The Commonwealth of Massachusetts

JOINT COMMITTEE ON MENTAL HEALTH AND SUBSTANCE ABUSE
STATE HOUSE, BOSTON 02133-1054

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NOTICE OF PUBLIC HEARING

On October 1, 2007 at 1:00 pm in Hearing Room A-2 the Joint Committee on Mental Health and Substance Abuse will hold a public hearing on the following bills:

H.1871 - An Act relative to mental health parity. (Rep. Ruth B. Balser)

H.1873 - An Act to improve access to mental health services. (Rep. Ruth B. Balser)

H.3534 - An Act to further define adverse determinations by insurers. (Rep. Thomas P. Kennedy)

S.1114 - An Act relative to adult day health services. (Sen. Harriette L. Chandler)

S.1125 - An Act requiring the Division of Medical Assistance to reimburse hospitals for the costs of psychiatric patients on medical units. (Sen. Richard T. Moore)

S.1126 - An Act to preserve access to behavioral health services. (Sen. Richard T. Moore)

S.1142 - An Act to ensure adequate adult day health services. (Sen. Marian Walsh)

An Executive Session will follow the Public Hearing

WORKING DRAFT *Updated: 8/13/08*
JOINT COMMITTEE ON MENTAL HEALTH AND SUBSTANCE ABUSE

WRITTEN TESTIMONY SUBMITTED AT PUBLIC HEARING ON OCTOBER 1, 2007

WRITTEN TESTIMONY SUBMITTED RE: H.1871

Letters from Legislators:
1. Rep. David B. Sullivan – **In support of H.1871**

2. Senator Steven A. Tolman – **In support of H.1871**

3. Rep. Byron Rushing – **In support of H.1871**

4. Rep. Kay Khan – **In support of H.1871**

5. Rep. Alice K. Wolf – **In support of H.1871**

6. Rep. Denise Provost – In support of H.1871

7. Senator Pamela P. Resor – **In support of H.1871**

8. Rep. Cory Atkins – **In support of H.1871**

9. Rep. Timothy J. Toomey, Jr. – **In support of H.1871**

10. Senator Edward M. Augustus, Jr. – **In support of H.1871**

11. Representative Christine E. Canavan – **In support of H.1871 (received by the Committee after 10/1/07 hearing)**

WRITTEN TESTIMONY SUBMITTED RE: *H.4423 (MHSA Com. Redraft of H.1871)*

Letters from Legislators:
1. Rep. David B. Sullivan – **In support of H.4423** (Rep. Sullivan's letter of 12/14/07 addressed to Senator Richard Moore, Senate Chair, Joint Committee on Health Care Financing and Rep. Patricia A. Walrath, House Chair, Joint Committee on Health Care Financing)

In opposition to H.1871
1. *Massachusetts Association of Health Plans (MAHP)* – ***In opposition to H.1871 (written testimony only)***

2. John J. Curley, Jr., J.D., Public, Government and Regulatory Affairs, Corporate Affairs Division, Blue Cross Blue Shield of Massachusetts – **In opposition to H.1871 (written testimony only)**

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1. Barbara A. Leadholm, Commissioner, Massachusetts Dept. of Mental Health – **In support of H.1871 *(and oral testimony)***

PANEL:

1. Maryanne Frangules, MOAR Project Coordinator, Massachusetts Organization for Addiction Recovery (MOAR) – **In support of H.1871 (and oral testimony)**

2. Deb Lavoie, parent of daughter in recovery from alcoholism – **In support of H.1871 (oral testimony only)**

3. Anne Robinson, COO and Executive Director, Multiservice Eating Disorders Association (MEDA) – **In support of H.1871 (oral testimony only)**

PANEL:

1. Marylou Sudders, President and CEO, Massachusetts Society for the Prevention of Cruelty to Children (MSPCC) – **In support of H.1871 (and oral testimony)**

2. Elena Eisman, Ed.D., Chair, Massachusetts Mental Health Coalition – **In support of H.1871 (and oral testimony)**

3. John McDonough, Executive Director, Health Care for All – **In support of H.1871 (and oral testimony)**

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1. David R. DeMaso, M.D., Psychiatrist-in-Chief, Children's Hospital Boston – **In support of H.1871 (and oral testimony)**

2. Susan Fendell, Senior Attorney, Mental Health Legal Advisors Committee – **In support of H.1871 (and oral testimony)**

3. Dr. Nancy Norman, Medical Director, Boston Public Health Commission – **In support of H.1871 (and oral testimony)**

4. Pat Lawrence, former President of NAMI, Massachusetts who co-wrote the Mental Health Parity Act of 2000 (Chapter 80 of the Mass. General Laws); consumer: mother of two daughters with mental illness; wife of late husband with mental illness – **In support of H.1871 (and oral testimony)**

NAMI, Massachusetts PANEL:

1. Jennifer Collier, NAMI, Massachusetts – **In support of H.1871 (and oral testimony)**

2. Toby Fisher, Director of Public Policy, NAMI, Massachusetts – **In support of H.1871 (and oral testimony)**

3. Sidney Gelb, Public Policy Chair, Board of Directors, NAMI, Mass. – **In support of H.1871 (and oral testimony)**

4. Ann Rudy, young adult consumer with mental illness – **In support of H.1871 (oral testimony only)**

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1. Clare D. McGorrian, Esq., HealthLaw Advocates – **In support of H.1871 (and oral testimony)**

2. Gary Gilberti, President, Massachusetts Association of Behavioral Health Systems – **In support of H.1871 (and oral testimony)**

3. Vicker V. DiGravio, III, President and CEO, Mental Health & Substance Abuse Corporations of Massachusetts (MHSACM) – **In support of H.1871 (and oral testimony)**

4. Timothy O'Leary, Deputy Director, Massachusetts Association for Mental Health, Inc. (MAMH) – **In support of H.1871 (and oral testimony)**

5. Paul Kusizk, parent – **In support of H.1871 (oral testimony only)**

6. George Sigel, M.D., The Public Sector Mental Health Study/Advocacy Group – **In support of H.1871 (written testimony only)**

7. John Palmieri, M.D., staff psychiatrist, Cambridge Health Alliance – **In support of H.1871 (written testimony only)**

8. Carol J. Trust, LICSW, Executive Director, National Association of Social Workers (NASW), Massachusetts Chapter – **In support of H.1871 (written testimony only)**

9. Lisa Lambert, Executive Director, Parent/Professional Advocacy League (PAL) – **In support of H.1871 (written testimony only)**

10. Massachusetts Coalition for Addiction Services – **In support of H.1871**

<u>Autism Society of America, Massachusetts Chapter (ASA) PANEL:</u>
1. Hugh Rutledge, President, ASA Massachusetts – **In support of H.1871 (oral testimony only)**

2. Anke Kriske, Admin. Asst., ASA Massachusetts – **In support of H.1871 (oral testimony only)**

3. Igor B. Rozenvald, M.D., New England Medical Center; parent of six-year-old autistic son; ASA Massachusetts – **In support of H.1871 (and oral testimony)**

<u>Testimony Re: H.1871 Received After Hearing:</u>
1. Joanne Cali, 32 Framingham Road, Southborough, MA 01772– **In opposition to H.1871 (email from Joanne Cali received by Chairwoman Balser on 10/23/07, after 10/1/07 hearing)**

2. Marie Power, RN, 155 Bond Street, Norwood, MA 02062 – **In support of H.1871 (oral testimony)** 10/16/07: Mary Lou Maloney of the Disability Policy Consortium and Marie Power, RN stopped by Chairwoman Balser's office to express support of H.1871. Mary Lou Maloney was bringing Marie Power to Chairwoman Balser's office. Marie Power is a retired RN and she said she fully supports H.1871. Antonetta gave Marie Power a copy of set of written testimony for the October 1, 2007 hearing.

NOTE: Vicker V. DiGravio, Pres./CEO of Mental Health & Substance Abuse Corporations of Massachusetts wrote Chairwoman Balser a thank-you letter of 12/6/07 to thank her for the committee's vote to move the committee redraft of H.1871 favorably out of committee at the Dec. 5, 2007 Executive Session

WRITTEN TESTIMONY SUBMITTED RE: H.1873

Letters from Legislators:

1. Rep. David B. Sullivan – **In support of H.1873**

2. Rep. Kay Khan – **In support of H.1873**

3. Rep. Steven J. D'Amico – **In support of H.1873 (received by the Committee after 10/1/07 hearing)**

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1. Carol J. Trust, LICSW, Executive Director, National Association of Social Workers (NASW), Massachusetts Chapter – **In support of H.1873 (and oral testimony)**

In opposition to H.1873:

3. Vicker V. DiGravio, III, President and CEO, Mental Health & Substance Abuse Corporations of Massachusetts (MHSACM) – **In opposition to H.1873**

WRITTEN TESTIMONY SUBMITTED RE: H.3534

Letters from Legislators:

1. Rep. Thomas P. Kennedy – **In support of H.3534**

2. Rep. Kay Khan – **In support of H.3534**

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1. Susan Fendell, Senior Attorney, Massachusetts Mental Health Legal Advisors Committee – **In support of H.3534 (and oral testimony)**

2. David Matteodo, Executive Director, Massachusetts Association of Behavioral Health Systems, Inc. – **In support of H.3534 (and oral testimony)**

3. Elena Eisman, Ed.D., Executive Director, Massachusetts Psychological Association – **In support of H.3534 (oral testimony only)**

In opposition to H.3534

1. Massachusetts Association of Health Plans (MAHP) – **In opposition to H.3534**

Testimony Re: H.3534 Received After Hearing:

1. Jennifer Honig, CLRD Co-Chair, Coalition for the Legal Rights of People with Disabilities (CLRD) – **In support of H.3534**

2. Massachusetts Hospital Association – **In support of H.3534**

3. John J. Curley, Jr., J.D., Vice President, Public, Government and Regulatory Affairs, Blue Cross Blue Shield of Massachusetts – **In opposition to H.3534 (received by the Committee after 10/1/07 hearing)**

4. Joanne Cali, 32 Framingham Road, Southborough, MA 01772– **In opposition to H.3534 (email from Joanne Cali received by Chairwoman Balser on 10/23/07, after 10/1/07 hearing)**

WRITTEN TESTIMONY SUBMITTED RE: S.1114

Letters from Legislators:

1. Senator Stephen M. Brewer – **In support of S.1114**

Massachusetts Adult Day Services Association (MADSA) PANEL:
1. Darcey Adams, LICSW, Director of Community Programs, Northeast Senior Health – **In support of S1114 (and oral testimony)**

