

AN EXAMINATION OF FEDERAL MENTAL HEALTH  
PARITY LAWS AND REGULATIONS

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

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# **AN EXAMINATION OF FEDERAL MENTAL HEALTH PARITY LAWS AND REGULATIONS**

**FRIDAY, SEPTEMBER 9, 2016**

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

The subcommittee met, pursuant to call, at 9:00 a.m., in Room 2322, Rayburn House Office Building, Hon. Joseph R. Pitts (chairman of the subcommittee) presiding.

Members present: Representatives Pitts, Guthrie, Shimkus, Murphy, Burgess, Blackburn, Lance, Bucshon, Brooks, Collins, Green, Capps, Castor, Matsui, Luján, Schrader, Kennedy, Cárdenas, and Pallone (ex officio).

Staff present: Adam Buckalew, Professional Staff, Health; Rebecca Card, Assistant Press Secretary; Blair Ellis, Press Secretary; Jay Gulshen, Staff Assistant; Heidi Stirrup, Health Policy Coordinator; Jeff Carroll, Democratic Staff Director; Tiffany Guarascio, Democratic Deputy Staff Director and Chief Health Advisor; Samantha Satchell, Democratic Policy Analyst; Andrew Souvall, Democratic Director of Communications, Outreach and Member Services; Arielle Woronoff, Democratic Health Counsel; and C.J. Young, Democratic Press Secretary.

Mr. PITTS. The subcommittee will come to order.

Before we begin, I want to make a note that Members may be filtering in and out throughout the hearing. Unfortunately, with the condensed September session, there are a number of scheduling conflicts this morning. But we wanted to be sure to have this important hearing before Congress recessed at the end of the month.

With that being said, the Chair recognizes himself for an opening statement.

## **OPENING STATEMENT OF HON. JOSEPH R. PITTS, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA**

Today's Health Subcommittee hearing will examine the Federal mental health parity laws and regulations. In 2008, Congress passed a bill requiring most group health plans to provide more generous coverage for treatment of mental illnesses, comparable to what is provided for physical illnesses. This Mental Health Parity and Addiction Equity Act, MHPAEA, which followed the Mental Health Parity Act of 1996, the MHPA, requires equivalence or a parity in coverage of mental and physical ailments. Parity means that insurers need to treat copayments, treatment limits, prior au-

thorization for mental health, substance use disorder the same way they treat for physical health care.

The MHPAEA originally applied to group health plans and group health insurance coverage and then was amended by the Affordable Care Act to also apply to individual health insurance coverage as well as Medicaid benchmark and benchmark-equivalent plans.

With more than 11 million Americans who suffer with severe mental illness, such as schizophrenia, bipolar disorder, major depression, this issue is vitally important for individual patients as well as families seeking appropriate care for their loved ones.

Since there seems to be ongoing discussions or protections as envisioned in the mental health parity laws previously enacted, it is timely for this committee to consider ways to streamline the mental health parity system.

Title VIII of the Helping Families in Mental Health Crisis Act, authored by committee member Tim Murphy of my home State, Pennsylvania, and Eddie Bernice Johnson of Texas, offers eight provisions concerning mental health parity, such as improved compliance guidance and disclosure support.

Of particular interest to our Democratic committee members is a proposal by Representative Joe Kennedy of Massachusetts, H.R. 4276, the Behavioral Health Coverage Transparency Act of 2015, and this bill offers one of the many approaches to modifying parity requirements.

Today, we have three expert panelists who will provide testimony and answer questions on the strengths and challenges of mental health parity standards. And I look forward to the testimony today.

[The prepared statement of Mr. Pitts follows:]

#### PREPARED STATEMENT OF HON. JOSEPH R. PITTS

The subcommittee will come to order.

The chairman will recognize himself for an opening statement.

Today's Health Subcommittee hearing will examine the Federal mental health parity laws and regulations.

In 2008, Congress passed a bill requiring most group health plans to provide more generous coverage for treatment of mental illnesses, comparable to what is provided for physical illnesses. This Mental Health Parity and Addiction Equity Act (MHPAEA), which followed the Mental Health Parity Act of 1996 (MHPA), requires equivalence, or parity, in coverage of mental and physical ailments.

Parity means that insurers need to treat copayments, treatment limits, and prior authorization for mental health and substance use disorder the same way they treat them for physical health care.

