still retain their authority to manage medical necessity reviews.

Mental health parity may in fact have a positive impact on the economy since untreated mental illnesses have been demonstrated to contribute to declining workplace productivity. Improving access to treatment will result in increased productivity and positive economic benefits. With the current parity law in place, consumers' work opportunities are hindered, which negatively affects both their sense of self-sufficiency and their recovery.

We thank you for your support and urge you to encourage the speedy passage of H. 4423.

Sincerely,

Susan Fendell
Senior Attorney

Cc: The Honorable Robert DeLeo
The Honorable Ruth Balser
The Honorable Patricia Walrath
The Honorable Angelo Scaccia
The Honorable Kay Kahn
Ms. Christie Hager

National Alliance on Mental Illness

June 24, 2008

Dear Legislator:

I am contacting you today as both a constituent and a member of the National Alliance on Mental Illness of Massachusetts, or NAMI Mass. I write to offer my strong support of **House Bill 4423, *An Act Relative to Mental Health Parity.***

- This legislation is essential to fully provide the proper and necessary insurance coverage to all those in the Commonwealth living with mental illness.
- Mental health insurance parity acknowledges that mental illness is not a choice, that it can be treated, and that treatment works.
- As family members and support providers, and consumers throughout the state, 5000 NAMI members are asking you for your support.
- It is imperative that the residents of the Commonwealth are able to receive full insurance coverage of vital and effective mental health treatment, regardless of the cause of their diagnosis.

This legislation is an important step in the effort to reduce the stigma surrounding all mental illness, and to ensure equal and effective mental health care for all Massachusetts residents.
For more information:

NAMI MASS 781-948-4048 Mental Health Parity

NAMI Mass websight:WWW.NAMIMASS.org

Thank you.

Sincerely,

Constituent & NAMI Mass member
Street Address: _____
_____

The Commonwealth of Massachusetts
Joint Committee on Health Care Financing

REP. PATRICIA A. WALRATH
HOUSE CHAIR
ROOM 236, STATE HOUSE
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SEN. RICHARD T. MOORE
SENATE CHAIR
ROOM 111, STATE HOUSE
BOSTON, MA 02133-1054
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February 13, 2008

Sarah Iselin, Commissioner
Division of Health Care Finance and Policy
Room 243, State House
Boston, MA 02133

Dear Commissioner Iselin:

Pursuant to section 38C of chapter 3 of the General Laws the Joint Committee on Health Care Financing is submitting a request for the Division to review the following mandate:

H.4423 An Act Relative to Mental Health Parity

This bill was reported favorably, as redrafted by the Joint Committee on Mental Health and Substance Abuse and referred to our committee. The original bill number was H.1871.

If you have any questions please contact Jessica Taubner at 617-722-2430.

Sincerely,

Patricia Walrath
PATRICIA A. WALRATH
Chairs, Committee on Health Care Financing

Richard T. Moore
RICHARD T. MOORE

2/15/08 Caroline mailed

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*** TX REPORT ***
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The Commonwealth of Massachusetts

HOUSE OF REPRESENTATIVES
STATE HOUSE, BOSTON 02133-1054

REP. PATRICIA A. WALRATH
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House Chairman
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mailed by S. Moore

FAX COVER SHEET

FAX NUMBER: (617) 722- 2346

TO: Ellen Sandler
DN. Health Care Finance & Policy

FROM: Jessica Taubner
Health Care Financing Committee

NUMBER OF PAGES: 2 (Including Cover Sheet)

COMMENTS:

MASSACHUSETTS

John J. Curley, Jr., J.D., Senior Vice President
Chief Government and Public Affairs Officer

July 28, 2008

The Honorable Salvatore F. DiMasi
Speaker of the House
Room 356, State House
Boston, MA 02133

The Honorable Therese Murray
Senate President
Room 332, State House
Boston, MA 02133

Re: Senate Bill 2840, *An Act Relative to Mental Health Parity*

Dear President Murray and Speaker DiMasi:

On behalf of Blue Cross Blue Shield of Massachusetts, I am writing to share our thoughts on Senate Bill 2840, *An Act Relative to Mental Health Parity.* Both the House and the Senate should be commended for their actions this legislative session in demonstrating a commitment to the improvement of behavioral health services for children and adults. While we agree with these efforts generally, we remain concerned about the significant need to maintain affordable coverage. As such, we believe that the Senate bill provides an appropriate balance and hope that this version is sent to the Governor for his signature.

Senate Bill 2840 improves upon the current law by adding four medically recognized disorders to the existing list of nine covered diagnoses. It further provides the Commissioner of Mental Health with the ability to identify additional mental disorders which should be covered. The alternative language found within House 4423 would instead require coverage for a voluminous list of behavioral health conditions, many of which do not have established, evidence-based treatments. The Division of Health Care Finance and Policy recently reported that this much broader expansion would add nearly $40 million to the health care system. At a time when budget shortfalls and the urgent need for cost containment dominate the legislative agenda, these added costs would seriously hinder the purchasing ability of consumers and employers and run counter to the goals of the state's landmark Health Care Reform law.

Accordingly, we respectfully ask you to adopt the reasoned approach of Senate Bill 2840. Please do not hesitate to contact me with any questions or comments you may have.

Sincerely,

John J. Curley, Jr.

Cc: Chairwoman Patricia Walrath, Joint Committee on Health Care Financing

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June 24, 2008

Hon. Salvatore F. DiMasi, Speaker
Massachusetts House of Representatives
State House, Room 356
Boston, MA 02133

Dear Speaker DiMasi:

On behalf of a coalition of business groups and health plans committed to ensuring access to quality and affordable health care in the Commonwealth, we are writing with regard to House Bill 4423, An Act Relative to Mental Heath Parity. The bill would expand the Mental Health Parity Law (Chapter 80 of the Acts of 2000) to require coverage on a parity basis for a broader range of conditions, resulting in higher health insurance premiums for employers and individuals. We are very concerned that the bill is scheduled for consideration by the House on June 26 in violation of both the mandate moratorium provisions of the Health Reform Law and the mandate review statute passed in 2002. At a time when we are seeing an economic downturn and we all continue to work to make health reform a success by containing costs, it is perplexing to us that the Legislature would add yet another costly and ill-advised mandate onto an already strained business community and onto consumers who need to comply with the individual mandate requirement.

The original Mental Health Parity Law was a carefully crafted compromise that balanced the need to ensure appropriate insurance coverage for those with serious mental illnesses against the potential cost of providing unlimited coverage for other services provided by behavioral health clinicians. That law requires parity coverage for serious mental illnesses and generous (but not unlimited) coverage for other conditions, such as relationship issues. House Bill 4423 would destroy that compromise and require parity coverage for all conditions listed in the Diagnostic and Statistical Manual (DSM-IV), making the Massachusetts law among the broadest in the nation.

It is important to note that while this debate has been taking place in Massachusetts, Congress has also been giving consideration to parity legislation. Provisions requiring coverage of the entire DSM-IV are likely to be removed from parity legislation that may move in Congress later this session. Senator Kennedy, in March, offered the House a compromise proposal that eliminated the proposed requirement for coverage of the entire DSM-IV. Business groups and others lobbied for such removal due to the costs associated with such a broad expansion of coverage.

We question the need for House Bill 4423. As mentioned above, the existing parity law already requires coverage for serious mental illnesses to the extent medically necessary. The issue is not with coverage available to Massachusetts residents, but, rather, with the availability of child psychiatrists and inpatient beds to service severely mentally ill children in the Commonwealth. House Bill 4423 does not address these important issues.

Instead, the bill before the House mandates additional insurance coverage for discretionary outpatient sessions aimed at personal growth and relationship issues. While, in theory, health plans would have the ability to manage the benefit, the reality is that there are not commonly accepted clinical standards upon which to make medical utilization determinations on these types of issues, making it difficult for health plans to effectively manage this benefit. It should be noted by way of example that a large Massachusetts health plan, at the request of one of its employer accounts, provides parity coverage for all DSM-IV conditions. Outpatient utilization for that account is almost double that of the health plan's overall experience. We believe these results would be illustrative of a similar trend should House Bill 4423 become law.

As you know, several of the signatories below were part of the broad coalition that helped to pass the State's landmark Health Care Reform Law. Controlling the rising cost of health care has emerged as the critical issue surrounding the long-term sustainability of health care reform going forward. Controlling health care costs are not new issues to the Massachusetts employer community. Having seen double digit rate increases for the past several years, employers have tried to take steps legislatively to rationalize the passage of costly mandates. In 2002, employers lobbied and got passed a mandate review law (M.G.L. Chapter 3 §38c) requiring the Division of Health Care Finance and Policy ("DHCFP") to review all proposed mandates to understand their impact on the cost of health insurance as well as the medical efficacy of a mandate's passage. Many states have similar laws in place.

Additionally, as part of the landmark health reform law, employers again worked for passage of a moratorium on new mandates until such time as DHCFP reviewed and issued a report on all existing mandates to assess their total costs and their medical efficacy. The moratorium was included as a mechanism to avoid adding new costs and was intended to help control the cost of coverage as individuals began purchasing coverage to comply with the individual mandate. Under Section 127 of Chapter 58, Acts of 2006, the moratorium is in effect until the latter of January 1, 2008 or until DHCFP publishes a comprehensive review of the mandated health benefits in effect on January 1, 2006. To date, that report has not been issued and, as such, the moratorium remains in place.

We are very concerned that the bill may be taken up prior to DHCFP completing its analysis and are concerned that there has not been sufficient time for it to complete a comprehensive analysis as DHCFP provided the plans with the necessary data requirements for its review last month and only recently completed collecting data from the major carriers.

Further, it is our understanding that DHCFP will be relying upon mandate studies from other states, specifically a study conducted by the California Health Benefits Review Program (CHBRP)

analyzing a similar bill. We have expressed our concerns with reliance upon the CHBRP report as a basis from which to draw affirmative conclusions about the impact of this mandate on Massachusetts' health care costs.

The Massachusetts and California health landscapes are different in a number of ways when analyzing mental health utilization and services. For example, California providers generally operate under a capitated system that creates incentives for tight networks of providers to not overtreat. Conversely, Massachusetts' health plans generally reimburse providers on a fee-for-service basis and have broad networks of mental health professionals. Additionally, California has two large behavioral health specialty plans overseeing utilization for a majority of California residents. Their utilization management techniques are far more aggressive than what typically occurs in the Massachusetts outpatient setting. Further, CHBRP was unable to review potential interventions for over 400 diagnoses listed in the DSM due to time constraints and the breadth of potential treatment protocols for the many mental health conditions that would be included in full parity. Finally, it is important to note that the California bill was vetoed due to cost concerns and the veto was not overridden by the California Legislature.

Additionally, Vermont's mental health law has been cited as being comparable to the language included in House Bill 4423. However, the Vermont and Massachusetts health landscapes are different in a number of ways when analyzing mental health utilization and services. Vermont has two health plans that cover the bulk of the insured market and is largely a capitated market. Those plans limit their networks of providers and aggressively manage the care; approving a limited number of visits at a time and requiring providers to request additional visits and complete detailed reports before granting approval.

Massachusetts has among the highest rate of mental health utilization in the country. According to statistics compiled by the state's Bureau of Managed Care, in 2006 (the last full year when data is available) Massachusetts commercial health plans covered nearly 2.1 million outpatient behavioral health visits for the treatment of major depression, eating disorders, chemical dependency, and other mental health disorders. This level of utilization is substantially higher than the national average.