2. Janet Gottler, Co-President, Massachusetts Adult Day Services Association (MADSA); Director of Long Term Care Programs, Kit Clark Senior Services, Dorchester, MA – **In support of S1114 (and oral testimony)**

3. Jean Seero, RN, Director, Mary Immaculate Adult Day Center, Lawrence, Mass. – **In support of S1114 (and oral testimony)**

WRITTEN TESTIMONY SUBMITTED RE: S.1142

Massachusetts Adult Day Services Association (MADSA) PANEL:
1. Darcey Adams, LICSW, Director of Community Programs, Northeast Senior Health – **In support of S1142 (and oral testimony)**

2. Janet Gottler, Co-President, Massachusetts Adult Day Services Association (MADSA); Director of Long Term Care Programs, Kit Clark Senior Services, Dorchester, MA – **In support of S1142 (and oral testimony)**

3. Jean Seero, RN, Director, Mary Immaculate Adult Day Center, Lawrence, Mass. – **In support of S1142 (and oral testimony)**

WRITTEN TESTIMONY SUBMITTED RE: S.1125

Letters from Legislators:

1. Senator Richard T. Moore – ***In support of S.1125***

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1. David Matteodo, Executive Director, Massachusetts Association of Behavioral Health Systems, Inc. – **In support of S.1125 (and oral testimony)**

Testimony Re: S.1125 Received After Hearing:

1. Massachusetts Hospital Association – **In support of S.1125**

WRITTEN TESTIMONY SUBMITTED RE: S.1126

Letters from Legislators:

1. Senator Richard T. Moore – ***In support of S.1126***

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1. Vicker V. DiGravio, III, President and CEO, Mental Health & Substance Abuse Corporations of Massachusetts (MHSACM) – **Recommended additions and changes to S.1126 (received by the Committee after 10/1/07 hearing)**

Testimony Re: S.1126 Received After Hearing:

1. Massachusetts Hospital Association – **In support of S.1126**

Prepared and compiled by Antonetta A. DiGiustini, Research Analyst

REQUEST for TESTIMONY for H. 1871

DiGiustini, Antonetta (HOU)

from JESSICA TAUBNER SENIOR RESEARCH ANALYST JOINT COM. ON HEALTH CARE FINANCING

From: Taubner, Jessica (HOU)
Sent: Friday, January 04, 2008 2:49 PM
To: DiGiustini, Antonetta (HOU)
Subject: FW: Testimony

Hi Antonetta,

I see that Michael is out. Good for him. I hope you enjoyed the holiday season and Happy New Year!

I am looking to get testimony on the first 2 bills noted below and then to browse through what I expect is a large amount of testimony for the children's MH bill. Would it be possible to do this early next week?

Thank you,
Jessica

From: Taubner, Jessica (HOU)
Sent: Friday, January 04, 2008 2:46 PM
To: Carr, Michael (HOU)
Subject: Testimony

Hi Michael,

How are you? Happy New Year!

I am hoping to get some testimony from you on several bills. As always, I am happy to come down and review/copy myself if that is easier. Here are the bills I am looking for info on:

- H.3881 Relative to Juvenile MH (redraft is S.2407), heard on 6/11/07
- H.2042 To Protect the Mentally Ill in Emergency Rooms, heard on 9/24/07
- H.1871 Mental Health Parity (new draft is H.4423), heard on 10/1/07 - I imagine there is a lot of testimony for this bill. Perhaps I can just browse through it instead of having it all copied?

Let me know what works best for you.

Thanks,
J

MASSACHUSETTS

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

Testimony
In Opposition
to
H. 1871

October 1, 2007

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

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

Re: House Bill 1871, *An Act Relative to Mental Health Parity*

Dear Senator Candaras and Representative Balser:

On behalf of Blue Cross Blue Shield of Massachusetts (BCBSMA), I am writing to express our opposition to House Bill (HB) 1871, entitled *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 1871 includes language that would require 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 coverage for "mental health benefits on a non-discriminatory basis...for the diagnosis and treatment of any mental disorders, as described in the most recent edition of the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association...or the most recent edition of the International Classification of

Diseases (ICD) and Related Health Problems." This mandate would require coverage for a voluminous list of behavioral health conditions. For many of these conditions listed in the DSM and ICD, 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. Several states that require mental health parity coverage under DSM or 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. Without exclusions and limitations, there is also the potential to shift the cost of certain mental health services included under DSM and ICD that are currently covered by school systems and the Department of Education to the private insurance market. This provision of mental health parity could cost up to $30 million per year or $1.25 per member per month (PMPM) or .5% of health care costs with a significant increase in behavioral and total medical expense.

In addition, HB 1871 includes a provision requiring coverage for the diagnosis and treatment of any mental disorders, as described in the most recent edition of the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC: 0-3R), DSM and ICD for children and adolescents up to age 21. This provision may also result in cost shifting and mandate coverage for conditions that are not currently covered by health plans.

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% 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.

Under Health Care Reform there is 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 has concluded its review and published results from a comprehensive analysis of mandated health benefits. 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.

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.

MASSACHUSETTS ASSOCIATION of HEALTH PLANS

FOR THE REC(

Testimony
In Opposition
to
H. 1871

COMMITTEE:	**Joint Committee on Mental I**
ISSUE:	**House Bill 1871, An Act Rel**
DATE:	**October 1, 2007**
POSITION:	**Oppose**

The Massachusetts Association of Health Plans (MA health plans, which provide health care coverage Massachusetts residents, opposes House Bill 1871, v Health Parity Law to include services beyond what traditional medical coverage.

The Commonwealth is at a critical stage in implementi [illegible] Law, with the affordability of coverage a major concern for many individuals, employers, and policymakers. Therefore, we would strongly caution against measures that will lead to significant increases in the cost of health care and would urge the Committee to send this bills to the Division of Health Care Finance and Policy to review the efficacy and need for expanding the Mental Health Parity Law and coverage of additional services and the impact the bills would have on the cost of coverage.

Health Plans' Commitment to High-Quality Mental Health Services

Massachusetts health plans add significant value to the health care system, focusing on getting patients the right care, at the right time, and in the right setting. We are proud that Massachusetts health plans continue to be rated the best in the nation.

Our health plans integrate mental health, medical care and pharmacy services to meet the specific needs of their members. Through disease management and care management programs, health plans identify members who are at risk of mental health problems and advise appropriate screenings or treatments at an early stage. Additionally, there are programs in place to ensure that health plan members receive the appropriate education, support, and coordination of care to follow through with prescribed therapies for treating depression.

MAHP member health plans are committed to ensuring that their members receive access to necessary and high quality services. For example, MAHP members, as well as their New England counterparts, lead the nation in follow-up care after hospitalization for mental health admissions. NCQA notes the importance of this measure as follow-up care helps to reduce the risk of repeat hospitalization, and identifies those in need of further hospitalization before they reach a crisis point.

State data indicates that health plan members have access to needed mental health services. In 2006, of 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
Mental Health Appeals	175	230	127	127	137
Eligible MH 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

Further, according to statistics compiled by the state's Bureau of Managed Care in 2005, Massachusetts health plan covered over 2 million mental health outpatient visits and almost 93,000 mental health inpatient days for the treatment of major depression, eating disorders, chemical dependency, and other mental health disorders.

	2003	2004	2005
Outpatient BH Utilization (non-physician encounters)	1,615,411	1,662,066	1,633,002
Outpatient BH Utilization (physician encounters)	452,669	410,698	417,246
Inpatient BH Utilization (total discharge days)	90,877	89,843	92,899

The low number of external appeals for mental health services and high number of covered services demonstrates that the state's health plans maintain a high level of quality and that health plan members are able to access necessary services.

Health Plans' Compliance with the Mental Health Parity Law

MAHP is supportive of the existing Mental Health Parity Law which was drafted in collaborative fashion in the 1999-2000 legislative session. Since then, the Division of Insurance (DOI) has undertaken several audits to ensure that health plans are complying with the law. The DOI requires that health plans provide members with adequate access to all mandated mental health provider types who offer the full range of mandated services, which includes a full range of outpatient, inpatient, and intermediate care services. Health plans must also ensure that they provide sufficient access to mental health providers, just as they do for other specialties, to avoid long waiting periods; and include the names of all mental health providers in their provider directories.

In 2002, DOI, in conjunction with the Department of Public Health and the Department of Mental Health (DMH) issued a bulletin (2002-07), reminding health plans of their obligations to provide coverage for appropriate mental health services consistent with the Mental Health Parity Law. The bulletin also stated that for a health plan to demonstrate good faith compliance with the mental health parity and managed care laws, each carrier should have working procedures in place to provide assistance to members, monitor its network and, in the event that no contracted provider is reasonably accessible to the patient that there is out-of-network treatment provided. Following the bulletin, in 2002,

the DOI conducted an audit of every health plan's mental health network, and all MAHP member health plans are fully complying with the mental health parity law.

Open-ended Expansion of the Mental Health Parity Law

Currently, the Mental Health Parity Law requires coverage of biologically-based mental disorders, as described in the most recent edition of the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM). The law also requires carriers to provide to children and adolescents under the age of 19 coverage of non-biologically-based mental, behavioral or emotional disorders described in the DSM that substantially interfere with or substantially limit their functioning and social interactions. House Bill 1871 expands the mental health parity law to mandate coverage for "mental health benefits on a nondiscriminatory basis... for the diagnosis and treatment of any mental disorders, as described in the most recent edition of the DSM. This could include:

- Learning Disorders
- Motor Skills Disorder
- Communication Disorders
- Rett's Disorder

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.

Further, extending parity to include these new diagnoses will be extremely costly. As the implementation of Chapter 58 progresses, one of the critical issues is and will continue to be affordability. Individuals will soon be required to purchase health insurance, and 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 (MCC). It is therefore imperative that careful attention be paid to the cost of health care. As House Bill 1871 includes an expansion of the mental health parity law we have serious concerns with what impact the bill will have on the cost of health care. Mandating an unlimited benefit for services for all disorders is no longer true parity with medical care.

In general MAHP opposes mandating health care benefits because it limits employers' and consumers' ability to manage their health care costs and can lead to significant increases in the cost of coverage. State and federal mandates account for 15 cents of every new health care dollar.[1] Further, according to reports issued by the Division of Health Care Finance & Policy (DHCFP), of the 12 proposed mandates DHCFP has studied, if enacted, they would add as much as $212 million to the cost of coverage.[1]

In the midst of the current debate on the affordability of health care reform, individuals who are now required to purchase coverage should have the ability to choose the coverage that is right for them. Mandated benefits run counter to this goal, forcing

[1] Mandate Review Reports by the Division of Health Care Finance & Policy

coverage of specific benefits that individual may not need or want. Finally, Chapter 58 recognized the impact of mandates on the cost of health care and included a moratorium on all new mandated benefits until the latter of either January 1, 2008, or until the DHCFP has concluded a review of, and published results from, a comprehensive review of mandated health benefits in effect on January 1, 2006. We believe that the intent of the moratorium was to help control the cost of coverage and avoid adding new costs as individuals must begin purchasing coverage to comply with the individual mandate.