The MHPAEA originally applied to group health plans and group health insurance coverage, and then was amended by the Affordable Care Act (ACA) to also apply to individual health insurance coverage as well as Medicaid benchmark and benchmark-equivalent plans.

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parity Act of 2015. This bill offers one of the many approaches to modifying parity requirements.

Today, we have three expert panelists who will provide testimony and answer questions on the strengths and challenges of mental health parity standards.

Mr. PITTS. I yield the balance of my time to the vice chair of the full committee, Mrs. Blackburn.

**OPENING STATEMENT OF HON. MARSHA BLACKBURN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TENNESSEE**

Mrs. BLACKBURN. Thank you, Mr. Chairman.

To our witnesses today, we thank you.

I want to thank the chairman for calling the hearing, and I want to thank all of my colleagues for the great work that we all did together as a team to pass that mental health reform package through the House, get it through the House in July. And I think it was significant that both sides came together on what I see as a very important issue today.

As we talk with you all, I am going to want to highlight some items pertaining to the Zika virus. I do have tremendous concern about what we see happening here.

Wall Street Journal had an article, and I would like to submit this for the record, Mr. Chairman. Researchers in the FDA now are mentioning that, with the Zika virus, we could potentially, probably will see an uptick in mental illness, Parkinson's, diseases of that nature, dementia, et cetera. And we know that the virus is fast-spreading, fast-growing—I think 16,000 cases now in the U.S. and our territories. And I am quite concerned about the parallels between the virus and some of the mental health issues that we have. So I do want to highlight that. And, Mr. Chairman—

Mr. PITTS. Without objection, so ordered.

Mrs. BLACKBURN. I appreciate that, and I yield back my time.

Mr. PITTS. Is anyone seeking time?

Mr. SHIMKUS. Mr. Chairman, just briefly.

I want to welcome the panelists. And I go to a local healthcare provider in the mental health space, John Markley from Centerstone, Illinois. And I asked him these very same questions: What can be done to be helpful? And he listed just three things real quick: The Federal Government should use additional specific guidance to State regulators on plans on how to implement the Federal parity law, identify parity violations, and enforce the law in both public and private insurance. The Federal Government should issue additional guidance detailing the parity law transparency requirements and modeling for issuers an appropriate disclosure of coverage and plan design. And the Federal Government, Federal and State regulators should robustly enforce requirements of the Federal mental health, substance use disorder parity law prospectively during plan approval and retrospectively through complete investigations. And I will probably hear some of that from the testimony from our panelists.

And I appreciate the time, Mr. Chairman, yield back.

Mr. PITTS. The Chair thanks the gentleman.

I also have a UC request. I ask unanimous consent to submit the following letters from America's Health Insurance Plans to the

President's task force; a letter from the Eating Disorders Coalition; a letter to Congress from 43 organizations representing providers, professionals, patients, family members, and consumers.

Without objection, so ordered.

[The information appears at the conclusion of the hearing.]

Mr. PITTS. The Chair now recognizes the ranking member of the subcommittee, Mr. Green, 5 minutes for an opening statement.

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

Mr. GREEN. Thank you, Mr. Chairman, for having this important hearing.

To our witnesses, thank each of you for taking your time out and being here this morning.

For too long mental health and substance use care has been siloed from the rest of the healthcare system and stigmatized. Perhaps the biggest barrier to accessing care has been higher cost, lack of coverage for mental health, and substance use care on par with the physical health care.

To begin to address this, Congress passed a Mental Health Parity Act in 1996. The law prohibited employer-sponsored group health plans from setting higher annual or lifetime dollar limits on mental health benefits than any other benefits. The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act in 2008 built on this first step and provided protections regarding equality of coverage for medical and surgical benefits and mental health and substance use benefits. This was further strengthened by the Affordable Care Act in 2010.

While the progress has been made, there is much room for improvement. Since MHPAEA was enacted in 2008, insufficient enforcement, inconsistent compliance, spotty disclosure of medical management information and other implementation barriers to accessing mental health and substance use services with equivalency to physical health services has mooted the promise of the law for many. Today, we will be hearing with witnesses from the current state of parity laws and on-the-ground enforcement. Without strong enforcement of the parity law, millions of people continue to struggle to get health care they need.