We believe that House Bill 4423 will make it more difficult for consumers and employers to obtain affordable coverage options and will disproportionately affect small employers. While large employers are able to self-insure and avoid covering certain state mandated benefits (or place limits on them), small employers typically do not have this option. As a result, they must include benefits they may not want or need. At a time when employers are struggling with rising health care costs, it is important they have the flexibility to manage their health insurance costs. We strongly urge you to take no action on House Bill 4423 until there has been sufficient time to understand the impact the bill will have on the cost of health care.

We thank you for the opportunity to offer comments and look forward to continuing to work with you to ensure access to quality and affordable health care for all Massachusetts residents.

Sincerely,

Richard C. Lord

Richard C. Lord, President & CEO
Associated Industries of Massachusetts

Paul Guzzi

Paul Guzzi, President & CEO
Greater Boston Chamber of Commerce

Peter Forman, President & CEO
South Shore Chamber of Commerce

Jon B. Hurst, President
Retailers Association of Massachusetts

Deanne Healey, Executive Director
Peabody Chamber of Commerce

A. Theodore Welte, CCE, President & CEO
MetroWest Chamber of Commerce

Jeanne L. Osborn, President and CEO
Greater Lowell Chamber of Commerce

Francis R. Carroll, Founder and CEO
Small Business Service Bureau, Inc.

Jean Russell, President
MA Association of Health Underwriters

John Hebert, Principal
Hebert Communications

Jim Edholm, President
BBI Benefits, Inc.

William Vernon, Massachusetts State Director
National Federation of Independent Business

Richard B. Kennedy, President & CEO
Worcester Regional Chamber of Commerce

Peter F. Kortright, President & CEO
Fall River Chamber of Commerce & Industry

Robert G. Bradford, President
North Shore Chamber of Commerce

Shannon Linde, Vice President
The MBA Group

Jeff Rich, Vice President
Northeast Business Trust

John Reis, Human Resources Manager
Interstate Container

Rose Sandoval, Cofounder
Benefit Strategy Partners

Vince Fiore, Sr., Owner
Fiore Toyota

Rolando A. Capanna, President
Winchester Benefits Group

Nancy M. Briss
Finelli Benefits LLC

Geoff Howard, Manager, Human Resources
Strategic Information Resources

Colleen M. Wade
W. Walsh Company

Maynard H. Southard, CEO & Treasurer
ECHO Industries, Inc.

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Tucker & Shepley Benefits and Insurance

Sandra A. Dennis, President
Sandra A. Dennis Insurance & Financial Services

John J. Curley, Jr., Senior VP and Chief Government and Public Affairs Officer
Blue Cross Blue Shield of Massachusetts

Bruce M. Bullen, Chief Operating Officer
Harvard Pilgrim Health Care

Thomas A. Croswell, Chief Operating Officer
Tufts Health Plan

Marylou Buyse, M.D., President
Massachusetts Association of Health Plans

cc: His Excellency Deval Patrick
Hon. Therese Murray, Senate President
Hon. Robert DeLeo, Chair, House Ways and Means Committee
Hon. Steven Panagiotakos, Chair, Senate Committee on Ways and Means
Massachusetts House of Representatives
Massachusetts Senate
Leslie Kirwan, Secretary, Executive Office for Administration & Finance
JudyAnn Bigby, MD, Secretary, Executive Office of Health & Human Services
Nonnie Burnes, Commissioner, Division of Insurance
Sarah Iselin, Commissioner, Division of Health Care Finance & Policy
Jon Kingsdale, Executive Director, Commonwealth Health Insurance Connector Authority

January 8, 2008

Hon. Representative Patricia Walrath, Chair
House Committee on Health Care Financing
State House, Room 236
Boston, MA 02113

Re: HB 4423: An Act Relative to Mental Health Parity

Dear Chairwoman Walrath:

On behalf of a coalition of business groups and health plans committed to ensuring access to quality and affordable health care in the Commonwealth, we are writing with regard to House Bill 4423. The bill seeks to expand the Mental Health Parity Law (Chapter 80 of the Acts of 2000) and would include services beyond what is currently provided under traditional medical coverage. This bill, as currently drafted, runs counter to the intent of Chapter 80, which was intended that mental health services be given equal coverage as physical health services; a position with which we agree.

At a time when residents, employers, and policymakers are struggling with rising health care costs, House Bill 4423 will exacerbate the challenge they face. To determine the efficacy and need for expanding the Mental Health Parity Law and the impact it would have on the cost of coverage, we ask that the Committee have the Division of Health Care Finance and Policy (DHCFP) conduct an analysis of House Bill 4423.

Currently, the Mental Health Parity Law, as outlined under Chapter 80, requires coverage of biologically-based mental disorders as described in the most recent edition of the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association. This includes schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder, delirium and dementia, affective disorders, and any biologically-based mental disorders appearing in the DSM that are scientifically recognized and approved by the commissioner of the Department of Mental Health in consultation with the commissioner of the Division of Insurance.

House Bill 4423 would expand the law by eliminating the reference to biologically-based disorders and require coverage for the diagnosis and treatment of mental disorders as described in the most recent edition of the DSM. Eliminating the reference to biologically-based disorders and requiring coverage for mental disorders described in the DSM would expand the list of services to include learning disorders, motor skills disorders, and communication disorders and other conditions that are not medical. This mandate opens the door to requiring coverage for diagnoses that are not appropriately treated in the behavioral health setting and would require coverage of "non-medical" services as part of medical coverage.

Diagnostic manuals serve to educate professionals and are not intended to serve as a list to establish insurance coverage. There are many medical diagnoses that exist but are not covered by traditional health insurance. For example, brow lifts are included in coding and diagnostic reference materials, but are a purely cosmetic procedure and not covered by health insurance. Other examples are procedures that are experimental or not proven; codes exist for these services, yet they are not covered by health insurance.

State data indicates that health plan members have access to needed mental health services. In 2006 (the last full year of data), of the nearly 3 million fully insured Massachusetts residents that were eligible for the state's external appeals program, the Office of Patient Protection received only 99 eligible appeals that concerned mental health issues, upholding or partially upholding health plan decisions in more than 77 percent of cases

	2002	2003	2004	2005	2006
Total Mental Health Appeals	175	230	127	127	137
Eligible Mental Health Appeals	125	156	89	87	99
Upheld/Partially Upheld Health Plan Decisions	86	95	52	57	76
Overturned Health Plan Decisions	39	61	37	30	23

Extending parity to include additional diagnoses will be extremely costly. As the implementation of the Health Care Reform Law progresses, one of the critical issues is and will continue to be affordability. With penalties for the individual taking effect in 2008, employers will need to be able to provide their employees with health insurance that is not only affordable but meets the state standards for Minimum Creditable Coverage. It is therefore imperative that careful attention be paid to the cost of health care. This bill as constructed would promote overuse of discretionary services without improving care for the seriously ill.

We believe that the Committee should send House Bill 4223 to DHCFP to examine the need for these services and the financial impact of the bill, as defined by the Mandate Review Law (Chapter 300 of the Acts of 2002). At a time when affordability is a major concern for everyone in health care, we believe it is important that DHCFP conduct a full analysis to determine how the legislation will affect the cost of coverage for individuals who are currently insured.

We thank you for the opportunity to offer comments and look forward to continuing to work with you to ensure access to quality and affordable health care for all Massachusetts residents.

Sincerely,

Eileen McAnneny
Associate General Counsel & Senior VP, Government Affairs
Associated Industries of Massachusetts

Dolores L. Mitchell
Executive Director
Massachusetts Group Insurance Commission

Paul Guzzi
President & CEO
Greater Boston Chamber of Commerce

Peter Forman
President & CEO
South Shore Chamber of Commerce

William Vernon
Massachusetts State Director
National Federation of Independent Business

Jon B. Hurst
President
Retailers Association of Massachusetts

Jeff Rich
Vice President
Northeast Business Trust

Marylou Buyse, M.D.
President and CEO
Massachusetts Association of Health Plans

cc: The Hon. Salvatore DiMasi, Speaker, Massachusetts House of Representatives

MASSACHUSETTS MENTAL HEALTH COALITION
195 Worcester Street
Suite 303
Wellesley, MA 02481

December 19, 2007

Representative Patricia Walrath, House Chair
Joint Committee on Health Care Financing
State House, Room 236
Boston, MA 02133

RE: H. 1871 New draft H.4423

Dear Chairperson Walrath:

The Mental Health Coalition, an organization composed of mental health professional and trade organizations and family and consumer groups, strongly supports "An Act Relative to Mental Health Parity," H. 1871.

The current coverage limitation based on mental health diagnosis alone is artificial and based in stigma. Mental health care should be rendered on a basis equal to physical health care. The time is long past when insurers should be able to deny health care coverage based on the type of illness from which the person suffers.

Such discrimination in insurance policies is inhumane and economically harmful to Massachusetts. When health plans do not cover necessary mental health treatment, the taxpayer inevitably foots the bill. Lacking treatment, persons with mental illness lose their jobs and private insurance and are made dependent upon public benefits or, worse yet, become homeless and end up in our jails.

The legislature started to correct insurance inequities with "An Act Relative to Mental Health Benefits." This legislature has the ability to bring Massachusetts into the 21st century by eliminating anachronistic and incorrect distinctions between mental health diagnoses and their treatment.

The Mental Health Coalition urges you to favorably report H. 1871.

Sincerely,

Elena Eisman /sf

Elena Eisman, Chairperson
Mental Health Coalition
Executive Director
Massachusetts Psychological Association

Carol J. Trust, LICSW, Executive Director
National Association of Social Workers, MA Chapter

Laurie Martinelli
Executive Director
NAMI-Mass

Vicker V. DiGravio III, President & CEO
Mental Health and Substance Abuse Corporations of Massachusetts

David Matteodo, Executive Director
Massachusetts Association of Behavioral Health Systems

Susan Fendell, Senior Attorney
Mental Health Legal Advisors Committee
Liaison for Coalition for the Legal Rights of Persons with Disabilities

Eugene Fierman, MD, President
Massachusetts Psychiatric Society

Sharon Reynolds, APRN, BC
Chair, Legislative Committee
Nurses United for Responsible Services (NURS)

MASSACHUSETTS

John J. Curley, Jr., J.D.
Vice President
Public, Government and Regulatory Affairs
Corporate Affairs Division

February 4, 2008

The Honorable Richard T. Moore, Senate Chair
Joint Committee on Health Care Financing
State House Room 111
Boston, MA 02133

The Honorable Patricia A. Walrath, House Chair
Joint Committee on Health Care Financing
State House Room 236
Boston, MA 02133

Re: House Bill 4423, *An Act Relative to Mental Health Parity*

Dear Senator Moore and Chairwoman Walrath:

On behalf of Blue Cross Blue Shield of Massachusetts (BCBSMA), I am writing to express our opposition to House Bill (HB) 4423, *An Act Relative to Mental Health Parity.* Although we support the overall goal of improving behavioral health services for children and adults in the Commonwealth, we believe this legislation could result in increased health care costs, adversely affect the ability of consumers and employers to purchase and maintain health insurance, and potentially lead to patients receiving care that may not be evidence-based or clinically appropriate. HB 4423 would require an overly broad expansion of coverage for mental health services and could result in a cost-shifting of services from school systems and the Department of Education to the private health insurance market, causing premiums to increase. The legislation requires "nondiscriminatory coverage for the diagnosis and medically necessary and active treatment of mental disorders and alcoholism and other drug abuse and dependence disorders, as described in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association."