It is for these reasons, we respectfully recommend that the Committee send House Bill 1871 to DHCFP so that the financial impact and clinical appropriateness of the provisions in the bill are reviewed to determine the need for expanding the Mental Health Parity Law and the effect it would have on the cost of coverage.

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[i] PricewaterhouseCoopers, *The Factors Fueling Rising Health Care Costs*, April 2002.

PAL

Parent/Professional Advocacy League

The Massachusetts Family Voice for Children's Mental Health

45 Bromfield Street, 10th Floor, Boston, Massachusetts 02108 617.542.7860 F: 617.542.7832 www.ppal.net

Testimony of Parent/Professional Advocacy League
H1871, An Act Relative to Mental Health Parity
October 1, 2007

Good afternoon, Chairwoman Balser, Chairwoman Candaras and members of the committee. My name is Lisa Lambert and I am the Director of PAL, the Parent/Professional Advocacy League. I am here today to support House Bill 1871.

Seven years ago when the existing mental health parity legislation was made into law, we breathed a sigh of relief. It had been a long, difficult struggle to pass this law and we envisioned great changes to access, to treatment and to the finances of families. The stories and challenges of families trying to get their children's mental health treatment paid for by their insurance company is what brought PAL into a coalition to pass this law. And some things did change, but others continue to be a struggle.

As you know, PAL is a statewide network of families and 100% of them have children and adolescents with ental health needs. There are approximately 1.5 million kids in the Commonwealth. About 70% of them have private insurance. Of the kids who have private insurance about 40% are affected by the mental health parity law with an additional 60% in self-insured plans. We also know from the Surgeon General's report on mental health that 1 in 10 children and adolescents have a mental health problem that impacts their functioning.

All of this information highlights that it is more likely for a child with a mental health disorder to be privately insured than on MassHealth. Although most adults with serious mental health needs have MassHealth, especially if they are unable to work, for children and teens with serious mental health needs this is untrue. Most of their parents are working and purchase the insurance through their employer. As a result, the changes made by the mental health parity law affect kids disproportionately.

Some of what we hoped for is working and has made an enormous difference for kids and families. Before the parity law was passed, in PAL support groups across the state we would hear in the late summer from parents that their outpatient benefit had run out. They most often had a benefit of 20 therapy visits which had been used, even rationed a bit. And the parents were desperate because they knew their child couldn't last until the next January when the benefit kicked in again. Some paid out of pocket, some applied for MassHealth and a small number pressured their health plan

for more visits. And many kids went into crisis because they lacked treatment.

This area has improved enormously. However, it has led to an unintended and unanticipated consequence. The present parity law requires that health plans provide benefits to children if their disorder substantially interferes with or limits their functioning. This is a more encompassing benefit than provided to adults, which lists certain biologically based mental disorders. Although health plans may use the definition of function to review benefits for kids, in practice many therapists are using the list of diagnoses to advocate with the health plan for benefits under parity. Because they must prove that the treatment is medically necessary, it is a more compelling argument to say that a 9-year-old with bipolar disorder needs an additional 12 weeks of therapy or a hospital admission than a 9-year-old who is having trouble getting up for school and is defiant at home. This practice is contributing toward diagnosing kids earlier. It is a difficult situation to resolve. The insurer insists that the treatment be medically necessary; the therapist can make the argument better through a diagnosis on the parity list. An unintended consequence of the law is the use of the list of biologically base mental disorders to access the parity benefit for kids.

This legislation expands the list to include diagnoses found in three diagnostic manuals. Children are often difficult to diagnose and this expanded list will make it far easier to diagnose children with what the clinician is sure is there and with a diagnosis that is age appropriate.

I was also pleased to see that this legislation references the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood. As you know, Massachusetts is among the top ten states in its rate of preschool expulsions. Children are almost always excluded from preschool because of difficult behaviors and those behaviors are often the result of unaddressed attentional or mood problems. Using this manual to identify mental health needs in very young children and then form a treatment plan is well thought out.

Lastly, each time we ensure that mental health treatment is available in a straightforward, easy to access way, we ensure that more people, including kids, receive it. And treatment works. Sometimes not as quickly as we'd like, but it works. And access to treatment reduces stigma. It is not some mysterious, hard to find remedy but simply an insurance benefit like any other.

I have often said that insurance is the tail that wags the dog, the dog being the mental health system for kids. The services that are made available in networks, approved under parity and easier to find are the ones that determine how well "our kids" do.

Submitted by: Lisa Lambert
Executive Director
617.542.7860 x203
llambert@ppal.net

NASW. MASSACHUSETTS CHAPTER ...the power of social work
National Association of Social Workers

Phyllis W. King, LICSW, DCSW
President

Carol J. Trust, LICSW
Executive Director

October 1, 2007

Testimony in favor of House 1871: An Act to Establish Comprehensive Mental Health Parity

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

On behalf of the National Association of Social Workers – MA Chapter, we would like to express our strong support for House Bill 1871. This legislation amends the Mental Health Parity Act of 2000 to include all disorders that are listed in the DC: 0-3R, DSM, and the International Code of Disease (ICD). House Bill 1871 establishes comprehensive mental health parity by requiring insurance companies to remove the distinction between "biologically based" and "non-biologically based" disorders. It further obligates insurance companies to provide coverage for all mental health conditions to the same degree that all other medical conditions are covered.

Social workers provide mental health services for individuals who suffer from varying types of cognitive and behavioral disorders and we do not believe the quantity or quality of care should be limited by an arbitrary distinction of "biological basis." This inequity has limited the amount of insurance coverage available for the treatment of substance abuse, eating disorders, post traumatic disorder, and a multitude of other disorders which are all serious ailments requiring mental health services. Denying services to people afflicted with these disorders because of arbitrary distinctions used by insurance companies significantly impacts the overall well-being and safety of these patients.

The mental health disorders addressed by this bill are varied and complex and they often affect many of our most vulnerable populations: children and youth, returning veterans and traumatized victims. For example, veterans often suffer from Post traumatic Stress Disorder (PTSD) a debilitating disease that is not widely enough acknowledged, diagnosed, or treated.

We support House Bill 1871 because it would require health insurance companies to provide coverage or access to metal health services and remove the barrier of gaining treatment based on the flawed designation of mental illnesses as "non-biological." Implementing these changes to current legislation is an important first step in ensuring comprehensive access to health care for all of the citizens of the Commonwealth.

Thank you,

Carol J. Trust

Carol J. Trust, LICSW
Executive Director

If you have questions or for more information contact Rebekah Gewirtz, NASW Director of Government Relations at 617.227.9635 x12 gewirtz@naswma.org.

Massachusetts Association For Mental Health, Inc.

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James Hooley
President

David K. Shapiro
Past-President

Bernard J. Carey, Jr.
Executive Director

October 1, 2007
By hand

To: Hon. Gale D. Candaras, Senate Chair
Hon. Ruth Balser, House Chair
Members of the Joint Committee on Mental Health and Substance Abuse

From: Bernard J. Carey, Jr., Executive Director
Timothy O'Leary, Deputy Director for Policy & Research
Massachusetts Association for Mental Health

Re: **HOUSE 1871 – AN ACT RELATIVE TO MENTAL HEALTH PARITY**

The Massachusetts Association for Mental Health, Inc. (MAMH) wishes to be recorded in support of the above referenced bill. We understand there will be some committee redrafting work to correct technical errors.

MAMH was very much involved in the drafting and passage of the mental health parity in health insurance law in 2000 (Chapter 80 of the Acts of 2000). We are proud of that effort, as it brought together all stakeholders, including the business and health insurance communities to craft legislation that addressed many (but not all) of the issues that had left Massachusetts as the single New England state without a mental health parity law.

Today, seven years later, it is time to enact full mental health parity as embodied in this legislation. We believe experience shows that mental health benefits can be effectively managed. The predicted unreasonable increases in insurance premiums as a consequence of the 2000 parity law never materialized.

MAMH supports this bill out of simple fairness. Mental illnesses and substance abuse disorders are treatable and health insurers should not be allowed to discriminate between or among illnesses, and impose higher co-pays or caps on some illnesses, but not on others.

It is important to note this legislation does not cerate an entitlement to services; it creates – at best – an expectation of coverage **if** the services are medically necessary.

Former DMH Commissioner Marylou Sudders, who probably had more to do with the passage of the parity law in 2000 than anyone, often said: this is not about access. It's about eliminating discrimination in providing health care coverage. MAMH believes that's as true today as it was in 2000.

Mental health parity does not mean (and should not mean) unlimited, unfettered access to services because insurance companies are only required to pay for services that are medically necessary. Moreover, they are free to use utilization review, case management, and all the managed care tools they use for other covered illnesses.

In short, this bill is about fairness - fairness to both the insurer and the insured. We support the bill and we would be pleased to work with the committee to address any redrafting or any other issues in connection with this legislation.

MHSACM

MHSACM, Inc.

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

Testimony in Support of H. 1871, *An Act Relative to Mental Health Parity*
Joint Committee on Mental Health & Substance Abuse
October 1, 2007

Good Afternoon. I am Vic DiGravio, President & CEO of Mental Health & Substance Abuse Corporations of Massachusetts (MHSACM), a statewide association representing 88 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. Thank you for the opportunity to testify today in support of An Act Relative to Mental Health Parity.

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 "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 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.

Children Under 19

The current law provides more expansive protection for children under the age of 19 by requiring non-discriminatory coverage of non-biologically-based mental, behavioral or emotional disorders if the condition substantially interferes with or substantially limits the child's functioning and social interactions. This expansiveness is belied by the serious barriers that a family must overcome to secure care (e.g., documentation of hospitalization, behavior dangerous to self or others, etc.).

MHSACM applauds the bill's recognition that children's mental healthcare is unique and requires a specialized approach. The bill wisely raises the coverage threshold to children and adolescents up to age 21, as the transition to young adulthood can be exceptionally challenging. In addition, the bill expands the diagnostic tools available to clinicians treating children and adolescents and eliminates the substantial interference/limitation requirement. These two devices will reduce or eliminate significant barriers to care for families seeking care for their children with unmet behavioral healthcare needs.

Substance Abuse Treatment

MHSACM 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.[1]

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".[2] 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.[3]

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.[4] 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).[5] 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.[6] 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.