I look forward to learning more about this critical, important issue, and I thank you. And I would like to yield a minute and a half to my colleague from California, Doris Matsui.

Ms. MATSUI. Thank you, Mr. Green.

What we really want to do today is treat mental illness as a disease and afford the same prevention, early intervention, and treatment that we strive to have for physical illnesses. We are starting to make progress, but we have much more work to do.

Mental health parity is an essential part of comprehensive reform. Parity is designed to ensure that insurance companies cover mental health benefits the same way they cover physical health benefits. Congress started this effort with a Mental Health Parity Act in 1996, and we have continued to build on it since then. We have made great strides with the Affordable Care Act by applying the concept of parity to more types of plans and more types of benefits and adding mental health and substance use disorder to the



list of essential health benefits. Yet we need to make sure that these laws are being applied and enforced consistently.

We included provisions to strengthen the parity law and the mental health reform bill this committee worked hard to pass before the August recess.

I also support the ideas my colleague, Representative Kennedy, has put forth to take these provisions a step further. I look forward to hearing from the witnesses today and what we can do moving forward to ensure that everyone has access to the treatments and services they need.

I yield back to the ranking member.

Mr. GREEN. Thank you. I thank my colleague for her work.

The time has come now to actually enforce the mental health parity laws. Over the last 20 years, as both a State legislator and a Member of Congress, I have watched how we have tried to improve it, but it has not been successful.

So, Mr. Chairman, I thank you for calling this hearing today, and again, hopefully, if not this session, then early next session, we can continue to work on making sure we provide the parity that mental health has with our physical illnesses in our insurance policies.

Does anyone else want time from my side?

I yield back my time.

Mr. PITTS. The Chair thanks the gentleman and now recognizes the ranking member of the full committee, Mr. Pallone, 5 minutes for an opening statement.

**OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY**

Mr. PALLONE. I just want to thank you, Mr. Chairman, and Mr. Green for this hearing on the state of mental health parity in America, because current mental health parity law requires that insurers treat mental health and substance use disorder care the same way they treat medical or physical care, and that includes co-payments, treatment limits, and prior authorizations.

Today, more than 41 million adults have some form of mental illness, but in 2014, less than half of them received mental health care. And more than 20 million people over the age of 12 have a substance use disorder, but only 2.6 million received treatment at a specialty facility in 2014. Perhaps this can be explained in part, because the majority of Americans do not know that there are mental health parity protections in current law.

This Congress, we have had several important conversations on the challenges facing our mental health system. And we recently passed a bipartisan mental health bill in the House, and I am pleased that we are here today to continue that work by having a more indepth discussion on mental health parity.

The last time we made major improvements to mental health parity laws was in 2010 when we passed the Affordable Care Act. The ACA expanded both parity protections and health insurance coverage, making early treatment and prevention services more accessible to millions of Americans. Under the ACA, all new individual and small group insurance plans are mandated to cover mental health and substance use disorder services as one of 10 es-

sential health benefits. In addition, the ACA expanded parity protections for mental health and substance use disorder services to individual health plans and certain Medicaid plans. So this essentially means that these plans must provide coverage for mental health and substance use disorder services at the same level as coverage for other medical services.

So, today, I am interested in hearing from our witnesses about how our current parity laws are being implemented and enforced, because without proper enforcement, those laws will not have the impact we hoped for them to have.

And, finally, I would like to thank Congressman Kennedy for his strong leadership on this topic and for requesting this hearing. He sponsored legislation this Congress that contains important parity provisions that were not included in our House-passed mental health bill. It is clear that we can and should be doing more to ensure that Americans are able to access necessary mental health and substance use disorder services, and I hope this hearing will shed some light on what steps we can take going forward.

So I would like to yield the remainder of my time to Congressman Kennedy.

[The prepared statement of Mr. Pallone follows:]

PREPARED STATEMENT OF HON. FRANK PALLONE, JR.

Thank you, Mr. Chairman. Good morning and thank you to our witnesses for joining us. We're here this morning to have a discussion on the state of mental health parity in America. Current mental health parity law requires that insurers treat mental health and substance use disorder care the same way they treat medical or physical care. This includes copayments, treatment limits, and prior authorizations.