This mandate would require coverage for a voluminous list of behavioral health conditions. For many of these conditions listed in the DSM, there continues to be significant debate over whether there is a clinically meaningful distinction between the disorder and other conditions that are currently covered by health plans. For many other

conditions, clearly established, evidence-based treatments have not been identified and validated. This provision of mental health parity could cost up to $1.25 per member per month (PMPM), or **$30 million per year**. This represents an increase in total health care expenses of 0.5 percent and an increase in behavioral health expenses of 10 percent. In order to control for unintended increases in cost, several states that require mental health parity coverage under DSM or the most recent edition of the International Classification of Diseases (ICD) do so with clearly delineated exclusions and limitations (e.g., exclude V codes, learning disorders, motor skill disorders, communication disorders, caffeine-related disorders, relational problems) that serve to appropriately target benefits. Also, it is important to note that the Department of Mental Health, in consultation with the Division of Insurance, already has authority to broaden parity by identifying other biologically based disorders appearing in the DSM that are scientifically recognized.

Without exclusions and limitations, there is also the potential to shift the cost of certain mental health services included under DSM that are currently covered by school systems and the Department of Education to the private insurance market. Any cost shifting would result in additional cost increases and corresponding premium increases above and beyond the $30 million identified above.

HB 4423 also attempts to create a statutory definition of intermediate services as "including, but not be limited to, community-based detoxification, acute residential treatment, partial hospitalization, day treatment and crisis stabilization licensed or approved by the department of public health or the department of mental health." Intermediate level of care includes a range of non-inpatient or community-based services that provide more intensive interventions compared to those that are available through the typical outpatient care. The purpose of intermediate care is to provide individuals with mental illness or youths with serious emotional disturbances access to medically necessary non-custodial treatment in the least restrictive, clinically appropriate setting. BCBSMA understands the importance of intermediate care in the continuum of coverage provided to our members in need of behavioral health services. As you may know, over the past year the Division of Insurance and the Department of Mental Health (DMH) have been working with various parties, including the health plans, to define intermediate care. We recommend that the Legislature defer to this collaborative and deliberate process for defining these services. For patients requiring residential services, BCBSMA continues to maintain that only acute residential services should be covered and that health plans should not be required to offer non-acute residential services and long term care. In many circumstances, non-acute care is custodial in nature and it is not appropriate for health plans to provide coverage for these services.

In addition, HB 4423 requires "coverage...be denied only by licensed mental health professionals," excluding denials due to lack of coverage or use of a non-participating provider. This provision appears to be aimed at "medical necessity" determinations, but may be overly broad as written. There are other reasons for a coverage denial outside the exclusions provided in the bill that are not based on medical necessity and health plans should retain the ability to deny coverage, if necessary. For example, denials due to visit or dollar limits and pre-authorizations that also apply to medical services, as well as cost

sharing provisions (e.g., coinsurance, copayments and deductibles), or even membership eligibility.

As the state works to implement health care reform, expanding quality health care coverage to the uninsured, we should be careful not to add costly new mandates that make coverage less affordable, hindering the ability of employers, individuals, and the state to afford health care. In considering the need for imposing a mandate that requires expanded mental health coverage, it is important to understand that state mandates play a significant role in the escalating cost of health care in Massachusetts. Overall, mandates account for 12 to 17 percent of BCBSMA's premiums and, in many cases, benefit only a small percentage of our members. Currently, BCBSMA estimates that approximately 10 percent of our members use the mental health benefit. Our members currently have access to a full range of mental health care options, and we are now considering various measures aimed at enhancing the quality of care delivered. In this environment, the imposition of a mandate to expand mental health parity seems unwise.

The Health Care Reform law imposed a moratorium on all new mandated health benefit bills until the later of either January 1, 2008 or until the Division of Health Care Finance and Policy (DHCFP) has concluded its review and published results from a comprehensive analysis of existing mandated health benefits. DHCFP has not yet issued its report. The moratorium is necessary so as not to add any new costs to the health care system while efforts are underway to expand coverage and maintain affordability. This endeavor should be given every chance to work without adding new costs to the system.

Even if there were no moratorium in place, with employers in Massachusetts demanding premiums that are affordable, we urge that you only enact this bill, which we view as a mandated benefit, judiciously after considering the full impact it would have on cost and quality. Pursuant to M.G.L. c.3, §38C, we recommend that House Bill 4423 be sent to DHCFP for review. This analysis will contribute to an informed legislative decision.

Thank you for your consideration. Please do not hesitate to contact me with any questions or comments you may have on this issue.

Sincerely,

John J. Curley, Jr.

John J. Curley, Jr.

The Commonwealth of Massachusetts
House of Representatives
State House, Boston 02133-1054

DAVID B. SULLIVAN
STATE REPRESENTATIVE

Committees:
Mental Health & Substance Abuse
Higher Education
Tourism, Arts & Cultural Development

ROOM 279, STATE HOUSE
TEL. (617) 722-2230
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6TH BRISTOL DISTRICT

799 N. MAIN STREET
FALL RIVER, MA 02720
TEL. (508) 676-1008

E-Mail: Rep.DavidSullivan@hou.state.ma.us

December 14, 2007

The Honorable Richard T. Moore, Senate Chair
The Honorable Patricia A. Walrath, House Chair
Joint Committee on Health Care Financing
State House, Room 130
Boston, MA 02133

Dear Senator Moore and Representative Walrath:

I am writing in full support of House Bill No. 4423, petition of Representative Ruth Balser and others, relative to mental health parity.

As you know, this bill was referred to the Joint Committee on Health Care Financing. I respectfully ask that the Committee issue a favorable report on H. 4423 as soon as possible and allow this very important bill to continue in the legislative process.

This legislation would expand the Mental Health Act of 2000 to provide coverage for any diagnosed mental health disorder described in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders or the most recent edition of the International Statistical Classification of Diseases and Related Health Problems. This bill eliminates the distinction between "biologically based" and "non-biologically based" disorders that is present in the existing law and provides necessary access to coverage for individuals suffering from such disorders as eating disorders, trauma, and substance abuse.

Thank you for your careful consideration of this issue. If you have any questions, please do not hesitate to contact my office.

Sincerely,

David B. Sullivan

David B. Sullivan
State Representative
6th Bristol District

The Commonwealth of Massachusetts
Joint Committee on Health Care Financing

REP. PATRICIA A. WALRATH
HOUSE CHAIR
ROOM 236, STATE HOUSE
BOSTON, MA 02133-1054
TEL. (617) 722-2430
FAX (617) 722-2346

SEN. RICHARD T. MOORE
SENATE CHAIR
ROOM 111, STATE HOUSE
BOSTON, MA 02133-1054
TEL. (617) 722-1420
FAX (617) 722-1944

February 13, 2008

Sarah Iselin, Commissioner
Division of Health Care Finance and Policy
Room 243, State House
Boston, MA 02133

Dear Commissioner Iselin:

Pursuant to section 38C of chapter 3 of the General Laws the Joint Committee on Health Care Financing is submitting a request for the Division to review the following mandate:

H.4423 An Act Relative to Mental Health Parity

This bill was reported favorably, as redrafted by the Joint Committee on Mental Health and Substance Abuse and referred to our committee. The original bill number was H.1871.

If you have any questions please contact Jessica Taubner at 617-722-2430.

Sincerely,

Patricia Walrath
PATRICIA A. WALRATH
Chairs, Committee on Health Care Financing

Richard T. Moore
RICHARD T. MOORE

2/15/08 Caroline mailed

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*** TX REPORT ***
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REP. PATRICIA A. WALRATH
3RD MIDDLESEX DISTRICT
BOLTON - HUDSON
MAYNARD - STOW

DISTRICT OFFICE:
TEL. (978) 897-9088

The Commonwealth of Massachusetts
HOUSE OF REPRESENTATIVES
STATE HOUSE, BOSTON 02133-1054

Mailed by S. Moore

House Chairman
Joint Committee on
Health Care Financing

ROOM 236, STATE HOUSE
TEL. (617) 722-2430
FAX (617) 722-2346

FAX COVER SHEET

FAX NUMBER: (617) 722- 2346

TO: Ellen Sandler
DN. Health Care Finance & Policy.

FROM: Jessica Taubner
Health Care Financing Committee

NUMBER OF PAGES: 2 (Including Cover Sheet)

COMMENTS:

COPY

Julie Papernik
66 Ethyl Way
Stoughton, MA 02067

Senator Edward Kennedy
2400 JFK Building
Boston, MA 02203

May 21, 2006

Dear Senator Kennedy,

I would like to report a great inequity. As a well insured individual, I have been able to get the best possible care for my son for his gastroenterological illness but I have not had access to the same best care for his psychological needs which his doctors decided is an integral part of his treatment. He really needs help!

I encountered this inequity in the state of Massachusetts but I am more than certain that it exists throughout the United States.

My eleven year old son has had continuous stomach pain since February. He has missed three months of school. He is being cared for by some of the best GI doctors in the country at Children's Hospital. Both his pediatrician and the GI doctors strongly believe that he needs psychotherapy to help him deal with his pain. No-one can even imagine how tough this illness has been for my son. He cannot sleep at night because of the pain and he has restricted activities during the day. No medicine has helped him. He may have to learn to deal with chronic pain for the rest of his life.

I am a state employee and I am enrolled in the Commonwealth Indemnity Plan Plus. I chose this plan so that my son could have access to the best specialists in the country including those at Children's Hospital and Massachusetts General Hospital. This plan costs more than $1,000 per month.

For the past three months, I have not been able to find a psychotherapist for my son. His pediatrician, his GI doctors and family friends who are specialists in that field have recommended numerous therapists for my son – psychiatrists, psychologists and social workers. Most of these recommended therapists were not covered by my insurance. The ones that were listed by the insurance as covered out of those recommended either have since dropped this insurance or did not return my call.

Children's hospital outpatient pain management clinic, upstairs from the GI unit where my son receives treatment, does not accept my insurance. The clinic was not able to refer my son to another therapist due to hospital policy. Massachusetts General Hospital does not accept this insurance for outpatient therapy for children even though they do accept this insurance for ongoing treatment of non-mental health related organic illnesses.

I believe that it is a disgrace that this inequity in insurance coverage exists in our state at this day and age. I am a single mother on a state employee's salary. I cannot afford to pay for out of network care. This would amount to approximately $50 per visit on a weekly basis for an extended period of time.

I hope that my son's story and my appeal will help persuade you to fight for equal insurance coverage in Massachusetts and in the rest of the country for treatment of both organic illnesses (including those that are mental health related) and non-organic illnesses (including those that are mental health related).

Sincerely,

Julie Papernik

cc: Commissioner of Insurance, Children's Hospital, Massachusetts General Hospital

Julie Papernik
66 Ethyl Way
Stoughton, MA 02072

State Representative Ruth B. Balser
State House
Room 33
Boston, MA 02133

H.1871

DO NOT INCLUDE IN WRITTEN TESTIMONY

State Senator Gale D. Candaras
State House
Room 213B
Boston, MA 02133

FILE IN FOLDER/FILE for H.1871

June 29, 2007

Dear Representative Balser and Senator Candaras,

I am writing this letter because I want to share with you the details of my son's story and my own story in order to demonstrate the real impact of the health care parity dilemma, and other important concerns, as they directly pertain to my family's circumstances. For most of his life, my son was in excellent health both physically and mentally but in 2005, he became suddenly and violently ill. Please see letter to Senator Kennedy attached.