Intermediate Care

Lack of clarity around intermediate care under the current Mental Health Parity Law has severely impacted the ability of families to get the range of medically necessary treatment and support services required to maintain community tenure or allow for re-integration into the community from out-of-home settings. As you know, the current law requires covered insurers to offer "a range of inpatient, intermediate, and outpatient services that shall permit medically necessary and active and noncustodial treatment for said mental disorders to take place in the least restrictive clinically appropriate setting."[7] The statute provides that the intermediate services "shall include, but not be limited to" community-based detoxification, acute residential treatment, partial hospitalization, day treatment and crisis stabilization licensed or approved by the Departments of Public Health or Mental Health. We believe that this has not been the case in many instances.

For example, most commercial insurers do not pay for day treatment, a highly structured stabilization program that is intended to bridge acute and community settings. Of those that do reimburse for this service, some will cover care only by re-categorizing the service as a lower-cost "intensive outpatient program," which is an entirely different level of care between day treatment and traditional outpatient services. Providers report similar experiences relative to partial hospitalization programs, which are non-residential, medically managed treatment programs for individuals that do not require more restrictive inpatient hospital care but do require more intensive services than can be provided at the outpatient level.

Certain insurers have specified a benefit limit for intermediate care in terms of days or visits, because the current law does not specify a minimum benefit for intermediate care. This is inappropriate, as the law's standard calls for medical necessity.

Further, the language of the parity law makes clear that the enumerated intermediate services are not meant to be an exhaustive list, the Division of Insurance reinforced this when it issued a bulletin jointly with the Department of Mental Health stating that it considers "blanket exclusions for residential services to not be permitted" under the parity law, and that insurers must cover "medically necessary and clinically appropriate intermediate care, including that which might be provided in a residential setting."[8] Despite this, residential providers report little experience with commercial insurers.

In addition, the lack of specificity around service types has resulted in confusion among insurers, families and care providers. Many services that are highly effective in the treatment of mental illness do not have corollaries in the general health care field. As a result, individuals with behavioral health disorders cannot access many of the services that offer the greatest potential for recovery, such as Family Stabilization Teams (FST) and Programs for Assertive Community Treatment (PACT), an evidence-based, multidisciplinary approach to providing treatment, outreach, rehabilitation, and support to people with serious mental illness. For example, some commercial insurers will pay for Family Stabilization Teams, an important short-term, intensive, therapeutic home-based service that stabilizes families during psychiatric crisis, but they do so only on an out-of-network basis. Families also report significant difficulty in securing insurer approval for residential treatment, particularly for adolescents with substance use disorders.

MHSACM recommends that the bill include language to clarify intermediate services and to reduce barriers that individuals and families face due to lack of specificity around benefits and services.

Private Sector Responsibility

The Commonwealth's 2006 health care reform law was predicated upon shared responsibility among individuals, government and the private sector. This is proving to be a laudable goal and a viable model. *An Act Relative to Mental Health Parity* follows this spirit of shared responsibility, and it will help reverse a trend in which the private sector shifts more of its responsibility onto the public sector and the public fisc. An example of this trend is the approach to mental health emergency services programs.

Emergency Services Programs (ESPs) utilization by insured individuals should be troubling to the Commonwealth. ESPs are community-based teams available around the clock to evaluate individuals with behavioral health crises presenting in hospital emergency rooms or other community sites and refer them to appropriate services. Their crisis intervention capacity helps individuals remain in their own communities, and avoids the cost and stigmatization of psychiatric hospitalization, when a less intensive level of care is safe and effective.

ESPs must provide care regardless of a patient's ability to pay or insurance status, but not all insurers will pay for the service. These insurers will neither contract with ESPs nor reimburse them on an out-of-network basis. Some of the health plans that do reimburse ESP services may seek to limit and/or define the service differently. Regardless, ESPs are providing the same firehouse model service to all Massachusetts residents in need of emergency behavioral health care. As a result, the Commonwealth is inappropriately subsidizing the care of commercially-insured individuals in need of emergency behavioral health services. It is time for private insurance to become full partners in the effort to help families and communities

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.

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

[3] 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

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

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[7] Chapter 80 of the Acts of 2000.

[8] Division of Insurance Bulletin 2003-11, Intermediate Care as part of Mental Health Parity Benefits.

Massachusetts Association of Behavioral Health Systems, Inc.

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Gary Gilberti
President

David Matteodo
Executive Director

Testimony to the Committee on Mental Health and Substance Abuse
Re: H. 1871
Presented by: Gary Gilberti, President
Massachusetts Association of Behavioral Health Systems
October 1, 2007

On behalf of the Massachusetts Association of Behavioral Health Systems (MABHS), I appreciate the opportunity to testify before the Joint Committee on Mental Health and Substance Abuse on H.1871: An Act Relative to Mental Health Parity. The MABHS represents 46 inpatient mental health and substance abuse facilities in the Commonwealth, which collectively admit over 45,000 patients annually. Our hospitals provide the overwhelming majority of acute inpatient mental health and substance abuse services in the Commonwealth.

The MABHS supports this bill as it would help end insurance law discrimination against the mentally ill. The current limitations on mandated mental health benefits are outdated: up to 60 days per year for inpatient mental health services; up to 30 days per year for inpatient substance abuse services, and $500 per year for outpatient treatment for substance abuse. The substance abuse mandated benefit has not changed since 1973. There is no logical reason for these limits: patient care in behavioral health is subject to intense management and oversight by Managed Care Organizations (MCOs). Managed care patients must receive prior approval by the MCO to begin treatment, and their ongoing inpatient and outpatient treatment is subject to regular review and approval by the MCO. **Parity should not increase inpatient length of stay in any way. In fact, since the original Parity Law passed in 2000 the average length of stay for patients in MABHS member hospitals' has gone down by approximately 10%.**

Increasingly it is becoming clear that Parity does not drive up costs. A recent study by the Division of Health Care Finance and Policy found that Substance Abuse Parity would increase costs by less than $10 per member per year. Additionally, upon reviewing the impact of Parity on the Federal Health Benefit Plan, it showed when the 8.5 million Federal employees became eligible for Parity for mental health and substance abuse, the proportion of people accessing mental health services slightly rose however, total spending for the services did not increase more than similar large employer insurance plans that did not have Parity.

Experience shows Parity should not drive up length of stay or significantly increase costs. We are pleased that Congress is recognizing this through their actions as under the leadership of Senator Kennedy and through the support of a broad coalition of insurers, business, providers, and consumers, the Parity bill passed the Senate last month. Similar action should be taken in Massachusetts. This is an opportunity for all parties to agree on H.1871 and move this legislation forward. We are hopeful that Massachusetts can move in concert with Federal action.

Please give H. 1871 a Favorable Report. Thank you for this opportunity to Testify.

MHSACM, Inc.

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As you know, the current law requires insurers to provide non-discriminatory coverage for the diagnosis and treatment "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.

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People denied treatment by insurers are faced with three choices:

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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).[5] 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.

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DONALD K. STERN
STEVEN L. WOLLMAN

Testimony of Mental Health Legal Advisors Committee

before the Joint Committee on Mental Health and Substance Abuse

in support of H. 1871 Mental Health Parity

October 1, 2007

I am testifying on behalf of Mental Health Legal Advisors Committee, an agency within the Supreme Judicial Court that represents low-income persons with mental disabilities and that provides information on mental health legal matters to health care providers, family members, the general public and, of course, the legislature. Over the past 15 years, I have provided assistance and representation to persons whose health insurance companies refuse to pay for medically necessary mental health services.

Mental Health Legal Advisors Committee strongly supports H. 1871. Our agency believes that the diagnostic division between unlimited and limited insurance coverage for mental health treatment 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 is inhumane and contrary to a society which has regard for human life.

While we strongly support H. 1871, we would like to see it go even farther to correct inequities in our health care system:

- True parity will not be achieved until clinicians, in consultation with their clients, determine medical necessity for the purpose of insurance coverage. This is why MHLAC supports H. 3534, which should be adopted along with H. 1871. Current law essentially permits insurers to determine the course of treatment for patients because insurers define medical necessity criteria and because they need not show by a preponderance of evidence that the treating clinician's determination of medical necessity is incorrect.
- Insurers must bear responsibility for mental health services rendered to children, not the schools. The limitation on educational services in the Parity Act should be eliminated. Rather, any service which has a mental health component and is medically necessary should be covered by insurers regardless of whether that service relates to how the child functions in school..
- Who is rendering the treatment and the treatment itself is more important than the site of the treatment. While it may be reasonable to delineate the qualifications of persons who may render service and what types of service may be delivered, it is not reasonable to limit where that treatment occurs.
- Services to children and adolescents should be rendered up to age 25.

Clinicians must determine medical necessity.

While the mental health parity act was a positive step forward, our experience proves that it did not come close to achieving true parity. Of course, on the state level it is difficult to deal with the gaping hole in coverage for people in self-insured plans. However, the legislature can close a big loophole in the application of parity to those plans that are covered. The loophole: insurers have been able to skirt the requirements of the parity act through the application of medical necessity criteria, authored by the insurers themselves.

One would think that the Managed Care Reform Act clearly spelled out that the treating clinician, not an insurance industry bureaucrat, was the person who, in conjunction with the patient, would determine what services were necessary to that individual. Indeed, Chapter 176O states:

> *The physician treating an insured, shall,* consistent with generally accepted principles of professional medical practice and in consultation with the insured, *make all clinical decisions regarding medical treatment to be provided to the insured....*

However, this proviso is added to the end of the paragraph:

> Nothing in this section shall be construed as altering, affecting or modifying either the obligations of any third party or the terms and conditions of any agreement or contract between either the treating physician or the insured and any third party.

The principle that the clinician treating the individual, rather than the insurer who has never seen the person in question, will make the clinical decisions for the insured is abrogated where the insurer need not pay for the care that the treating clinicians believes is medically necessary. It is always ironic to see at the bottom of denial notices the insurer's "escape from liability" language that states that the insured need not necessarily discontinue treatment and paraphrases the statute: "All decisions regarding your behavioral health treatment is the responsibility of you and your provider." However, the statute's pronouncement of the supremacy of the doctor's determination of medical care rings hollow when that care is not covered by insurance.

Currently, insurance companies subject to Chapter 176O, must pay for services that are (1) a covered benefit under the insured's health benefit plan and (2) are medically necessary. Unfortunately, the statute allows the insurer to develop medical necessity criteria: "A carrier may develop guidelines to be used in applying the standard of medical necessity." While the statute sets some parameters for these guidelines, e.g., they must be

updated biennially, these parameters do not preclude the establishment of guidelines that serve as roadblocks to care.