Today, more than 41 million adults have some form of mental illness, but, in 2014, less than half of them received mental health care. And more than 20 million people over the age of 12 have a substance use disorder, but only 2.6 million received treatment at a specialty facility in 2014. Perhaps this can be explained in part because a majority of Americans do not know that there are mental health parity protections in current law.

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Today I'm interested in hearing from our witnesses about how our current parity laws are being implemented and enforced—because without proper enforcement, our parity laws will not have the impact we hope for them to have.

Finally, I'd like to thank Congressman Joe Kennedy for his strong leadership on this topic and for requesting this hearing. He's sponsored legislation this Congress that contains important parity provisions that were not included in our House-passed bill. It's clear that we can and should be doing more to ensure that Americans are able to access necessary mental health and substance use disorder services, and I hope this hearing will shed some light on what steps we can take going forward.

I look forward to hearing from our witnesses today—and I'd like to yield the remainder of my time to Congressman Kennedy.

Mr. KENNEDY. I want to thank the ranking member and the ranking member of the subcommittee, Mr. Green.

I also want to thank Chairman Upton and Chairman Pitts for allowing us to have this hearing today and for their leadership on mental health and continuing to make mental health parity a priority for this committee.

I also want to thank Mr. Selig for his work and the work of Health Law Advocates, which has touched thousands of patients and families across Massachusetts. It is a privilege to have you representing our Commonwealth today, sir.

And to all the tireless advocates out there who have helped inform our efforts in this committee, without your support, we wouldn't be where we are today. I thank you.

When the House passed this committee's mental health bill in July, it was a needed step forward in our efforts to fix a deeply flawed system. But our work is far from over, because no matter how many providers we train, grant programs we fund or community health centers we expand, failure to ensure basic insurance coverage for those services means the vast majority of working and middle class families can't afford them, and that is why I am grateful for today's hearing.

Parity, the simple idea that substance use disorder and heart disease should be treated the same is the law. That is not what this debate is, in fact, about. But without proper enforcement and transparency, the law is little more than empty words. It is meaningless to the patients and families who need and deserve the access the Mental Health Parity Act, the Mental Health Parity and Addiction Equity Act, and the Affordable Care Act were intended to guarantee. And that lack of enforcement and transparency has devastating consequences.

I recently read a story of a mother whose son Matt lost his life after an insurance company continually refused to cover long-term treatment for his substance use disorder. She wrote that she, quote, "used to wish that Matt had cancer, at least he would have received timely, nonbiased treatment."

Beneath the heartbreaking stories and anecdotes are statistics to back them up. Claims for mental health care are denied at nearly twice the rate as claims for physical health. Twenty-four out of 25 insurance companies in California charged higher copays or coinsurance for mental health care than physical health care, according to investigation by State regulators. Guided by those stories and statistics, I introduced the Behavioral Health Coverage Transparency Act to force insurers to disclose the rates and reasons for denials for mental health care while holding insurers accountable for any violations through random audits. Beyond those provisions, it would create a portal where patients not only lodge complaints but learn more about their coverage options. That lack of accessible information is a major roadblock to health care. My own legislative director, a health policy expert, spent over 2 unsuccessful hours on the phone with her insurance company last week trying to get the medical necessity documents she is entitled to by law and still has yet to receive them.

Parity is a promise we made to millions of Americans who suffer from mental illness. It is not just a legislative technicality or regu-

latory minutia; it is their lifeline. We haven't yet made good on that promise. We are allowing insurers to hide behind a curtain of proprietary information and a broad language of denial. Unless and until this committee becomes serious about ensuring parity as a lived reality for patients and the families who love them, meaningful mental health reform will remain out of reach.

In this body, those reforms begin in this committee room, and I hope that my colleagues will join me in calling for parity to be included in any conference report that reaches the President's desk.

Thank you. I yield back.

Mr. GUTHRIE [presiding]. Thank you.

The gentleman yields back.

All opening statements have been concluded, and all members have the opportunity to submit statements for the record.

I would like to introduce the panel we have before us today. First, I will introduce all three. Then we will have their opening statements. Ms. Pamela Greenberg, president and CEO, Association for Behavioral Health and Wellness; we also have Dr. Michael A. Trangle, senior medical director, Behavioral Health Division, HealthPartners Medical Group; and Matt Selig, executive director, Health Law Advocates.