I am addressing this follow-up letter to you because my family's issues are state issues, first and foremost, and you co-chair the Joint Committee on Mental Health & Substance Abuse.

My two stories are success stories, largely thanks to the expertise, the good-will, and the charity of our health care providers who have done everything in their power in order to help me and my son.

Unfortunately, I do not have the same praise for my insurer – Commonwealth of Massachusetts Group Insurance Commission (GIC). They have provided excellent insurance coverage for my son's physical illness but they have not provided the same excellent insurance coverage for our family's behavioral and mental health care needs.

In this letter, I want to recount from memory the nightmare that we lived through so that maybe you can help us and other families in Massachusetts who face similar challenges - those families who are afraid to come forward with their particular stories because of the immense stigma associated with mental illness.

My Son's Story

2005 – sudden and violent illness ...

In February, 2005, my son had the stomach flu. About two weeks later, and for the next several months, he had violent vomiting reflex episodes (between 65 and 125 episodes per day) and severe abdominal spasms.

After discounting many different possibilities with thorough tests (everything from strep to seizures to nervous tics) our trusted pediatrician sent my son to the emergency room at Childrens' Hospital.

We went to the ER several times before my son was admitted to the surgery ward at Childrens' since his abdominal x-rays showed a mass which the doctors believed was an ingested foreign object.

During his hospitalization, my son was seen by numerous specialists, residents and interns. After many tests, it was determined that he had gastroenterological motility issues. His system was thoroughly flushed and he was released from the hospital in relatively good health with a prescription for motility enhancing medications.

Effect of illness on my son's life ...

In 2005, due to his illness, my son had missed two and a half months of school. He had dropped out of all extra-curricular activities, including the sports that he loves so much. He had trouble eating and drinking, even though he was hungry and thirsty. At night, he could not sleep and when he would finally fall asleep in the early morning hours, he would wake up in pain.

Some doctors' insensitivity to human suffering and parental strife ...

We spent countless hours in the emergency room. During our last visit to the ER, my son was violently ill and I remember that I stood there limply in utter disbelief as the resident on duty was explaining to me that my "son's pain isn't the same as the other children's pain" who were in the emergency room at the same time as my son.

Shortage of child psychiatrists in the ER and elsewhere ...

Even though, there was no psychiatrist on duty and the floating psychiatrist was busy with an emergency at another hospital, this psychiatrist did show up several hours later and spent about 3-5 minutes with me and my son. Subsequently, the ER Attending Physician released my son and prescribed strong psychotropic medications. He also told me to continue the motility enhancing medications prescribed earlier by the gastroenterologist because there were physical indications to his overall condition and he thought that the combined medications should relieve him of his pain in two to three weeks – a month at most.

Propensity to prescribe psychotropic medication to children without a reliable, complete evaluation and diagnosis from a qualified psychiatrist ...

I did not give my son any psychotropic drugs. The doctor's reasons for prescribing them seemed unconvincing to me when my son had not been diagnosed with a mental illness, although at that point I was willing to try almost anything to ease my son's pain. It was hard to remain vigilant.

Eventually, the motility medications helped, my son's pain abated and he was able to return to school. He had no symptoms from June 2005 until February 2006.

2006 – pain recurs ....

This time, the doctors took a different approach from the start. While they could not discount my son's physical symptoms, and continued appropriate medical tests and procedures, they strongly urged me to consult with a psychotherapist without further delay. In their opinion, a qualified psychotherapist was instrumental to helping my son cope with his chronic recurring pain.

Insurance plan not viewed as dependable among qualified behavioral and mental health professionals – subsequent impact on my son's life ...

After following many leads and recommendations, I was still not able to find a qualified specialist in this field who would take my son as a patient, despite all the doctors' and specialists' names found on my insurer's list of behavioral and mental health providers.

By this time, in 2006, my son had missed three months of school because of his inability to function due to unrelenting pain.

The gastroenterologist prescribed a low dose antidepressant so that my son could sleep at night. After six weeks, I stopped giving this medicine to him because he became unusually sad in addition to his usual pain, although with this medication, he was able to sleep through the night - most nights.

I was beyond desperate and there was no-one to turn to. The State Attorney General would not help due to a conflict of interest since GIC was the insurer for state employees. I reached out to Senator Kennedy and the Insurance Commissioner with a desperate plea.

Mother's plea answered ...

After my letter to Senator Kennedy and the Insurance Commissioner, a special GIC/UBH liaison was assigned to my case.

Even so, there was not one child psychiatrist in <u>all of Boston and the Boston area</u> who would take my son as a patient with my insurance. Finally, the GIC/UBH liaison was able to find and approve one Cambridge based psychiatrist who was very difficult to reach because he didn't have a receptionist or an answering service and once we set up a thirty minute appointment, he cancelled at the last minute because of a conflicting mandatory court appearance.

During this time, with the liaison's involvement, my son also visited a therapist recommended by his school who was listed as a provider on the UBH web site and who

agreed to see my son. At my son's first therapy session, I learned that this very nice man's wife, a psychologist, customarily took over the man's child patients. They were both very nice people. I don't want to tell you anything else about this experience – only that they were not able to help my son, mainly because they were not specialists in this area.

My son's story has a happy ending ...

Suddenly, a prominent specialist in the field, originally recommended by both my son's pediatrician and his gastroenterologist – one who did not take my son as a patient previously due to our insurance problems - agreed to take my son as a patient because he was able to negotiate an individual agreement with the active involvement of the GIC/UBH liaison.

Over the past year, this behavioral health specialist helped my son to manage his chronic pain. Also, he helped me to build a strong support system for my son both in and outside of school.

2007 – a great year so far...

With progressive behavioral therapy, my son no longer needs medication and even though he still has recurring abdominal pain once in a while, he is able to manage it successfully. He is a happy, thriving and well adjusted twelve-year-old. This year, he was able to stay in school. He made the honor roll and he reclaimed his prowess in various sports and other interests both in and outside of school.

At this juncture, I could stop writing this letter but my other story is also a success story and I want to tell it to you as well. You, the reader, may make certain inferences about what I am writing and the format, based on your perception, your background and perhaps based on your education. However, I want you to know that when I wrote this letter, it was my intention to tell you the real story. This letter is long because I have a lot to say.

My Story

Brief history of mental illness on mother's side ... and fear – in my case, unsubstantiated – that my son's medical doctors would be more likely to miss a serious physical illness by hastily attributing his physical symptoms to a mental cause based on genetics ...

I am 38 years old. I am a single mother.

In 1990, in my senior year at Boston University, I had my first episode of what was later diagnosed as a biologic mental illness.

I had a second episode in 1993 when I was working as a project manager in the private sector. I had Blue Cross/Blue Shield at this time, and I did not have any trouble securing the appropriate medical help. Within several weeks, I was back on the job.

I did not take any medication for my mental illness until my son was born. At that time, I decided that I can no longer take any chances with my health and I need to take all and any necessary precautions to make sure that I can provide a healthy and safe environment for my son.

When I left my job in order to be with my son, I was able to self-pay for Blue Cross/Blue Shield. With this insurance, I was able to secure an excellent psychiatrist, highly recommended by my obstetrician. I had a problem free pregnancy and upon this psychiatrist's advice, I started to take medication for my mental illness shortly after the birth of my son. I'll never forget that this psychiatrist visited me in the hospital on the day my son was born, in order to offer her support and remind me of the importance of medication for my condition and for my son's well-being.

I was lucky that an esteemed doctor felt that she could not abandon her patient, even when this patient could no longer afford to compensate her for her services ...

In 1996, I was accepted to New England School of Law. My savings ran out and I took out a large educational loan. I could no longer afford private health insurance. My psychiatrist did not accept Mass Health but she volunteered to treat me for free while I was in law school because she knew how difficult it would be for me to transition to a new specialist without a private insurance plan during a highly demanding time in my life.

People with mental illness can be very successful and can lead a normal life when they have access to good mental health care ...

I am very grateful to my doctor for supporting me and helping me succeed.

In 1999, I graduated from law school, passed the Bar Exam and secured a job at a prestigious state office.

Commonwealth of Massachusetts Group Insurance Commission ...

At this time, I chose GIC as my insurer. It was the most expensive plan but I needed the security and flexibility of a dependable insurance plan due to my chronic condition. My doctor had closed her practice and moved and I needed to find a new psychiatrist.

Health care parity issues/insurance plan not viewed as dependable among qualified behavioral and mental health professionals – subsequent impact on my life ...

I was surprised that with my GIC plan, I could visit practically any medical specialist of my choice without a referral but it was extremely difficult to find a psychiatrist that would take me as a patient. I wanted to find a specialist close to my work, in order to limit the hours I would have to take off for doctor's visits. Despite the doctors' names found on my insurer's list of providers, there were only two available psychiatrists in all of Boston that would take my insurance – both at Mass. General Hospital. When I called to make an appointment, however, I was told that no hospital psychiatrist or therapist can take a patient with my insurance. I appealed to my insurer who originally referred me to

these two psychiatrists and after some time, my insurer secured an appointment for me with one of these two specialists.

I had and continue to have excellent medical care for my mental illness. With my doctor's help, I remained a successful, productive, contributing adult through the next seven years – a good mother to my son and a reliable worker with an excellent employment record despite all the difficulties associated with my son's illness.

Cost of health insurance/billing issues/health insurance disparity ...

I am in no way implying that all claims have to be paid, either for physical, mental, behavioral or surgical care. The insurer offers coverage based on the benefits they promise and as otherwise required by law. I intend to make good on all my legitimate debts.

My GIC plan costs over $1,100 per month. Over the course of my son's illness, GIC paid tens of thousands dollars for my son's medical bills. They paid for all the expensive and invasive medical procedures in a timely manner. When I had skin cancer surgery, the bills were promptly paid.

However, GIC did not provide coverage for many mental health care claims and when they did remit payments, they did not do so in a timely manner. I currently owe several thousand dollars to Massachusetts General Hospital and to my son's behavior specialist in unpaid claims. Since neither provider had a contract with my insurer (until a few weeks ago), I remain responsible for these unpaid bills.

In my understanding, my son's behavioral health billing issue is a "codes" issue. Even though my insurer agreed to pay initially, they did not pay some of my son's behavioral health costs because the insurance coverage codes that this specialist is using to accurately describe my son's condition and the therapy provided have not been approved.

Insurance billing issues for treatment of biologic mental illness are difficult to deal with even when this patient's mental illness is in remission ...

My billing issues for my own chronic condition are much harder to describe. I don't think you have the time to hear all the details. I'll try my best to outline the problems briefly.

These bills have accumulated over the years, partially due to the inattention, lack of training and organization of my insurer, the administrators and their staff. The claims that were paid were repeatedly remitted to the wrong party. Checks were sent back by the provider to be reissued and some were lost in transit. Every time I have called my insurer to ask them to correct their errors, they would blame the provider for billing omissions. I would have to re-tell my whole story to each insurance representative although I believe there was a computer record of my previous calls.

One example of my frustration ...

In 2006, the special GIC/UBH liaison told me that the billing problems were due to a UBH computer "bug" and that these problems had been permanently corrected;

nevertheless, the whole billing nightmare recurred several months later. When I called UBH again, they blamed the provider for the billing errors, as was their routine. They would not transfer me to the GIC/UBH liaison. I was told that they're not aware that a person by that name works at UBH or has ever worked there. When I asked to speak to the manager, I was told that the manager would call me back within 48 hours. No-one ever returned my call. I called GIC and I told my entire story to various representatives. I was transferred from one department to another and then back again. Finally, someone from GIC returned my call and gave me the contact information for the special GIC/UBH liaison that had previously helped me. They told me that this liaison is an employee of UBH.