Particularly in the field of mental health, broad guidelines may be interpreted to the detriment of insureds. For example, progress or the lack of progress is often a determination based upon the subjective perception of the insured. "Objective" outcome measures, such as the surveys used by Pacificare, are sometimes misused by the insurance company to deny care. If the patient is progressing, he or she no longer needs care and the services are not medically necessary. If the patient is not progressing, the services are ineffective and thus the services are not medically necessary.

The regulation that addresses medical necessity, 211 Code Mass. Regs. 52.03, defines medical necessity in a way that is subject to broad interpretation, and thus, if the interpretation is left to insurers, will result in limited access to care. The regulation speaks of services that are "most appropriate" for the insured and that are "known to be effective."[1] The judgment call as to what is "most appropriate" for the individual insured should be left to the treating clinician, not a utilization reviewer who has never spoken

[1] Subject to manipulation by insurers, 211 Code Mass. Regs. 52.03 states:

> Medical Necessity or Medically Necessary, health care services that are consistent with generally accepted principles of professional medical practice as determined by whether:
>
> (a) the service is the most appropriate available supply or level of service for the insured in question considering potential benefits and harms to the individual;
>
> (b) is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; or
>
> (c) for services and interventions not in widespread use, is based on scientific evidence. National Accreditation Organization, JCAHO, NCQA, URAC or any other national accreditation entity approved by the Division that accredits carriers that are subject to the provisions of M.G.L. c. 176O and 211 CMR 52.00.

with the patient. Unfortunately, current law allows the judgment of insurance company staff to supersede that of the treating clinician.

Chapter 176O also set up an appeal procedure that consumers can access if their insurance company denies care. Unfortunately, because of who defines medical necessity, the burden of proof and the time-consuming nature of appealing denials, this appeal procedure does not guarantee consumers receive the medically necessary mental health care promised by the parity act as it now exists or as amended under H. 1871.

The appeal procedure through the Office of Patient Protection may only be used after internal appeal procedures are exhausted. And internal appeal procedures are not triggered until there is a clear denial. There is no clear denial until the treating clinician speaks first with a utilization reviewer and then engages in a doc-to-doc review with another clinician. By this time, telephone tag and repeated explanations have usually worn the clinicians down and they will accept the limited care offered by the insurer. Only in rare circumstances will the clinician insist on the full care she or he finds necessary. This is because the prospect of an appeal raises visions of innumerable unpaid hours and more than a 50% chance of failure in the face of a system weighted in favor of the insurer.

In fact, very few disagreements concerning denials of care proceed through the insurers' internal appeal procedures. As previously noted, the Byzantine appeal processes are burdensome and uncompensated. One clinician reported spending 15 hours to get authorization for 15 sessions. It is no wonder clinicians often give up at the point of the doc-to-doc review, thereby robbing their patients of their appeal rights.

There is now before the legislature a bill that would encourage clinicians to advocate for their clients by placing the burden of proof on the insurance company if the company chooses to deny services requested by the treating clinician: H. 3534. If The Act to Further Define Adverse Determinations by Insurers were in place, an insurance company would not be able to deny coverage unless it could prove by a preponderance of the evidence that care was not medically necessary.

Those few cases that go on to the insurer's internal appeal process should be judged by a standard that recognizes the superiority of the treating clinician's knowledge of his or her patient. H. 3534 provides this recognition. It does not make the clinician infallible, but it does ensure that if the insurance company is going to deny services, it should have *a preponderance of the evidence* that the service is not necessary. Insurance companies must be stopped from second guessing our trained professionals who have dedicated themselves to caring for others. Only in this way will mental health parity be achieved.

Insurers should pay for all medically necessary mental health care for children.

Insurers often attempt to evade the Parity Act's mandate to provide mental health care to children by claiming the services are school related.[2] Let's be real: if a child has mental health problems and is school age, the mental health problems will affect his or her school performance. This is true for most significant physical health problems – even

[2]The exact language of the Parity Act is "Nothing in this section shall be construed to require an insurer to pay for mental health benefits or services: ... which constitute educational services required to be provided by a school committee pursuant to section 5 of chapter 71B...." While Chapter 71B provides that insurers must pay for medically necessary services, the statute goes on to state that "the determination of medical necessity shall be made by the third party payor under its standard program of utilization review...."

a broken bone. If left untreated, school performance will suffer. Yet insurers would not dream of denying payment for the setting of a broken bone.

The legislature should clarify that any mental health services that are medically necessary – even if they are related to school performance – must be covered by private insurers. Bickering between schools and insurers over who should pay for services delays treatment and harms children.

Clearly, if a pediatrician requested a psychological evaluation of the child, insurers are less likely to balk at the request than if a school initiates the request. The same is true for other treatment. But the source of the request should not be relevant to whether the service is medically necessary.

Schools are not able to assume the costs of mental health care that should be covered under an insured's policy. Nor should taxpayers be required to boost the profit margins of private companies by subsidizing services for which insureds pay premiums. The legislature should correct this problem for the benefit of our children, our schools, and our public fisc. This can be done by narrowing the exception in parity for education services. The limitation on benefits for educational services should not be applicable when said treatment is rendered in conjunction with treatment for mental disorders.[3]

[3] We suggest that the language be modified to read "The limitation on benefits for educational services required to be provided by a school committee pursuant to section 5 of chapter 71B established by subsection (i) shall not apply when said treatment is rendered in conjunction with treatment for mental disorders pursuant to this section nor shall said limitation on benefits established by said subsection (i) impose or be construed to impose any restriction or limitation in connection with benefits for the treatment of mental disorders pursuant to this section." *See, e.g.,* Mass. Gen. L. ch. 175 § 47B (f). It should be clear, however, that services rendered under the Parity Act should not apply to any lifetime limit on benefits. Otherwise, the use of private insurance could contradict the federal requirement that schools provide free appropriate public education.

Site of service should not be controlling

Section (g) of the Parity Act delineates the location of covered services. The Parity Act unnecessarily limits access to mental health services in section (g). We have been approached by licensed clinicians who would like to offer their services in the schools because they have found that their adolescent clients do not keep appointments if they must go to a mental health clinic or therapist's office. What is key to quality control is the licensure of the professional who renders or supervises the services, not the site of the treatment.

Services to children and adolescents should be covered to age 25

Under the current parity laws, children and adolescents are provided mental health benefits on a non-discriminatory basis until an ongoing course of treatment, as specified in said adolescent's treatment plan, is completed and while the benefit contract under which such benefits first became available or subsequent contract remains in effect. If the language in H. 1871 is adopted, it will have a fortuitous affect on all children until age 21, but will inadvertently do damage to those chronically ill children in ongoing treatment who are 21 through 25 years of age and still covered by their parent's family policy. Massachusetts law requires most insurers to cover dependent children through age 25 and other children up to age 25 for two years after their status as dependent children ends. The language of H. 1871 should be amended to ensure that those children covered by a parent's policy are provided mental health benefits on a non-discriminatory basis throughout the period of coverage. The simplest manner to do so would be to require the provision of benefits on a non-discriminatory basis through age 25.

In summary, we hope the legislature will correct the key problem we have found with the application of parity: that as long as the insurance companies decide what is medically necessary – or even as long as treating clinicians do not have a presumption of knowing what is medically necessary for their patients – mental health parity will remain elusive. Other difficulties as noted above exist in the implementation of mental health parity; but we believe the primacy of the insurer's determination of medical necessity is the key barrier to access to adequate mental health care.

Respectfully submitted,

Susan Fendell
Senior Attorney

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Statement of
John E. McDonough
Executive Director, Health Care For All

Monday, October 1, 2007

Health Care For All strongly supports H.1871: An Act Relative to Mental Health Parity, sponsored by Rep. Ruth Balser, to make true mental health parity a reality in Massachusetts.

Seven years ago, Massachusetts took an important first step by passing legislation requiring health insurers to cover mental health disorders that were "biologically-based" to the same extent they cover physical disorders. Though this act was significant, it does not include coverage for many "non-biologically based disorders," including substance abuse, eating disorders, and trauma.

Rep. Balser's legislation requires coverage for any disorder recognized by the American Psychiatric Association. Under H1871, individuals suffering from eating disorders, those battling addiction, and persons recovering from trauma will have treatments covered by their health plans.

By providing equal coverage for physical and mental health needs, this legislation will help end the stigma traditionally connected with mental illness.

Health Care For All is committed to building a health care system in Massachusetts that is responsive to the needs of all residents, including those living with mental illness.

The time is now for true mental health parity. We applaud Rep. Balser for her leadership and initiative on this issue.

# # # # #

The Massachusetts Mental Health Coalition

Testimony in Support of H-1871

I am Dr. Elena Eisman, Chair of the Massachusetts Mental Health Coalition and Executive Director of the Massachusetts Psychological Association. The Massachusetts Mental Health Coalition is comprised of 10 statewide organizations representing mental health consumers and their families, professionals, and treatment facilities. As a group we came together to draft the original Parity bill through which we hoped to gain true and comprehensive parity for people with mental health and substance abuse diagnoses. That action led to a much improved benefits structure for the treatment of these conditions but not a full and comprehensive Parity law.

Chairwoman Balser's bill H 1871 would fulfill our goal of true parity for people suffering with mental health and substance abuse conditions. As we all know, the cost of health insurance coverage is the same no matter what illnesses you might develop which cause you to use your insurance. To have the ability to access coverage when you need it dependant of the classification of your health problem is unfair and unconscionable and nonsensical. A parent with a sick kid should be able to use the insurance they pay for to treat their child regardless of the classification of their illness. The employer paying for health coverage of their employee should expect that their dollars will go to getting the employee the necessary treatment to get them back to work regardless of the classification of their illness. It is time to close the loopholes in coverage for once and for all. This bill would do it and would do it with a minimal cost. This is because most of the expense of mental health parity coverage has already been subsumed under the current law. Passage of this bill would make our universal healthcare law universal as to conditions covered not just coverage.

Massachusetts Mental Health Coalition Member Organizations

Massachusetts Association of Behavioral Health Systems
Massachusetts Mental Health Counselors Association
Massachusetts Psychiatric Society
Massachusetts Psychological Association
Mental Health Legal Advisors
Mental Health and Substance Abuse Corporations of Massachusetts
National Alliance On Mental Illness-Massachusetts
National Association of Social Workers-Massachusetts Chapter
Nurses United for Responsible Service
Parents/Professional Advocacy League

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The Massachusetts Mental Health Coalition is comprised of 10 statewide organizations representing mental health consumers and their families, professionals, and treatment facilities. As a group we came together to draft the original Parity bill through which we hoped to gain true and comprehensive parity for people with mental health and substance abuse diagnoses. That action led to passage of Chapter 80 with a much improved benefits structure for the treatment of these conditions but it is not a full and comprehensive Parity law.