Thank you for coming today, and you each have 5 minutes to summarize your testimony, and your written testimony will be placed in the record. If you notice the lights, you will get a yellow light when you get close, and then when the red light, it would be time to sum up if you haven't concluded at that point.

And I will begin with recognizing Ms. Greenberg for 5 minutes.

**STATEMENTS OF PAMELA GREENBERG, MPP, PRESIDENT AND CEO, ASSOCIATION FOR BEHAVIORAL HEALTH AND WELLNESS; MICHAEL A. TRANGLE M.D., SENIOR MEDICAL DIRECTOR, BEHAVIORAL HEALTH DIVISION, HEALTHPARTNERS MEDICAL GROUP, REGIONS HOSPITAL; AND MATT SELIG, EXECUTIVE DIRECTOR, HEALTH LAW ADVOCATES, INC.**

**STATEMENT OF PAMELA GREENBERG**

Ms. GREENBERG. Good morning, Vice Chairman Guthrie, Ranking Member Green, and distinguished members of the subcommittee. Thank you for the opportunity to testify before you today.

My name is Pamela Greenberg, and for the last 18 years, I have served as the president and CEO of the Association for Behavioral Health and Wellness. ABHW is an association of the Nation's leading specialty behavioral health companies. These companies provide an array of behavioral health services to over 170 million people in both the public and private sectors. Since its inception in 1994, ABHW has actively supported mental health and addiction parity. And we believe that it is important to diagnose and treat mental health and substance use disorders at an early stage. ABHW is an original member and at one point chair of the Coalition for Fairness in Mental Illness Coverage. In my testimony today, I will provide a brief overview of MHPAEA, discuss compli-

ance and enforcement, and discuss some next steps as we continue to move forward with parity implementation.

MHPAEA, as members have already said, expands upon the Mental Health Parity Act of 1996 that created parity for annual and lifetime limits between mental health and physical health benefits. MHPAEA applies to plans with over 50 employees. It does not mandate coverage for mental health and substance use disorders. The law and regulations state that financial treatment and non-quantitative treatment limits can be no more restrictive than those on the physical side. Additionally, the law requires the disclosure of medical necessity criteria and the reason for denial. The law also provides that if out-of-network services are available on the physical health side, they must also be available on the mental health side.

It is important to note that parity was not intended to be the panacea for all mental health and addiction issues. For example, parity does not address our workforce shortage issues nor does it look at the quality of care that is being provided.

The Affordable Care Act extended MHPAEA to individual markets, small group, and qualified health plans. Parity also applies in Medicaid and TRICARE.

Since MHPAEA's passage in 2008, our member companies have had numerous meetings with the regulators to help us better understand and operationalize the regulations. Our member companies have teams of dozens of people from multiple departments working diligently to exchange information and perform the required analyses.

The analyses are complex. For example, in order to complete the parity analysis, ABHW member companies review a variety of documents, including summary plan documents, medical necessity criteria, and medical management program descriptions. And then they document the underlying processes, strategies, evidentiary standards, and other factors considered by the plan. And then they review these findings with the organization's legal team and recommend any needed changes. Our members have been audited for parity compliance at both State and Federal levels.

The DOL and HHS have been enforcing MHPAEA through investigations and health plan audits. In its January 2016 report to Congress, the DOL reported that, since October 2010, they have conducted 1,515 MHPAEA investigations and cited 171 violations. HHS has also received complaints and, to date, has been able to avoid litigation by resolving the issues through voluntary changes by the health plans. Regulating agencies have also issued multiple sets of frequently asked questions and fact sheets.

This year, President Obama established a White House Mental Health and Substance Use Disorder Parity Task Force that is going to—that is working to improve parity. I ask that our comment letter to the task force be included in the record.

To say that parity is not being implemented and enforced is a misrepresentation. It is important to recognize the strides that have been made and work together to develop best practices to move forward. We have to make sure that we are not so rigid with our implementation of parity that we end up ignoring the dif-

ferences that exist between behavioral and physical health and, as a result, compromise quality care.

Further discussion is needed on the disclosure issue. Transparency and disclosure of information to consumers is important, but we also have to keep in mind the results of a new research paper that found that 86 percent of participants could not define deductible, copay, coinsurance, and out-of-pocket maximum in a multiple-choice questionnaire. Recent legislative attention in the area of disclosure has contributed to the issuance of additional guidance. What is missing from this discussion has been the volume and technical nature of these documents. There needs to be a more concise option for consumers to understand how their health plan has implemented parity without burying them with hundreds of documents.