Again, feeling lucky that another esteemed doctor did not abandon her patient, even when this patient could not compensate her fully for services rendered...

Both Mass. General Hospital and my son's provider have been very patient and understanding and have been trying methodically to resolve the billing issues on my behalf. Several years back, when my doctor found out that bill collectors were calling me regularly regarding the unpaid claims, she was able to stop this from happening.

Other considerations associated with my son's illness ...

By the middle of 2006, I had missed many days of work due to my son's illness and have suffered financially as a result. At this time, I fell behind in my educational loan payments.

In Jan. 2007, I was laid off from work by the new administration. I have not been able to find a new job as yet and I pay more than half of my unemployment benefits for my GIC "39 week extension plan".

I fear that my attendance record and my credit history may somehow be adverse factors in my present job search for a highly competitive position in the public sector. I hope this fear will prove to be unsubstantiated as well, but I fear nonetheless.

Yet, I remain optimistic. I am grateful for the unyielding support from my family's health care providers and the help from our extended family and friends through this ordeal.

My son has suffered much pain. For many endless days and sleepless nights, I felt utterly helpless as a parent, with no one to turn to when some of the best doctors in the world could not provide relief for my son's pain. I never thought this could happen to me because I had a good job and the best insurance plan available for state employees.

I am aware of positive changes that have occurred in the past years and I know that many people of different persuasions committed to the same cause have been working hard to transform our state's behavioral and mental health care system in view of today's laws, standards and expectations.

I am also aware of the changes that GIC is in the process of making. I have not felt the impact of these changes so far but I know that changes like this take time to execute. I

hope it won't be too long because I have no intention of changing insurers. This plan is the best one for state employees and I have already committed my life to public service.

In summary ...

I want you to know that my insurer's disparate coverage for my family's behavioral and mental health care needs had a direct negative impact on the quality of our lives because I was not able to find appropriate care for my son when he was in dire need of such care.

Prompt and appropriate insurance payments for apt mental and behavioral health services are key to successful health care parity reform.

There is a great need for simplified, improved and flexible billing and claims procedures for mental and behavioral health services not only so that our health care providers can be fairly compensated for their work but also so that consumers like me won't lose their mind due to the current adverse insurance billing practices that persist despite legislation already in place.

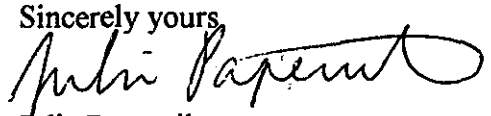
In addition to the issues raised in this letter, and other pressing state concerns regarding mental illness and substance abuse, I hope that you continue to fight hard for increased funding necessary to provide proper education in this area to medical professionals, employers and the public at large. Only education can lead to understanding.

Mental illness is the least understood and worst treated disability. By a long shot, it's still a slow uphill battle for public acceptance, inclusion and proper accommodation. In this regard especially, I appreciate your leadership and perseverance.

This letter, as you've surely noticed by now, is not in the form of a legal brief but my voice is strong nonetheless!

I know that with your support, my voice will be heard because it's time!

Sincerely yours,



Julie Papernik

cc:

Governor Deval Patrick
Massachusetts State House
Room 360
Boston, MA 02133

Senator Edward Kennedy
2400 JFK Building
Boston, MA 02203

DiGiustini, Antonetta (HOU)

In Support of H.1871

(After the 10/1/07 Hearing)

From: DiGiustini, Antonetta (HOU)
Sent: Tuesday, October 16, 2007 5:36 PM
To: Balser, Ruth - Rep. (HOU)
Cc: Carr, Michael (HOU)
Subject: Additional Support for H.1871

Dear Ruth--FYI re: additional support for H.1871. I've just placed t desk/computer after covering for the front desk. Christina had alre when I got back to my desk/computer. Thank you--Antonetta

From the Message Log for 10/16/07:
Re: Support for H.1871 and the 2 ER bills-- Mary Lou Maloney of Disability Policy Consortium and Marie Power, RN stopped by to express support of H.1871. Mary Lou Maloney was bringing Marie Power to RBB's office. Marie Power is a retired RN & she said she fully supports H.1871. They also asked about the 2 ER Bills (H.2042 and H.1891); they inquired about the status of H.1871 & the 2 ER bills. Antonetta informed them that the bills have had hearings, but are still in the Committee on MHSA and suggested that Marie Power could send the Committee written testimony/a letter in support of the 3 bills, which Marie Power will do. Antonetta gave Marie Power a copy of packet of written testimony for the October 1st hearing, which includes testimony for H.1871 (she had requested copies of written testimony for H.1871). (Antonetta, 3:45 p.m.)

Marie Power, RN - In support of H.187
155 Bond Street
Norwood, MA 02062

DiGiustini, Antonetta (HOU)

From: DiGiustini, Antonetta (HOU)
Sent: Tuesday, October 16, 2007 5:36 PM
To: Balser, Ruth - Rep. (HOU)
Cc: Carr, Michael (HOU)
Subject: Additional Support for H.1871

Dear Ruth--FYI re: additional support for H.1871. I've just placed this in the message log when I got back to my desk/computer after covering for the front desk. Christina had already emailed you the message log for today when I got back to my desk/computer. Thank you--Antonetta

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Marie Power, RN – In support of H.1871
155 Bond Street
Norwood, MA 02062

DiGiustini, Antonetta (HOU)

From: Balser, Ruth - Rep. (HOU)
Sent: Monday, November 05, 2007 6:19 PM
To: DiGiustini, Antonetta (HOU)
Subject: FW: oppose HBs 1871 and 3534

Antonetta, pls print these out and file with the appropriate bills.
Representative Ruth B. Balser
House Chair, Joint Committee on Mental Health & Substance Abuse
Room 33, State House
(617) 722-2060
www.ruthbalser.org

From: Joanne Cali [mailto:calipren@earthlink.net]
Sent: Tuesday, October 23, 2007 8:44 PM
To: Balser, Ruth - Rep. (HOU)
Subject: oppose HBs 1871 and 3534

October 23, 2007

Re: House Bills 1871 and 3534

Rep. Ruth Balser

Madam Chair:

I want to state my strong opposition to House Bills 1871 and 3534. Please defeat these bills, because both will give a carte blanche to psychiatrists to more liberally label and drug kids. Eight million school children are already drugged, and literacy plummets while violence escalates. Clearly, these tactics aren't working. Are we really to believe that, suddenly, all kids that can't learn quickly are really crazy -- that all of a sudden kids are really disordered, rather than just having the normal trials and tribulations of growing up?? 1871 targets babies and toddlers, and 3534 will force insurance payments for disorders that NO LAB results prove even exist! They are a matter of opinion.

The manuals proposed in these bills describe normal childhood behaviors as disordered. Few children escape diagnosis when their parents or teachers decide they are misbehaving or "having trouble". These bills also propose that infants from zero to three be evaluated. Will an infant's crying - the only communication (of hunger or discomfort) that an infant gives a parent - now be labelled "depression", and consequently drugged?! Will the high energy level of children - which we as adults bemoan the loss of - now be labelled a "hyperactive" disorder. Let's change this label back to what it once was - "normal childhood behavior". We all knew kids didn't have long attention spans, and that they were very active. And that they became bored in school, depending on how interesting a presentation the teacher made. Can we place the burden of teaching BACK on the teachers - and quit blaming (and drugging) the kids?!

Effective educators such as Dr. Maria Montessori, physician and psychiatrist, railed against keeping kids nailed to their desks. She knew the freedom to move enables children to practice coordinating their

bodies, and learn to handle the material universe without breaking things, etc. SURVIVAL traits in children are being rampantly labelled "disorders" by psychiatrists. Psychiatric drugs stunt skull growth, enlarge hearts, can cause death, suicide and violence.

Please stand up and support proper love and care for our children, and thwart the cold, clinical "evaluation" and drugging of our future generation. This just has to stop.

Sincerely,

Joanne Cali

32 Framingham Road, Southborough, MA 01772

MHSACM

MHSACM, Inc.

251 West Central Street, Suite 21, Natick, MA 01760 (508) 647-8385 / Fax (508) 647-8311 www.mhsacm.org

Vicker V. DiGravio III, *President / CEO* **Ellen Attaliades, MA,** *Chairman*

H. 4423 / Committee Redraft & H. 1871

December 6, 2007

Representative Ruth Balser, Chair
Joint Committee on Mental Health and Substance Ab
State House, Room 33
Boston, MA 02133

Thank-you letter to Chairwoman Balser for vote to move Com. redraft of H. 1871 favorably out of committee on Dec. 5, 2007 (received: 12/17/07)

Re: H. 1871, An Act Relative to Mental Health Parity

Dear Chair Balser:

On behalf of the membership of Mental Healt Massachusetts, Inc (MHSACM), I would like to c reporting H. 1871, *An Act Relative to Mental Health* statewide association representing 88 community-based mental health and substance abuse provider organizations. Our members are the primary providers of publicly-funded behavioral healthcare services in the Commonwealth, serving approximately 117,000 Massachusetts residents on any given day.

The Mental Health Parity law that was passed in 2000 was landmark legislation for the people of the Commonwealth in terms of insurance coverage of mental illness, but MHSACM members' experience with the law since then has proven that it falls short of the needs of many Massachusetts families. H. 1871 expands the scope of the existing law to ensure that individuals with behavioral health needs get the treatment they need and deserve by eliminating archaic distinctions among mental disorders. MHSACM strongly supports this comprehensive parity legislation that guarantees full coverage for substance use disorders on the same terms and conditions as physical disorders, and we are extremely grateful for your action on this bill.

Thank you for your continued commitment to individuals and families across the Commonwealth in need of behavioral health care. I look forward to continuing to work with you on this important piece of legislation.

Madame Chair,

Thank you!

Sincerely,

Vicker V. DiGravio III
President/CEO

December 5, 2007

Representative Balser,

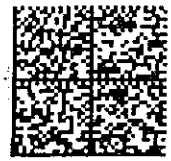
Thank you so much for your leadership on the expansion of mental health parity. We are all very excited that the Committee favorably reported the bill and look forward to working with you in the coming months to ensure final passage.

Sincerely,

Vic DiGiovanni

Vic DiGravio President/CEO

MENTAL HEALTH & SUBSTANCE ABUSE CORPORATIONS OF MASSACHUSETTS, INC
251 West Central Street, Suite 21
Natick, MA 01760



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Representative Ruth Balser, House Chair
Joint Committee of Mental Health + Substance Abuse
State House, Room 33
Boston, MA 02133

/1033

Massachusetts Coalition for Addiction Services

The *Massachusetts Coalition for Addiction Services* strongly supports passage of H. 1871, *An Act Relative to Mental Health Parity*

This Act will greatly enhance access to medically necessary services for insured individuals who suffer from substance use disorders and will dramatically improve their overall health outcomes

By adopting H. 1871, the state will finally reject the discrimination that causes people with addiction disorders to go without medically necessary care

Parity for Addiction Treatment Provides Fundamental Fairness for ALL Citizens

People with substance use disorders have been denied fair and equitable health insurance coverage for too long. Since 1956, the American Medical Association has recognized alcoholism and drug addiction as a disease. It is time for this disease to receive fair and equitable coverage by insurance companies. H. 1871 will end this discrimination by ensuring that substance use disorders are treated like other illnesses.