Chairwoman Balser's bill H 1871 would fulfill our goal of true parity for people suffering with mental health and substance abuse conditions. As we all know, the cost of health insurance coverage is the same no matter what illnesses you might develop which cause you to use your insurance. The situation we have now, where the ability to access coverage when you need it is dependant on the classification (mental or physical) of your health problem is unfair, unconscionable and nonsensical. A parent with a sick child should be able to use the insurance they pay for to treat their child regardless of the classification of their illness. The employer paying for health coverage of their employee should expect that their dollars will go to getting the employee the necessary treatment to get them back to work regardless of the classification of their illness. It is time to close the loopholes in coverage for once and for all. This bill would do it and would do it with a minimal cost. This is because most of the expense of mental health parity coverage has already been subsumed under our current law. Passage of this bill would make our universal healthcare law universal as to conditions covered not just coverage.

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Committee on Mental Health and Substance Abuse
Mental Health Parity Hearing
RE: H1871
October 1, 2007

Chairwoman Balser, Chairwoman Candaras, members of the Committee, thank you for holding this hearing on the vital issue of mental health parity,

My name is John Palmieri, I am a staff psychiatrist at the Cambridge Health Alliance, and I am here to testify in support of H1871 for mental health parity. I would like to thank the Committee for giving me the opportunity to share my thoughts and expertise with you today.

As part of my final year of residency training last year, I had the opportunity to survey parity legislation in the US and was able to speak with a broad base of providers in the mental health community. From those interactions, I conclude that parity makes sense, that it is just and that concerns about cost have not been realized in other states.

As a clinician, I have the difficult task of negotiating through the maze of authorizations to provide services for my patients. In my contact with treatment providers in the community, I hear endless stories of patients needing to terminate treatment prematurely because a diagnosis was not considered part of the parity mandate. The consequences of such limited access to treatment are multiple. We all know that people who cannot access services through more traditional outpatient mechanisms will often seek assistance in emergency settings. I spent countless hours in the Emergency Department at Massachusetts General Hospital, and I can tell you that, on a daily basis, we see patients who present simply because they have not been able to obtain outpatient services. This is unquestionably a more costly and less efficient use of health care dollars.

Other scenarios are more dire. There are occasionally stories in the local and national media which illustrate dire consequences of people not being able to access treatment. In the context of such tragedies, there is often at least symbolic mobilization of resources to address the service gaps. I would argue that it makes much more sense to cast out a net to prevent such occurrences.

Another problem specifically with diagnostic exclusion is that clinicians will often change a patient diagnosis to reflect one which is covered under parity. There is often comorbidity, so this is not necessarily dishonest. However, it occasionally leaves people mislabeled, and patients are burdened with inaccurate diagnoses for many years. Also, it removes needed attention from the identification, treatment and allocation of resources to study the non-parity diagnoses. In effect, the more we trivialize them, the less likely we are to develop treatments which could effectively prevent and treat them.

The biological versus non-biological distinction makes no scientific sense. Our understanding of the neurobiology of mental illness and substance abuse is making

dramatic gains, and the distinction between the physical and the psychological is archaic and not at all current with present advances in knowledge and technology.

Parity is just. People with mental illness live in the shadows of stigma, prejudice and discrimination. Not allowing people with Post-Traumatic Stress Disorder or Alcohol Abuse to receive needed care is yet another form of institutional discrimination. There is increasing awareness that psychiatric illnesses are more on par with chronic illnesses like Hypertension and Diabetes; they should be treated as such. Parity as such is a fundamental human right; denying it only serves to shame and blame people who suffer from such afflictions.

The cost argument for parity has not held. States with more advanced parity laws have not faced insurmountable cost barriers. Most have demonstrated negligible increases and suggest that ongoing management of care and utilization review mechanisms work well to prevent unnecessary cost escalation. In Vermont, for example, the cost of parity was 19 cents per member per month. In a major analysis of federal employee parity published in the New England Journal of Medicine, parity was not shown to lead to a significant increase in health care costs as compared to non-parity plans (Goldman HH et al., 2006. Behavioral Health Insurance Parity for Federal Employees. *NEJM, 354*(13), 1378-1386). Mental illness is increasingly recognized as a major factor in the global burden of disease. Most psychiatric disorders respond well to treatment, and the failure to provide such has tremendous economic impact. Lost productivity and preventable emergency care are but two cost consequences.

In conclusion, parity not only makes clinical, scientific, and economic sense, but it also asserts fundamental human rights. People with psychiatric illness are everywhere, in our families, neighborhoods, workplaces and schools. I encourage you to provide the recognition and attention that these people need to live productive and fulfilling lives. Thank you again for inviting me to speak on this issue.

H1871 An Act Relative to Mental Health Parity
Testimony
By
Pat Lawrence
October 1, 2007
Past-President NAMI of Massachusetts
Author of Biologically-Based Mental Health Parity Bill (check it out-my name is on all the bills)
Passed May 2, 2007

The sight of a 16 year old sharpening a buck knife on her wrist is one a parent will close up in her memory to be opened only for a worthwhile reason; this is such a reason. The chaos of EMT's and firefighters invading my house to save the life of my teenager who had ingested a bottle of pills with a bible by her bedside and a candle lit, for God only knows what, is another. And then we have the policeman husband so full of rage with an arsenal of rifles and ammunition in the garage that the only answer in the middle of the night when he wants to commit suicide and take me with him is to escape to the safety of the car with bag packed ready to travel anywhere to crawl into a safe room with a lock on the door. That was my life in 1989. And then my middle child became schizophrenic.

As if things couldn't get worse, but with time, determination, boundless work, and heartfelt love, they got better. My husband, fortunately or unfortunately, lost both his legs and his life to diabetes with his arsenal way out of reach. His physical illnesses were many, but his real diagnosis and pain was Borderline Personality Disorder. With tough love, I left my child with suicidal tendencies and without Mom to witness her deeds, they resolved. But her diagnosis and pain is still Borderline Personality Disorder.

So then, why did I limit the Parity Bill. Why did I list the DSMIV disorders that were proven by the National Institute of Mental Health to improve with medication. Why did I fight so hard for the one third of my family with Axis 1 schizophrenic brain disorder and leave the other two thirds saturated with pain from Borderline Personality Disorder, qualifying only for Axis 2, in the background. The key words are-"improve with medication." A sure thing. Cannot be disputed. Biologically-based- a physical illness. The brain a physical part of the body. You really cannot argue with that. And nobody did. The Bill was passed unanimously.

Mental illness has been profoundly stigmatized since civilization began. Ridiculed and misunderstood, so many lives have been given up and put behind locked walls because of a chemical

imbalance in the brain. My idea back in 1997 when I first filed the bill with Senator Fred Berry and Representative Byron Rushing was to take it in baby steps. Let Massachusetts treat the sickest and see the impact it can cause on the lives of thousands of mentally ill and their families. The push for the Mental Health Parity Bill in 1998 when I became President of NAMI of Massachusetts and put 25 billboards up across Massachusetts proclaiming that mental illness was a physical illness and the DMH put similar bus cards in 350 subway cars was a beginning. When hundreds of advocates got together and fought just as hard as I, we made an impact. When the bill passed unanimously, the first baby step had been taken.

The time for baby steps is over. There are people out there suffering from brain disorders not yet proclaimed biologically based, but research is not done with them yet. Soon we will look back on the witch- hunt of the mentally ill and cry for the number of suicides that could have been prevented. Cry for the premature deaths from horrendous psychotic medications that could have been prevented by more research. Mourn for the addicted kids who have overdosed on illegal substances and adults who could have been treated and cured for their substance abuse addiction that certainly is biologically based. The brain is a very complicated organ from which all emotion, dreams, and love make the person. Give the brain a chance. Give the people of Massachusetts treatment for all disorders within the brain. Money will be saved, lives will be saved, and we will start a new beginning for the nation and the future.

Incidentally: My schizophrenic daughter, Laurie, nine times in the locked unit, threatened with a shelter when the insurance ran out, is now going for her bachelor's degree sustained with the only medication that works-a life threatening medication that brings her mind back to normalcy but could physically kill her body in a two week period of time.

My eldest daughter is Vice President of Merrill Lynch, wants nothing to do with her dysfunctional family and

My youngest daughter has Borderline Personality Disorder. Help her.

Rep Balser 1871

TESTIMONY FOR LEGISLATION HEARING AT STATE HOUSE REGARDING MENTAL DISEASE COVERAGE BY HEALTH INSURANCES, OCTOBER 1, 2007.

Igor B. Rozenvald, MD

Autism incidence is one in 97 to 160 children (depending on the study) and is on the rise. These disorders are more common than many other diseases. However, insurance coverage and availability of treatment for autism spectrum disorders are inadequate. The autistic disorders are traditionally placed in a category of **developmental** disorders. This is a main reason why insurance companies deny coverage for treatment of autistic disorders. Legislation enforcing coverage of autism spectrum disorders by health insurance companies is one key area where involvement of State and Federal Governments is essential.

I would like to illustrate a case from my personal experience. My son is 6 years old presently and he has a diagnosis of autism spectrum disorder from 2.5 years of age. He is denied insurance coverage for speech therapy by TUFTS HEALTH PLAN. In a coverage determination letter the clinical coverage criteria are listed.
It is specifically stated that Autism spectrum disorders may be covered with following provisions:

1. Diagnosis must be confirmed by documentation from a pediatric neurologist or a developmental pediatrician.
2. The member's individualized education plan (IEP), as developed by school department, must be submitted.
3. Documentation must support the position that therapy will achieve functional gains beyond those expected as a result of growth and maturation.

This third provision is extremely subjective and opens an easy way for insurance to deny coverage. Furthermore, in the next section TUFTS HEALTH PLAN presents LIMITATIONS:

The following conditions would not meet the medical necessity guidelines and therefore coverage would not be authorized:
A. Maintenance therapy when improvement is not expected.
B. Self-correcting disorders.
C. Services that are primarily educational in nature and encountered in school setting (e.g psychosocial speech delay, behavioral problems, attention disorders, conceptual handicap, mental retardation, developmental delays, stammering and stuttering).
Other limitations are listed as well.

An obvious discrepancy in criteria listed by TUFTS HEALTH PLAN is that while they state that autism could be covered the LIMITATIONS section makes it immediately clear that by using section C autistic disorders can be easily denied coverage as all of them

have manifestations associated with psychosocial speech delay, behavioral problems, attention disorders, conceptual handicap, developmental delays.