Some ideas to consider include the development of a document that a plan would use to explain how they have performed the parity analysis. Another idea is to provide examples that would include scenarios of questions a consumer might ask and then also the documents they may want to request to answer those questions. A third area that needs additional attention is education to all stakeholders as to what is and isn't included in parity. HHS is working with States and the National Association of Insurance Commissioners. DOL has issued a compliance assistance guide and the check sheet to assist employers, and SAMHSA has information on their Web site.

If I could just finish up. Our members are faced with disparate and sometimes incorrect interpretations by State agencies enforcing the Federal law, and we would like to see more consistent enforcement. We also support the release of the identified information that are found by the regulators.

And, finally, if I could just bring two issues to your attention, and those are the disclosure of substance use records related to 42 CFR in part 2 and meaningful use incentives for behavioral health providers. We hope that the committee considers those issues at a later date.

Thank you for the opportunity to testify today, and I look forward to ongoing discussions as we move forward.

[The prepared statement of Ms. Greenberg follows:]



**AN EXAMINATION OF FEDERAL MENTAL HEALTH PARITY  
LAWS AND REGULATIONS**

**STATEMENT OF  
PAMELA GREENBERG, MPP  
PRESIDENT AND CEO  
ASSOCIATION FOR BEHAVIORAL HEALTH AND WELLNESS**

**BEFORE THE  
HOUSE ENERGY AND COMMERCE HEALTH SUBCOMMITTEE**

**SEPTEMBER 9, 2016  
WASHINGTON, DC**

**Introduction**

Good Morning, Chairman Pitts, Ranking Member Green, and distinguished members of the Subcommittee. Thank you for the opportunity to testify before you today on the important issue of mental health parity laws and regulations. My name is Pamela Greenberg, and for the last 18 years I have served as the President and CEO of the Association for Behavioral Health and Wellness (ABHW). ABHW is an association of the nation's leading specialty behavioral health companies. These companies provide an array of services related to mental health, substance use disorders, employee assistance, disease management, and other health and wellness programs to over 170 million people in both the public and private sectors. ABHW and its member companies use their behavioral health expertise to improve access and health care outcomes for individuals and families.

Since its inception in 1994, ABHW has actively supported mental health and addiction parity and we believe that it is important to diagnose and treat mental health and substance use disorders at an early stage. ABHW was an original member of the Coalition for Fairness in Mental Illness Coverage (Fairness Coalition), a partnership developed to win equitable coverage of mental health treatment. Other members of the Fairness Coalition were the American Hospital Association, American Medical Association, American Psychiatric Association, American Psychological Association, Federation of American Hospitals, Mental Health America, National Alliance on Mental Illness, and the National Association of Psychiatric Health Systems. In the four years prior to passage of the Mental Health Parity and Addiction Equity Act (MHPAEA), ABHW served as the Chair of the Fairness Coalition. We were closely involved in the writing of the Senate legislation that became MHPAEA and actively participated in the negotiations of the final bill that became law.

Since MHPAEA's passage in 2008, we have worked closely with the law's three regulating agencies: the Department of Labor (DOL), the Department of Health and Human Services (HHS), and the Department of Treasury, to ensure that our member companies understand the intent of the regulations in order to properly implement MHPAEA. In those dozens of conversations, we also have had the opportunity to



provide information to the regulators on challenges presented by the law, the regulations, and their enforcement.

In my testimony today I will provide a brief overview of MHPAEA, discuss compliance and enforcement, and suggest some next steps as we continue to move forward with parity implementation.