Parity for Addiction Treatment is Cost-Effective and will Save Money

Insurance parity for addiction treatment will NOT dramatically increase insurance premiums and will save the state money. A 2004 study by the Massachusetts Division of Health Care Finance and Policy (DHCFP) showed that the average premium increase due to parity for addiction treatment would be only 0.27% (under $10 per member annually). DHCFP also found that states that already have addiction parity mandates have experienced decreased lengths of stay for costlier inpatient services and increased use of more cost-effective services. [1]

There is Great Need for Parity for Addiction Treatment in Massachusetts

According to the *National Survey on Drug Use and Health* and the *2002 Behavioral Risk Factor Survey*, it was estimated that approximately 570,000 people in Massachusetts are in need of addiction treatment. Of that number approximately 370,000 did not seek treatment and another 117,000 sought treatment but did not access services. The major reasons cited for not seeking or accessing services were:

- No insurance
- Insurance did not cover addiction treatment
- Insurance did not cover full cost of treatment

Addiction Treatment Works!

The 2004 DHCFP report states that "[d]ecades of research have established that a variety of alcohol and drug abuse treatment methods are successful," provided that individuals are permitted to remain in treatment for adequate periods of time.[2] Massachusetts Department of Public Health data indicate there are many positive outcomes from treatment; it significantly improves employment and rates of abstinence, and decreases criminal involvement, homelessness, and the use of emergency rooms and inpatient services.[3] In addition, the National Institute on Drug Abuse reports that treatment reduces substance use by 40-60%, helps alleviate psychological and social problems, and reintegrates individuals into their families and communities.[4]

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[1] Division of Health Care Finance and Policy, Commonwealth of Massachusetts Mandated Benefit Review, Review and Evaluation of Proposed Legislation Entitled: An Act to Provide Equitable Coverage for Substance Abuse, Senate Bill 872, provided for the Joint Committee on Insurance.

[2] Idem

[3] Substance Abuse Treatment Outcomes and System Improvements, Bureau of Substance Abuse Services, June 2000.

[4] National Institute on Drug Abuse, Principles of Drug Addiction Treatment, 1999.

MOAR –Massachusetts Organization for Addiction Recovery
C/o Boston ASAP – 3rd floor, 30 Winter Street, Boston, MA 02108
Toll free –1-877-423-MOAR or (617) 423- 6627
Fax – (617) 423-6626 — e-mail – MOARfran@aol.com

Testimony in Support of House Bill

H1871 An Act Relative to Mental Health Parity

Sponsored by Representative Ruth B. Balser

October 1st, 2007

To The Mental Health Substance Abuse Committee,
Senate Chair Gale Candaras and House Chair Ruth Balser:

In recognition of The MOAR

Mission:
Our Mission is to organize recovering individuals, families and friends into a collective voice to educate the public about the value of recovery from alcohol and other addictions.

Vision:
MOAR envisions a society where addiction is treated as a significant public health issue and recovery is recognized as *valuable* to our communities.

MOAR supports House Bill 1871 Parity. The bill recognizes the need for full coverage of addiction, as a disease, as biologically based, and that addiction is recognized by The American Psychiatric Association.

We support the bill because it is time to end insurance discrimination.

1. Addiction is a treatable chronic disease.
2. Addiction coverage would only cost 83¢ per insured member per month
3. Addiction covered by full parity would reduce the demand for state funded treatment by patients with private insurance, thus allow the state to support very important recovery support services.

The Problem

570,343 Massachusetts residents are in need of treatment for alcoholism or other addictions, and only 82,196 are actually receiving treatment.[1] Why? these individuals (1) have no insurance coverage; (2) have insurance that does not cover addiction treatment; and/or (3) they can not afford to pay for treatment out-of-pocket.

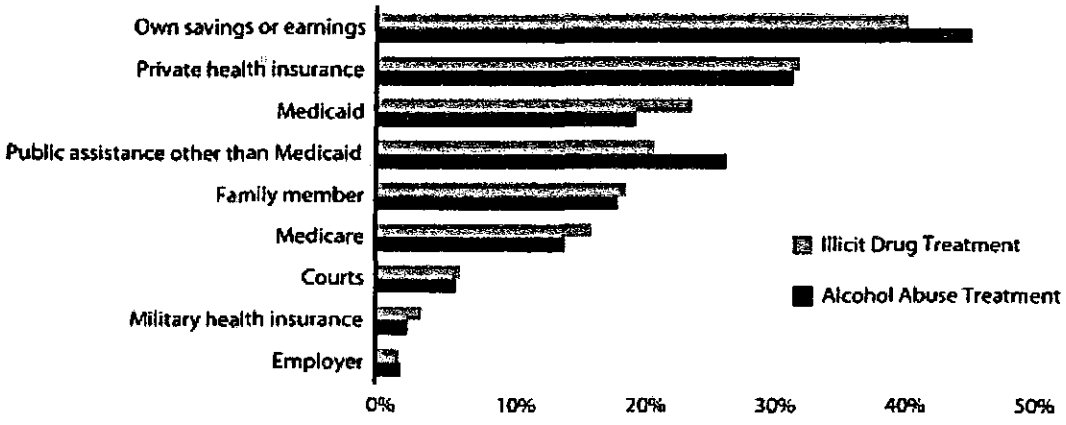
[1] Substance Abuse and Mental Health Services Administration, "National Survey on Drug Use and Health, 2002"

Of those who are receiving treatment, the single largest source of payment is individual earnings or savings, as highlighted by the figure below.[2]

How people pay for treatment

According to the Substance Abuse & Mental Health Services Administration's 2003 National Household Survey on Drug Use and Health (issued September 2004), most of the 1.1 million people who received specialty treatment for an illicit drug problem in 2003 paid for it at least partially from their own pocket (40.3 percent). That was true of alcohol treatment, too (45.1 percent).

The money has to come from somewhere



Note that the estimates of treatment by source of payment include persons reporting more than one source.
Source: SAMHSA 2003 National Household Survey on Drug Use and Health

Patients with private health insurance are often barred from receiving adequate treatment, because Massachusetts state law does not protect patients from addiction treatment restrictions from private insurers beyond the current minimal mandated substance abuse benefit, which has not been changed since 1973. Currently, the state mandate is 30 days of inpatient treatment and $500 of outpatient treatment per year.

As a result, individuals who are denied treatment by their insurers are faced with three choices:

1. They are forced to pay out of their own pockets, even though they are paying health care premiums.
2. They do not utilize treatment because they can not afford it.
3. They will compete for a public funded bed.

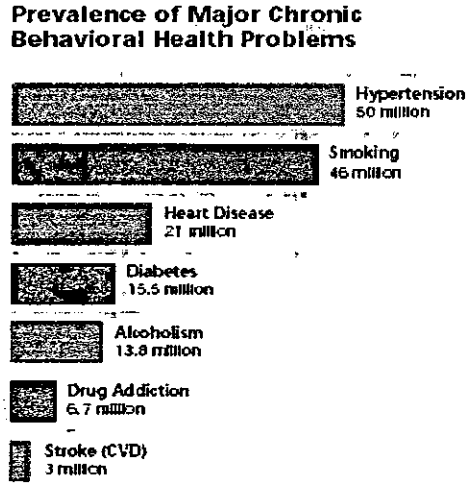
We are talking about real people suffering from addictive disease requiring long term treatment.

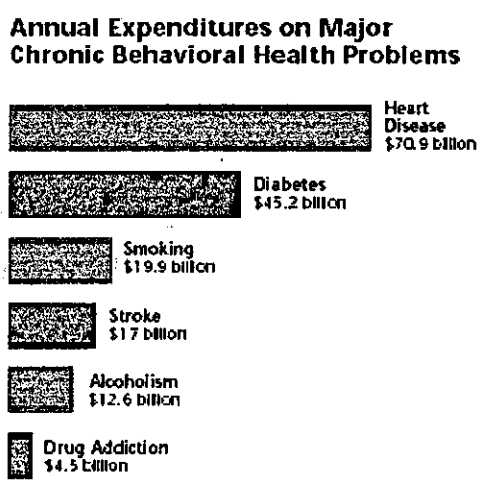
Addiction is a Disease

[2] Graphic Source: "Insurers Give Substance Abuse New Identity: It's a Disease", Managed Care Magazine, April 2005. Accessed 7/11/05 at http://www.managedcaremag.com/archives/0504/0504.addiction.html

Addiction is medically diagnosable, biologically-based, and treatable chronic disease. Private insurers are finally beginning to grasp that reality as well[3]. Diabetes, heart disease, and addiction can not be cured; but they can be managed. However, authorizing treatment for other chronic diseases are based on medical need and not restricted by arbitrary benefits limitations.

When comparing the prevalence and costs of chronic diseases, heart disease, smoking and diabetes far outweigh alcohol and drug dependence.[4] Substance Abuse Parity will set the standards for addiction treatment on similar ground to other chronic diseases.





Addiction Parity is Cost- Effective

The exclusion of addiction treatment from the core services provided by the health insurance plans financially undermines the efforts to reform health coverage. **The health care costs of addicts who receive adequate treatment drop by 24%.**[5] In contrast, when insurers create barriers to treatment, not only do healthcare costs of their members increase, but the burden on the state increases by the increase in demand for free treatment provided by the Department of Public Health.

According to a SAMHSA report on public and private expenditures, "from 1991 to 2001, private insurance payments for addiction treatment fell 1.1 percent, even as overall healthcare spending rose 6.9 percent ... In contrast, public financing for treatment accounted for 76 percent of treatment dollars in 2001, up from 62 percent of treatment dollars in 1991. Of that, state and local sources other than Medicaid accounted for 38 percent."[6]

---

[3] "Insurers Give Substance Abuse New Identity: It's a Disease", Managed Care Magazine, April 2005. Accessed 7/11/05 at http://www.managedcaremag.com/archives/0504/0504.addiction.html

[4] Graphic Source: Physician Leadership on National Drug Policy, "Position Paper on Drug Policy", 2000. Accessed 7/12/05 at http://www.plndp.org/Resources/researchrpt.pdf

[5] Center for Alcohol and Addiction Studies, "Substance Abuse Benefits Make Dollar Sense"

[6] "Study Shows Dropoff in Private Treatment Funding", Join Together. Accessed 7/12/05 at http://www.jointogether.org/y/0,2521,576656,00.html

Treatment Saves Lives and Money

In 2004, MA Division of Health Care Finance & Policy conducted a study of addiction treatment and parity

- The average premium increase due to substance abuse parity would be only 0.27% (under $10 per member annually). Treatment is less expensive than alternatives, such as not treating or imprisonment. Treatment costs on average $7,000 annually; the untreated medical costs of substance abuse are $14,000 annually.
- Massachusetts would save $6 to $25 million annually under parity.

Treatment Works Facts

- **Addiction Treatment Works; Recovery is an Investment.**
- **Addiction Treatment** helps reduce illegal drug use by 50%.
- **Addiction Treatment** reduces criminal activity by 80%.
- **Addiction Treatment** increases employment and decreases homelessness, results in marked improved physical and mental health, and reduces risky sexual behaviors.
- **Addiction Treatment** is as effective as treatments for other illnesses: diabetes, hypertension, asthma.
- **Addiction Treatment** reduces medical visits by 53% .