The principal basis for this logic is flawed. The autistic disorders are the result of **abnormal brain development**, which manifests as abnormal function of the brain. That is why those disorders are in a category of developmental problems. **Being developmental disorders they are disorders of brain development (both abnormal functional and structural development).**

Based on the word **"developmental"** insurance companies make an excuse not to cover services as they claim that problem should be addressed at school. However, such patients need specific clinical interventions outside the school system as well, including appropriate quantity and quality of occupational therapy, speech/language interventions and neurobehavioral treatment. By analogy, there would be no problem in coverage for conditions related to abnormal development of the pancreas, heart, kidney and liver. The brain is an organ, and its abnormal development leading to specific problems is a medical condition. The autistic disorders are recognized in the International Classification of Diseases (ICD) and they have specific ICD-9 codes (DSM-IV-TR: 299.0) reflecting the fact that they are diseases. **Therefore, treatment of disorders originating from aberrant brain development should be covered by insurance companies when treatment outside the school system takes place. The main, well-established, beneficial and non-invasive treatments for autistic disorders are behavioral, occupational and speech therapy and their combinations.**

State and federal governments should pass legislation requiring that health insurance companies cover treatment for autism spectrum disorders (ASD) including behavioral therapies, occupational therapy, speech therapy and other beneficial treatment modalities.

I would like to add that even being a practicing physician I spend hours on correspondence and argumentation with my health insurance and achieve only limited success. The majority of parents with autistic children do not know how to argue their case. Therefore, many children do not get appropriate amounts and quality of treatment, as far from all parents can afford sufficient amounts of expensive professional services. Therefore, many autistic children do not achieve a level of development at which they could be productive members of society, and instead end up on various government-provided programs. Consequently, it is in the best interest of state and federal governments to establish and enforce by law that all appropriate tests and treatment modalities for autistic disorders that take place outside school system be covered by health insurance companies. In order to achieve this goal at state level, here in Massachusetts, H.1871, An Act Relative to Mental Health Parity, should include language specifying full-parity coverage of autism spectrum disorders.

Igor B. Rozenvald, MD;
New England Medical Center;
E-mail: irozenvald@tufts-nemc.org

October 1, 2007

Joint Committee on Mental Health and Substance Abuse:

The National Alliance on Mental Illness of Massachusetts (NAMI-Mass) is a grassroots, family-based support and advocacy group. NAMI-Mass promotes support for individuals living with mental illness and their families; education to raise awareness about mental illness and to eliminate stigma; advocacy at state, national, and local levels; and research into causes, symptoms, and treatment of mental illness.

NAMI-Mass offers its strong support of HB1871, *An Act Relative Mental Health Parity.* This legislation is essential to offering full support to those in the Commonwealth living with mental illness.

In 2000, Massachusetts took a major step forward in support of the mental health care of our residents with the passage of the Mental Health Parity Law. Time has proven that while the legislation was an important victory for the mental health community, there are major gaps in the current system.

Currently, people with conditions that are considered "non-biologically based" are not covered by this law. These conditions include substance abuse, eating disorders, and post-traumatic stress disorders. We at NAMI-Mass strongly believe that it is wrong to make a judgment of which mental health concerns are deserving of coverage based on their origin. It is imperative that residents of the Commonwealth are able to receive full coverage of vital 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.

Sincerely,

NAMI-Mass

Testimony of Dr. Nancy Norman
Medical Director, Boston Public Health Commission
Joint Committee on Mental Health and Substance Abuse
October 1, 2007
In Favor of H1871

Good afternoon Chairwoman Balser, Chairwoman Candaras, and members of the Committee. Thank you for the opportunity to testify today. My name is Dr. Nancy Norman and I am the Medical Director at the Boston Public Health Commission. I am here to support House Bill 1871, "An Act Relative to Mental Health Parity," sponsored by Chairwoman Balser. I'd like to begin by thanking the Committee, and especially the Chairwomen, for your incredible commitment to preventing and treating mental health and substance abuse disorders.

The Boston Public Health Commission is tremendously active in prevention, support, and treatment for individuals and families struggling with mental health and substance abuse issues. We have a Child and Adolescent Mental Health Program that works with adolescents, families, and providers; we run School-Based Health Centers across the city that work with children with mental health and addiction issues; and we have an entire Substance Abuse Services Bureau that provides extensive outpatient and residential treatment programs, as well as education and community mobilization to prevent substance abuse. So we know how mental illness and addiction affects families and communities.

House Bill 1871 would protect Massachusetts residents dealing with mental health issues from

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unfair treatment from insurance companies. The bill simply requires insurers to cover mental illnesses on par with physical illnesses – not more and not less, but the same. The bill recognizes that many mental illnesses, including addiction, are chronic relapsing diseases, not so different from diabetes and asthma. Currently, insurers can enforce strict limits on treatment visits and impose very high out of pocket costs for mental health treatment. The result is lack of access to necessary treatment; in some cases – as in detox access for an individual with a drug addiction – this barrier can be the difference between life and death.

The Boston Public Health Commission has worked for years with partners around the state to eliminate the stigma associated with mental illness and addiction. But today, there is still stigma, still ignorance, still the belief that mental illness is somehow due to one's own weakness, still the belief that the lives of people who live with mental illness are somehow less important than others. This stigma comes from all angles, and this bill will not end it. But this bill does say loud and clear that the Commonwealth of Massachusetts will not sanction discrimination from medical providers and health insurers – the very organizations whose missions are to treat those in need.

Racial and ethnic health disparities in mental health have been widely documented. For example, in Boston we have found that Latino adults are 50% more likely than White adults to report poor mental health, and we found that cost is more often a deterrent to accessing care for residents of color than for White residents. Because this bill creates more equitable access to mental health services, it is an important step toward closing this gap.

House Bill 1871 also makes economic sense. When individuals cannot access proper treatment – whether because stigma prevents them from seeking help or because they cannot afford to pay out of pocket for treatment – we know that money is lost in the long run. Conditions persist and deteriorate, families are strained and sometimes fall apart, workplace productively declines, emergency room use increases, and additional social services are sometimes necessary.

The state also pays a high price – in many cases picking up the tab for treatment that insurers refuse to cover. For example, public sector payments for substance abuse treatment have continued to rise nationally, while payments from private payers have declined.[1] Here in Massachusetts, a prime example is the Bureau of Substance Abuse Services (BSAS) at DPH, which acts as a payer of last resort for substance abuse treatment. In some cases – such as short term and long term residential treatment – BSAS is the only payer who will cover needed services. In other cases, private payers severely limit the number of visits they will cover, forcing BSAS to pick up the tab for the remainder of medically necessary treatment. Were insurers to equitably cover these treatment services, the state could save millions each year.

This is a commonsense bill that simply asks health insurers to treat people suffering from mental illness like they treat everyone else. I urge the Committee to act quickly on this bill, because mental illnesses and addictions are not on hold while we deliberate. This is the year to pass true mental health parity. Thank you once again for the opportunity to testify.

[1] Growth of Public, Private Insurance, and Out-of-Pocket Payments for SA versus All Health, 1991 – 2001. (SAMHSA).

Testimony of Dr. Nancy Norman
Medical Director, Boston Public Health Commission
Joint Committee on Mental Health and Substance Abuse
October 1, 2007
In Favor of H1871

Good afternoon Chairwoman Balser, Chairwoman Candaras, and members of the Committee. Thank you for the opportunity to testify today. My name is Dr. Nancy Norman and I am the Medical Director at the Boston Public Health Commission. I am here to support House Bill 1871, "An Act Relative to Mental Health Parity," sponsored by Chairwoman Balser. I'd like to begin by thanking the Committee, and especially the Chairwomen, for your incredible commitment to preventing and treating mental health and substance abuse disorders.

The Boston Public Health Commission is tremendously active in prevention, support, and treatment for individuals and families struggling with mental health and substance abuse issues. We have a Child and Adolescent Mental Health Program that works with adolescents, families, and providers; we run School-Based Health Centers across the city that work with children with mental health and addiction issues; and we have an entire Substance Abuse Services Bureau that provides extensive outpatient and residential treatment programs, as well as education and community mobilization to prevent substance abuse. So we know how mental illness and addiction affects families and communities.

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Children's Hospital Boston

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Relating to Mental Health Benefits
HB1871
JOINT COMMITTEE ON MENTAL HEALTH AND SUBSTANCE ABUSE
October 1, 2007
October 1, 2007, hearing room #A-2

Introduction

Good morning Chairwomen Canderas and Balser and members of the Committee.

Thank you very much for the opportunity to speak to you today.

My name is Doctor David R. DeMaso. I am the Psychiatrist-in-Chief at Children's Hospital Boston and Professor of Psychiatry and Pediatrics at Harvard Medical School. I have over 25 years in child and adolescent psychiatry practice in the Commonwealth. I oversee the mental health clinical, teaching, and research services at Children's. My particular area of interest and specialty has been directed toward understanding the connection between emotional and physical illnesses in children and adolescents.

I am speaking to you today on behalf of Children's Hospital Boston and its Department of Psychiatry. We formally endorse this legislation and strongly support HB 1871, "An Act Relative to Mental Health and Substance Abuse."

Through the Mental Health Parity law enacted by the Massachusetts legislature into law in 2000 and related health care legislation, it is now our legal obligation and societal responsibility to address mental health needs on the same basis as physical health needs. The mental health parity law applies an equal standard to both emotional and physical illnesses.

While I commend your work on the 2000 parity law which substantially improved the insurance coverage of mental health benefits for certain statutorily covered commercial plans and for children, individuals with mental disorders and their families must still cope with loopholes such as treatment limitations, and the feelings of being less deserving of treatment than people with a physical illness.

While the passage of parity was a significant first step in the right direction, it falls short of what needs to be done and what other states have accomplished. **What we need is a law that equalizes emotional and physical health. We need to extend the protections**

that we have for children to all age groups, reduce the barriers to access to care, and begin the process of getting rid of the stigma associated with emotional disorders.

As far as I can tell, the major objection to passage of mental health parity laws is the alleged cost impact on insurance coverage that would result. I would like to tackle this question directly.

<u>Costs of Not Having Parity</u>

There are three types of financial costs associated with failing to enact a comprehensive parity law that must be accounted for as you consider its potential impact.

First, there is the cost of administrative inefficiency, or put more bluntly, the cost of hassles and nonsense that we as clinicians and health professionals are put through simply to get our patients the care that they both need and deserve. For example, one of my current trainees was a resident of Minneapolis and chief resident in an adult psychiatry training program. Upon coming to Boston one of her initial observations was that one had to jump through so many hoops in order to get coverage and care for her Massachusetts patients (e.g., multiple phone calls). In support of her observations I would like to cite a recent article by myself and a colleague at CHB which reported that psychiatrists are more than twice as likely as primary care physicians or other medical specialists to report intensive prior authorization requirements and three times as likely to face frequent denials.[1,2] They report that their staff spent less time appealing review decisions than other physicians, but that seems to be because psychiatrists themselves are devoting more time to the appeals process; they also report being less successful than other physicians in resolving.[1,2]

Second, there is the cost of disorganized care. Mental health issues do not arise in a vacuum. The often coexist with physical health problems. Numerous studies show that patients with untreated mental illness have poorer physical health outcomes. At a time when we are all seeking to reduce costs in the health care system, there is a strong case to be made that an integrated approach to mental health care can have significant overall benefits. Yet a parity law that places different rules around mental health care tends to produce the opposite result. Your primary care physicians is generally able to refer to the individual medical specialist of their choice, yet in referring to a mental health specialist they find themselves referring a network provider panel. This makes subsequent coordinated and integrated care problematic given the unfamiliarity of the clinicians in working together.

Third, there is the cost of patient confusion and marginalization. The needs of patients – our relatives, friends and neighbors – should be at the center of how we design

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[1] Rosenberg E, DeMaso D. A doubtful guest: managed care and mental health. Child Adolescent Psychiatric Clinics, in press

[2] Schlesinger M, Wynia M, Cummins D. Some distinctive features of the impact of managed care on psychiatry. Harvard Review of Psychiatry 2000; 8: 216-230

our mental health system. Instead, we are forced to weigh the human cost of having barriers erected in attempts to access care. The primary barrier is of course the different rules for mental health care than physical health care. Navigating this system of care for the average patient is a maze, and without help, many simply give up. A secondary impact is, of course, the inherent discrimination in the system. I believe the stigmatizing consequences of the way this law currently operates leave people less likely to seek care in the first place. The failure to identify and treat mental illness early has long-term financial implications not just in the health care system, but in the economy as a whole.

In summary it's the cost of bureaucratic nonsense, erecting artificial barriers, and the discrimination in categories of disorders that are currently covered that is most concerning to me and my colleagues.

Cost of Having Parity

Counterbalanced against the costs of failing to enact a more comprehensive parity law are the alleged costs of expanded coverage. I am not a health economist but am keenly aware of national studies and reports on the financial impact of comprehensive parity coverage. Many of these reports have shown us that implementing full parity results in minimal increases in health care costs. Our national leaders are making steady progress in advancing parity reform at the federal level. The Senate bill was passed unanimously last week—this gives us every indication that our national leaders understand the limitations of the current law and the importance of breaking down the barriers. A Boston Globe editorial this past Tuesday (September 25, 2007) reported that the Congressional Budget Office estimates that the Senate bill would increase the cost of employer-sponsored premiums by an average of 0.4 percent.

We need a law that equalizes emotional and physical health

In conclusion, by supporting Massachusetts Mental Health Parity reform and comprehensive parity you will open the door, remove artificial barriers, reduce stigma, and become a national leader in mental health reform much like you are in health reform--the Time is Now!

Thank you for your time and attention to this important bill. I am happy to take questions at this time.

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Joint Committee on Mental Health & Substance Abuse
Mental Health Parity
Marylou Sudders, President & CEO
Massachusetts Society for the Prevention of Cruelty to Children
October 1, 2007

Good afternoon Madame Chairs and members of the Committee. My name is Marylou Sudders, President of the Massachusetts Society for the Prevention of Cruelty to Children and the former Commissioner of Mental Health.

It was during my tenure as Commissioner that for the first time in more than twenty years there was any significant change in the state's mandated insurance coverage for mental disorders. As many of you know, up until 2000, bills were filed every year since 1978 to increase the insurance coverage for mental disorders; they never made it out of Committee.

It took the courage of legislative champions such as Representative Scaccia who told the then Speaker that he was resolved to see the law changed. It took the courage of Representatives Nancy Flavin and Ronald Mariano before her as the House Chairs of Insurance and their Senate counterparts Robert Bernstein and Therese Murray....plus the voices of many legislators, consumers and family members that packed the hearing rooms, the press conferences and the halls of the state house. It also took the courage of then Governor Cellucci, who became a champion for mental health parity.

Despite fierce opposition from the insurance industry, many in the small business community and the Church of Scientology, a core group of mental health family and advocacy groups forged on. It helped that the GIC had recently included mental health parity as part of the insurance coverage for state and municipal staff, including legislators. It helped that the voices of families and individuals had gained respect and acknowledgement....and it helped that in the second year of the bill's debate, that Associated Industries of Massachusetts did not oppose the bill, but took a position of neutrality.

As is true for many bills that become laws, it is not fully comprehensive, excluding substance abuse and allowing insurers too much latitude in interpreting benefit coverage. The compromises agreed to at that time were made to calm the fears of cost overruns. But, there is no question that Chapter 80 of the Acts of 2000 provided better coverage, particularly for outpatient services and offered a platform for future reform.

A major obstacle to passing a fully comprehensive law has always been the "cost factor". No state has repealed a parity law after its passage, and several states have expanded their laws through amendments. A 2006 article in the New England Journal of Medicine puts the cost issue to rest. The report examined what happened after the federal employees health insurance program eliminated limits on mental health and substance abuse services. Over a two year period, researchers found that the proportion of people using mental health services rose by 1.35 to 2.75 percentage points...but both spending and use of mental health services didn't increase. What did significantly change was that consumer out of pocket spending dropped significantly. To quote from the study, "when coupled with management of care, implementation of parity in insurance benefits for behavioral health care can improve insurance protection without increasing total costs." Similar findings were reported by SAMHSA in its study of Vermont's parity law, which is the most comprehensive law in the country.

Massachusetts was part of the first wave of mental health parity laws in the country; there are now 41 states with various forms of parity. In the climate of post health care reform, it is now time for Massachusetts to take the final step....to pass a parity law that once and for all provides coverage for mental disorders, including substance abuse on the same terms and conditions as physical disorders. Simple, elegant and a bold rejection of stigma and discrimination.

Thank you.

MENTAL HEALTH PARITY HEARING
HB 1871

TESTIMONY OF
BARBARA LEADHOLM, M.S., M.B.A.
COMMISSIONER
DEPARTMENT OF MENTAL HEALTH
OCTOBER 1, 2007

Good afternoon Chairwoman Balser, Chairwoman Candaras and members of the committee. I am Barbara Leadholm, commissioner of the Department of Mental Health and I am honored to be here today to discuss mental health parity.

I am new to this role, but not to Massachusetts and the public mental health system. I began my career in Massachusetts as a psychiatric nurse clinician at Brookside Health Center in Jamaica Plain. I have held positions in the Department of Mental Health as well as the departments of Welfare and Medicaid. Since 1996, I worked for Magellan Health Services. It is a privilege to return home, to serve our citizens and to continue to build a public mental health system that involves all stakeholders and increases awareness of our respect for consumers and families, that focuses on our strength-based approach to care and our commitment to recovery and resiliency. I can tell you that without any doubt, I am very pleased to be back.

House Bill 1871 – the Mental Health Parity Bill – is the foundation of these principles. And on behalf of Governor Patrick and Executive Office of Health and Human Services Secretary Bigby, I stand before you in support of House Bill 1871. Without mental health insurance parity, society perpetuates the myth that mental illness is a character flaw, something influenced by attitudes and myths rather than science. It is an illness, it is treatable and treatment works. While parity does not guarantee access to treatment, it eliminates discrimination in insurance coverage and dispels stigma. Coverage increases the acceptability of the illness and addresses stigma head on.

As you know, this 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. It brings the Commonwealth's parity into line with other states that have found significant advantages, with minimal cost impact, in covering the full range of mental disorders, as opposed to a restricted list. Under the state's current law, full parity is afforded only to a specific list of "biologically based" disorders which include: schizophrenia; schizoaffective disorder; major depressive disorder; bipolar disorder; paranoia and other psychotic disorders; obsessive compulsive disorder; panic disorder; delirium and dementia; and affective disorders. This list is under-inclusive—it omits such disorders as eating disorders, post traumatic stress disorder, and other depressive disorders which can be significantly disabling and have both biological and non-biological components.

Reasons to amend the current mental health parity statute are compelling and fundamental:

- Mental health parity improves access to treatment
- The cost impact of mental health parity is minimal
- Since untreated mental illnesses, in particular depression, have been shown to result in increased loss workplace productivity more than any other disease, improving access to treatment should result in increased productivity with resulting benefits to the economy
- Our current mental health parity system arbitrarily discriminates among categories of mental disorders

Like all of us, consumers want jobs—meaningful employment that provides individuals with mental illness the necessary sense of independence and productivity. Work affords mental health consumers the best opportunities for recovery. Our current parity law is a barrier to this goal.

Untreated mental illness places a significant burden on the workplace and the cost to employers. Presenteeism (attending work with impairments that impeded performance) interferes with our efficient and effective companies, small and large. Mental illness causes more days of work loss and work impairment than many other chronic conditions such as diabetes, asthma and arthritis.

The statistics are staggering: about 217 million days of work are lost annually due to productivity decline related to mental illness and substance abuse disorders. This costs our nation's employers $17 billion each year.

Studies have shown that the financial impact of full parity pales in comparison. A RAND study of the Federal Employees Health Benefits Program, the largest health plan in the nation with 8.5 million members, showed that parity increased insurance protection without increasing total costs. Another report issued by the U.S. Substance Abuse and Mental Health Services Administration found that after the passage of Vermont's mental health parity law, considered the most comprehensive in the country, spending for mental health and substance abuse services declined slightly while the likelihood of obtaining mental health services rose between 18 and 24 percent in the two health plans examined.

Fears that full mental health parity will increase the financial burden for health insurance providers are just that—fears—and do not bear out in the findings of these and several other studies and in the experience of other states with full parity laws. I am happy to share the studies I've mentioned and others with you.

There is a particularly critical need that must be considered in any deliberation of full parity for our citizens. In Massachusetts, an average of 500 U.S. soldiers return home from active duty and combat in Iraq and other countries. A recent study conducted by the U.S. Army showed that 1 in 8 returning soldiers suffers from PTSD. The study also showed that less than half of combat veterans with mental health problems are seeking care, mainly because of the fear and shame of stigma. In this light, establishing full mental health parity that includes post-traumatic stress disorder becomes our obligation, not only to the brave soldiers who return home, but also to their families and loved ones.

Thank you for your support of full mental health parity for all citizens of the Commonwealth. I am happy to answer any questions you may have.