It is time to stand up for the many families in Massachusetts, who are paying out of pocket, or do not seek treatment because they are denied coverage. H1871 will not stop insurers and managed care firms from denying access, or necessary length of time to recover from the physical aspects, and be able to comprehend a plan for living in recovery. However, it does offer the opportunity for increased treatment access and stay. The next thing to do is to have Licensed Alcohol and Drug Clinicians insurance reimbursed with the authority to determine medical necessity.

I ask you to search your conscience .....

Massachusetts has the highest rate of drug overdoses in the nation..... we have seen a surge of youth suffering from this disease. The high rate of 18-25 year olds in our systems. Think about the past budget cuts and decreased insurance coverage, the destruction of 28 day detox/rehabilitation/ decreased coverage for family counseling/..... where is the cost savings..... We can no longer afford to "treat and street" nor expect that a "spin dry" detox is going to medically clear an individual to make an educated step in their plan for recovery.

At minimum, we need to make H1871 law.

Let's End Insurance Discrimination,

Maryanne Franzulis

MOAR Executive Director

1 National Survey on Drug Use and Health and the 2002 Behavioral Risk Factor Survey for Massachusetts.

2 Information from CSAT ATR - 2004

3 Division of Health Care Finance and Policy, Commonwealth of Massachusetts Mandated Benefit Review, Review and Evaluation of Proposed Legislation Entitled: *An Act to Provide Equitable Coverage for Substance Abuse*, Senate Bill 872, provided for the Joint Committee on Insurance.4 The Lewin Group, Actuarial Assessment of MA Senate Bill. 872: "An Act to Provide Equitable Coverage for Substance Abuse", May 24, 2004. Much of this research excerpted from Sana Fadel, Coalition to Increase Access to Treatment

Keeley League and Advocacy

1890

KEELEY LEAGUE NO. 1, DWIGHT, ILLINOIS, IN OPEN AIR SESSION

The Public Sector Mental Health Study/Advocacy Group

P.O. Box 600553
Newtonville, MA 02160-0005
(781) 762-3967

October 1, 2007

Dear Representative Balzer and Khan:

It is a pleasure to support House Bill 1871 and the refreshing revisit of the initial Parity Bill. You, both with the support of many other legislators and advocates, have worked tirelessly to make access to care easier especially for those with persistent and chronic mental illness.

This bill makes some necessary changes that are very important. I also hope that you both are able to observe how these laws become operationalized. As in many things, the devil is in the details and that is what I, as a practitioner, live with daily as I try to provide medically necessary services.

The role of the insurance companies is key to the successful implementation of full Parity. I hope that you will join me and others in helping that industry properly monitor but not micromanage the mental health benefits that you have fought so hard to establish.

Many thanks.

Sincerely,

George Sigel, M.D. for
The Public Sector Mental Health Study/Advocacy Group

The Commonwealth of Massachusetts
House of Representatives
State House, Boston 02133-1054

DAVID B. SULLIVAN
STATE REPRESENTATIVE

Committees:
Mental Health & Substance Abuse
Higher Education
Tourism, Arts & Cultural Development

ROOM 279, STATE HOUSE
TEL. (617) 722-2230
FAX (617) 722-2821

6TH BRISTOL DISTRICT

799 N. MAIN STREET
FALL RIVER, MA 02720
TEL. (508) 676-1008

E-Mail: Rep.DavidSullivan@hou.state.ma.us

September 27, 2007

The Honorable Gale D. Candaras, Senate Chair
The Honorable Ruth B Balser, House Chair
Joint Committee on Mental Health and Substance Abuse
State House, Room 33
Boston, MA 02133

Dear Senator Candaras and Representative Balser:

I am writing in full support of House Bill No. 1871, petition of Representative Ruth Balser and others, relative mental health parity.

As you know, this bill was referred to the Joint Committee on Mental Health and Substance Abuse, and will be heard on Monday, October 1 at 1:00pm. I respectfully ask that the Committee issue a favorable report on H. 1871, and allow this matter to continue in the legislative process.

This legislation would expand the Mental Health Act of 2000 to provide coverage for any diagnosed mental health disorder described in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders or the most recent edition of the International Statistical Classification of Diseases and Related Health Problems. This bill eliminates the distinction between "biologically based" and "non-biologically based" disorders that is present in the existing law and provides necessary access to coverage for individuals suffering from such disorders as eating disorders, trauma, and substance abuse.

Thank you for your careful consideration of this issue. If you have any questions, please do not hesitate to contact my office.

Sincerely,

David B. Sullivan

David B. Sullivan
State Representative
6th Bristol District

COMMONWEALTH OF MASSACHUSETTS

MASSACHUSETTS SENATE

STATE HOUSE, BOSTON 02133-1053

SENATOR STEVEN A. TOLMAN
2ND SUFFOLK AND MIDDLESEX DISTRICT

ROOM 511B
TEL. (617) 722-1280
FAX (617) 722-1069
E-Mail: Steven.Tolman@state.ma.us

COMMITTEES:
SENATE COMMITTEE ON WAYS AND MEANS
(VICE CHAIRMAN)

October 1, 2007

Senator Gale D. Candaras, Chair
Representative Ruth B. Balser, Chair
Joint Committee on Mental Health and Substance Abuse
State House - Room 33
Boston, MA 02133

Dear Chairwomen:

I write in support of *H. 1871, An Act Relative to Mental Health Parity.* I urge you to report this bill out of committee with a favorable recommendation.

This legislation will provide full parity to the entire spectrum of mental health disorders identified by the American Psychiatric Association (APA). The current mental health parity law in Massachusetts, "An Act Relative to Mental Health Benefits" (also known as the Mental Health Act of 2000), draws a line between "biologically" and "non-biologically" based disorders; providing parity only to disorders that are "biologically based." Disorders that fit into this group include but are not limited to: Schizophrenia, bi-polar disorder, and obsessive-compulsive disorder. Other illnesses, such as eating disorders, substance abuse and addiction, were categorized as "non-biologically based," leaving those who suffer from these ailments without comprehensive coverage. *H. 1871* removes the distinction between the two groups of mental health disorders and gives full parity to *all* APA recognized disorders, thus providing long-awaited coverage to all those who deserve and so desperately need it.

This legislation is a cost-effective measure that will go a long way towards eliminating the stigma associated with mental illness. Without coverage from health plans, the mentally ill are forced to seek treatment through state agencies, leaving the financial burden for this vulnerable population on the taxpayers. Through *H.1871*, the Commonwealth will recognize all mental illnesses as diseases, and in doing so, will allow all those in need of care to seek proper, economical treatment. More importantly, *H.1871* it will serve as an extension of Massachusetts' commitment to ensuring that all of its citizens receive quality, comprehensive health care.

Again, I urge you to report *H.1871* out of committee with a favorable recommendation. Thank you very much for your consideration of this matter. If you have any questions or concerns, please feel free to contact my office.

Sincerely,

Steven A. Tolman

Steven A. Tolman

The Commonwealth of Massachusetts
House of Representatives

BYRON RUSHING

Second Assistant Majority Leader

Byron.Rushing@state.ma.us

State House - Room 481
Boston, MA 02133-1054
(617) 722-2180
(617) 722-2881 (F)

9th Suffolk District
South End
St. Botolph
Lower Roxbury
Fenway
Kenmore
Prudential
Copley Place
West Campus,
MIT

October 1, 2007

Representative Ruth Balser, Chair
Joint Committee on Mental Health and Substance Abuse
State House Room 33
Boston, MA 02133

Re: H. 1871, *An Act Relative to Mental Health Parity*

Dear Madam Chair Balser:

I am writing in support of H. 1871, *An Act Relative to Mental Health Parity,* which is before the Committee today.

The current Massachusetts Mental Health Parity law, passed as Chapter 80 of the Acts of 2000, "An Act Relative to Mental Health Benefits," expanded the mandate on private health plans but stopped short of full parity.

H. 1871 would provide treatment for all mental health illnesses regardless of whether or not there is biological basis. All individuals would be covered for treatment of mental health and substance abuse disorders, as all other medical conditions are covered. I strongly believe that this bill furthers the Massachusetts commitment to increasing access to comprehensive health care for all the people of Massachusetts.

I urge the Committee the report this bill favorably, and I thank the Committee for its careful consideration on this matter.

Yours truly,

Byron Rushing

Cc: Representative Ruth Balser

The Commonwealth of Massachusetts
House of Representatives

BYRON RUSHING

Second Assistant Majority Leader

Byron.Rushing@state.ma.us

State House - Room 481
Boston, MA 02133-1054
(617) 722-2180
(617) 722-2881 (F)

9th Suffolk District
South End
St. Botolph
Lower Roxbury
Fenway
Kenmore
Prudential
Copley Place
West Campus,
MIT

October 1, 2007

Senator Gale Candaras, Chair
Joint Committee on Mental Health and Substance Abuse
State House Room 213B
Boston, MA 02133

Re: H. 1871, *An Act Relative to Mental Health Parity*

Dear Madam Chair Candaras:

I am writing in support of H. 1871, *An Act Relative to Mental Health Parity,* which is before the Committee today.

The current Massachusetts Mental Health Parity law, passed as Chapter 80 of the Acts of 2000, "An Act Relative to Mental Health Benefits," expanded the mandate on private health plans but stopped short of full parity.

H. 1871 would provide treatment for all mental health illnesses regardless of whether or not there is biological basis. All individuals would be covered for treatment of mental health and substance abuse disorders, as all other medical conditions are covered. I strongly believe that this bill furthers the Massachusetts commitment to increasing access to comprehensive health care for all the people of Massachusetts.

I urge the Committee the report this bill favorably, and I thank the Committee for its careful consideration on this matter.

Yours truly,

Byron Rushing

Cc: Representative Ruth Balser

The Commonwealth of Massachusetts
HOUSE OF REPRESENTATIVES
STATE HOUSE, BOSTON 02133-1054

KAY KHAN
REPRESENTATIVE
11TH MIDDLESEX DISTRICT (NEWTON)
ROOM 146, STATE HOUSE

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Committees:
Vice Chair
Consumer Protection & Professional Licensure
Health Care Financing
State Administration & Regulatory Oversight

October 1, 2007

The Honorable Ruth B. Balser
House Chair, Joint Committee on Mental Health and Substance Abuse
Room 33
State House
Boston, MA 02133

The Honorable Gale D. Candaras
Senate Chair, Joint Committee on Mental Health and Substance Abuse
Room 213B
State House
Boston, MA 02133

Dear Chairwoman Balser, Chairwoman Candaras & Members of the Committee:

I am writing to voice my support for an *Act to Improve Access to Mental Health Services* bill **(H. 1871),** introduced by Chairwoman Ruth B. Balser. As a co-sponsor of H. 1871, I strongly believe that this legislation would enhance access to necessary mental health and substance abuse treatment for the people of the Commonwealth while saving the state much needed funds.

H. 1871 would expand the Mental Health Act of 2000 into a comprehensive mental health parity bill, bringing full parity to all mental health disorders, including substance abuse, addiction, eating disorders, and trauma. The Act of 2000, unfortunately, limited coverage for so-called "non-biologically based" disorders; as a result, coverage for treatment of substance abuse, eating disorders, trauma, and other conditions is limited. This legislation would eliminate the distinction between biologically-based disorders and other mental health and substance abuse disorders listed in psychiatric and diagnostic manuals, so that all individuals would be covered for treatment of mental health and substance abuse disorders, as all other medical conditions are covered.

Thank you for your consideration on this important matter. I respectfully request that the Committee adopt a favorable report for H. 1871 as expeditiously as possible.

Sincerely,

Kay Khan

Kay Khan
State Representative

The Commonwealth of Massachusetts
HOUSE OF REPRESENTATIVES
STATE HOUSE, ROOM 134 BOSTON 02133-1054

REP. ALICE K. WOLF
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Vice Chair
Committee on Public Health
Member, Committee on Ways & Means
Member, Committee on Education

October 1, 2007

Joint Committee on Mental Health and Substance Abuse
State House Room 33
Boston, MA 02133

Dear Chairwoman Candaras, Chairwoman Balser and Honorable Members of the Committee:

I write in support of House Bill 1871, *An Act Relative to Mental Health Parity.* I am a co-sponsor of this bill.

Massachusetts law provides full parity for specific mental disorders: schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder, delirium and dementia, and affective disorders. Private insurers, HMOs and the Group Insurance Commission may not impose annual or lifetime limits in terms of dollars or visits on the biologically-based mental disorders listed. Disorders not covered under this law include post-traumatic stress disorder (PTSD), eating disorders and substance abuse.

H. 1871 seeks to provide treatment for all disorders identified by the American Psychiatric Association, rather than drawing a distinction that may not exist between "biologically-based" disorders and "non-biologically based" disorders. By expanding coverage for mental health and substance abuse, H. 1871 builds on the Legislature's progress towards comprehensive universal health care.

I urge the committee to report this bill favorably. Thank you for your consideration.

Sincerely yours,

Alice K. Wolf
State Representative

The Commonwealth of Massachusetts

HOUSE OF REPRESENTATIVES
STATE HOUSE, BOSTON 02133-1054

DENISE PROVOST
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COMMITTEES:
Elder Affairs
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Personnel and Administration

September 27, 2007

The Honorable Gale Candaras
Committee on Mental Health and Substance Abuse, Chair
State House Room 213-B
Boston, MA 02133

The Honorable Ruth Balser
Committee on Mental Health and Substance Abuse, Chair
State House Room 33
Boston, MA 02133

Dear Chairwoman Candaras and Chairwoman Balser:

I write today in support of House bill 1871, *An Act Relative to Mental Health Parity.* I am a co-sponsor of this important proposed legislation because of its tremendous importance not only in reducing the costs to the Commonwealth for the care of people with mental disorders, but also in conveying the crucial message that Massachusetts realizes the seriousness and legitimacy of all disorders recognized by the American Psychiatric Association. This is a significant step toward the goal of minimizing the stigmatization of people suffering from mental illnesses of all kinds.

Full parity of this type of care is an issue of particular concern for my district in Somerville, where there is a great unmet need for treatment not currently mandated by the Massachusetts Mental Health Parity Law, especially for detoxification and post-trauma programs. It seems a sad irony that these services not presently covered are those services so badly needed in low-income communities.

I urge you to report this bill favorably out of your Committee, and reaffirm the Commonwealth's commitment to improving the quality and accessibility of healthcare for all of its citizens.

Respectfully submitted,

Denise Provost

Representative Denise Provost

COMMONWEALTH OF MASSACHUSETTS

MASSACHUSETTS SENATE

STATE HOUSE, BOSTON 02133-1053

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EDUCATION
CHILDREN & FAMILIES
TOURISM, ARTS AND CULTURAL DEVELOPMENT

Joint Committee on Mental Health and Substance Abuse
Room 33
StateHouse
Boston, MA 01233

October 1, 2007

Dear Chairwomen Balser and Candaras,

H1871, An *Act relative to Mental Health Parity*, will greatly enhance access to necessary mental health and substance abuse treatment for the people of the Commonwealth while saving the state much needed funds.

The current Massachusetts Mental Health Parity Law, passed as chapter 80 of the Acts of 2000, "An Act Relative to Mental Health Benefits," expanded the mandate on private health plans but stopped short of full parity. The previous Mental Health parity bill draws a distinction between "biologically-based disorders" and "non-biologically based disorders," giving full parity to the so-called "biologically-based disorders" while setting a limit on coverage for all remaining behavioral health disorders. H1871 closes this loophole by requiring coverage for any disorder identified by the American Psychiatric Association.

This legislation continues the commitment Massachusetts has made to improving the quality and accessibility of healthcare. By passing H1871, the legislature continues its historic role in protecting access to mental health and substance abuse treatment. At the federal level, Senator Ted Kennedy is the sponsor of similar mental health parity legislation. In fact, his bill passed the US Senate unanimously on September 18. H1871 supports Senator Kennedy's efforts by showing the nation that his own state has a model statute, and complements it as it requires the same coverage for state-regulated policies, that his bill would require for federally-regulated policies.

Because mental health parity fights stigma against a vulnerable population, saves the state money and furthers the Massachusetts commitment to increasing access to

comprehensive health care for all the people of Massachusetts, I respectfully as that you support this bill and give it a favorable report.

Sincerely,

Pam Resor

Senator Pam Resor

The Commonwealth of Massachusetts
House of Representatives
State House, Boston 02133-1054

CORY ATKINS
STATE REPRESENTATIVE
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Science and Technology
Transportation

Chair of:
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TESTIMONY

Hearing October 1, 2007

To: Members of the Joint Committee on Mental Health & Substance Abuse
From: Representative Cory Atkins
Date: October 1, 2007
Re: H. 1871, An Act Relative to Mental Health Parity

I write today in support of H. 1871, which would expand health benefits coverage that were established in Chapter 80 of the Acts of 2000, "An Act Relative to Mental Health Benefits." This legislation seeks to correct health coverage to include treatment for **all** mental disorders identified by the American Psychiatric Association.

The statute passed in 2000 went a long way to improve coverage for the diagnosis and treatment of mental disorders, requiring health plans to provide the same coverage for mental health disorders as it would for physical disorders. However, this law differentiated between "biologically based" and "non-biologically based" mental disorders, providing that health plans give full parity to all "biologically based" disorders but only limited coverage to some of the "non-biologically based" illnesses. Some of the mental disorders not currently requiring coverage by the statute of 2000 include: substance abuse, eating disorders, and trauma - all of which are among the ten leading causes for the loss of years of healthy life according to the World Health Organization. It is appalling that we in the Massachusetts legislature, with such a celebrated history of protecting healthcare access, have permitted such a loophole for some of our fellow citizens most in need of help to slip through and suffer.

We in the legislature must correct this oversight and establish true equality for all those who suffer from mental illness and seek aid. Senator Ted Kennedy has already sponsored similar mental health parity legislation in the US Senate, which was passed unanimously on September 18, 2007. By passing H. 1871, we in the Commonwealth will be supporting Senator Kennedy's efforts by providing a model example of how healthcare coverage should be provided equally for all those in need of care. We must continue our state's fine tradition of being a progressive voice and "ahead of the times" in our policies for the benefit of all of our citizens, and especially for those who need our help to rid themselves of mental disorders.

I thank the committee for its time and consideration of this legislation and ask the members to report this bill favorably out of committee in a timely and efficient manner.

The Commonwealth of Massachusetts
House of Representatives
State House, Boston 02133-1054

TIMOTHY J. TOOMEY, JR.
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ROOM 166, STATE HOUSE

September 24, 2007

Representative Ruth Balser
House Chair, Joint Committee on Mental Health & Substance Abuse
Room 33, State House

Chairwoman Balser:

I am writing to express my full support for H1871, An Act Relative to Mental Health Parity, and to respectfully request the Joint Committee on Mental Health & Substance Abuse reports favorably on the bill. Thank you for your consideration.

Best regards,

Timothy J. Toomey Jr.

COMMONWEALTH OF MASSACHUSETTS

MASSACHUSETTS SENATE

STATE HOUSE, BOSTON 02133-1053

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ELECTION LAWS (CHAIR)
EDUCATION (VICE CHAIR)
PUBLIC SERVICE (VICE CHAIR)
VETERANS AND FEDERAL AFFAIRS (VICE CHAIR)
WAYS AND MEANS
LABOR AND WORKFORCE DEVELOPMENT

October 1, 2007

Chairwoman Gale D. Candaras
Joint Committee on Mental Health & Substance Abuse
Room 213-B
Boston, MA 02133

Chairwoman Ruth B. Balser
Joint Committee on Mental Health & Substance Abuse
Room 33
Boston, MA 02133

Dear Chairwoman Candaras, Chairwoman Balser and Members of the Joint Committee on Mental Health and Substance Abuse:

As the Committee considers ***House Bill 1871: An Act Relative to Mental Health Parity***, I would like to state my strong support for this vital legislation, of which I am a proud co-sponsor.

We should be proud that Massachusetts is already one of 31 states in the nation to enact a form of mental health parity legislation. The current Massachusetts Mental Health Parity Law, Chapter 80 of the Acts of 2000, "An Act Relative to Mental Health Benefits," expanded the mandate on private health plans but stopped short of full parity. The 2000 statute requires health plans to cover the diagnosis and treatment of certain mental disorders to the same extent that they cover the diagnosis and treatment of physical disorders, drawing a distinction between "biologically-based disorders" and "non-biologically based disorders," giving full parity to the so-called "biologically-based disorders" while setting a limit on coverage for all remaining behavioral health disorders. Some of the disorders that are currently limited for full parity are schizophrenia, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder, delirium and dementia. While this is a good first step for Massachusetts, the time has come to provide full parity for these mental illnesses.

Mental health parity strives to equalize mental health insurance coverage with physical health coverage. By stating that mental health deserves equal insurance coverage with other health conditions, parity legislation makes a powerful anti-stigma

statement. By fully covering these mental health conditions, we are also stemming off the possibility of individuals who do not seek any treatment, making for bigger problems and higher costs later. Another possibility is that mentally ill patients will consult primary care physicians, who may be less experienced in dealing with mental illnesses and less qualified to properly diagnose and treat the patient. With the introduction of our landmark health care reform law, Massachusetts has proven its commitment to health care and wellness to its citizens and to the rest of the nation. By amending the current mental health parity law, we have the opportunity to provide for truly comprehensive parity on a nondiscriminatory basis.

Again, I would like to offer my full support for this much-needed effort and I hope the committee will act favorably on House Bill 1871. Thank you.

Sincerely,

Edward M. Augustus, Jr.
State Senator

The Commonwealth of Massachusetts
House of Representatives
State House, Boston 02133-1054

CHRISTINE E. CANAVAN
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ASSISTANT MAJORITY WHIP
FLOOR DIVISION LEADER

Special Legislative Committee
on Foster Care

To: The Honorable Gale D. Candaras, Senate Chair
Joint Committee on Mental Health and Substance Abuse
State House, Room 213B

The Honorable Ruth B. Balser, House Chair
Joint Committee on Mental Health and Substance Abuse
State House, Room 33

From: Representative Christine E. Canavan
Second Floor Division Leader

C&C

Date: Monday, October 1, 2007

RE: H. 1871, An Act relative to mental health parity

In order to give the general public adequate time to present their arguments, I will not testify in person, but ask you to accept this written testimony as a show of support for the following legislation:

1871, An Act relative to mental health parity. As a cosponsor of this legislation, I believe that **H. 1871** is an important step in addressing the mental health needs of the residents of the Commonwealth. This legislation would eliminate the distinction between biologically-based disorders and other mental health and substance abuse disorders listed in the psychiatric manuals. This would ensure that all individuals would be covered for treatment of mental health and substance abuse disorders, just as they are covered for all other medical conditions.

It is my sincere hope that the committee duly notes all testimony and gives a favorable response to **H. 1871**.

I appreciate your time, and I thank you in advance for your consideration.