### **Overview of MHPAEA**

MHPAEA expands upon the Mental Health Parity Act of 1996 that created parity for annual and lifetime limits between mental health and physical health benefits. MHPAEA applies to employer plans with over 50 employees that choose to provide coverage for mental health and substance use disorders. MHPAEA does not mandate coverage for mental health and substance use disorders. The law states that financial (copayments, coinsurance, etc.) and treatment limits (day or visit limits) can be no more restrictive than those on the physical side. Additionally, the law requires the disclosure of medical necessity criteria and the reason for a denial, if one is issued. The law also provides that if an out-of-network benefit is offered for physical health, it also needs to be offered for mental health and substance use disorders. ABHW, and many others, supported all of these provisions. The interim final rule issued in 2010 and the subsequent final rule released in 2013 added parity for nonquantitative treatment limitations (NQTLs). Examples of NQTLs are medical management, formulary design, and provider network admission standards. The processes, strategies, evidentiary standards, or other factors used by a health plan to apply an NQTL to mental health or substance use disorder benefits must be comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used on the physical side. What is important to keep in mind with NQTLs is that the parity comparison is not a mathematical one. Even though the same process is applied, the results may be different; but this does not mean the plan is noncompliant with MHPAEA. It is equally important to note that parity was not intended to be the panacea for all mental health and addiction issues. For example, parity does not address our workforce shortage issues, nor does it look at the quality of care that is being provided.

The Affordable Care Act extends MHPAEA to small group and individual market plans and requires qualified health plans in the health insurance market place to offer mental health and substance use disorder benefits as part of the essential health benefits and provide these behavioral health benefits at parity with physical health benefits. Additionally, a State Medicaid Director's letter issued in 2013 discussed parity in Medicaid; and in March 2016, a final rule was issued regarding the application of parity to Medicaid. Just last week a final parity rule was issued for TRICARE. At this point, virtually everyone with behavioral health insurance coverage, with the exception of Medicare beneficiaries, should have parity in their mental health and substance use disorder benefit.

#### **Compliance and Enforcement**

As with most regulations, the MHPAEA rules have grey areas that are open to different interpretations. Since the Interim Final Rule was issued, ABHW has worked to identify these areas and to seek clarification from the regulators as to their intent. Our member companies have proactively worked to understand and implement MHPAEA. We have had numerous meetings with the regulators to help us better understand the regulatory guidance and to discuss how plans can operationalize the regulations. Our member companies have teams of dozens of people from multiple departments in both physical and behavioral health working diligently to exchange information and perform the required parity analyses in order to implement and provide a mental health and substance use disorder parity benefit to their consumers.

The analyses are complex. One member company explained to the regulators that they have to perform analyses with over one hundred health plans for just one of their employer customers. This includes obtaining information on financial, treatment, and nonquantitative limits from each physical health plan, which may or may not be the same company as the behavioral health plan, and performing the financial analysis in the case of quantitative limits or the no more stringent analysis for NQTLs. These analyses need to be completed for each variation of the medical plan offered by our customers. Our member companies' customers can include employers, health plans, and states.

For example, in order to complete the parity analysis, ABHW member companies perform some version of the following with each medical plan:

1. Review summary plan documents of benefit descriptions
2. Review medical necessity criteria and medical policy
3. Review medical management program descriptions
4. Review network-related issues, including credentialing and reimbursement
5. Conduct discussions with group health plan administrator and medical/surgical plan regarding process for development and application of NQTLs
6. Document underlying processes, strategies, evidentiary standards, and other factors (including, but not limited to, all evidence) considered by the plan (including factors that were relied upon and were rejected) on this compliance tool as evidence of completion
7. Review findings with the organization's legal team
8. Review findings with stakeholders and recommend changes to benefits or practices (if any)

ABHW members have been audited for parity compliance at both a state and federal level. At a state level this could include one or more of the following activities: market conduct exams, state regulatory inquiries, attestations, and audit questionnaires. In one state, this audit process has taken over one year. The DOL and HHS have also been actively enforcing MHPAEA through investigations and health plan audits. In its January 2016 report to Congress, the DOL reported that since October 2010, the DOL's Employee Benefits Security Administration (EBSA) had conducted 1,515 investigations related to MHPAEA and cited 171 violations. Kaiser Health News reported that HHS found 196 possible violations from September 2013 to September 2014, and all complaints were resolved through voluntary changes by the plans. This means of resolution is a better solution than a lawsuit; as the problem gets resolved more expediently; and tax payer and health care dollars are not wasted on legal fees.

In addition to enforcement, the three federal regulating agencies have issued multiple sets of frequently asked questions (FAQs) that provide both guidance and education as to the intent of the final regulation. This year, President Obama also established a White House Mental Health and Substance Use Disorder Parity Task Force (Task Force) that will “identify and promote best practices for executive departments and agencies (agencies), as well as State agencies, to better ensure compliance with and implementation of requirements related to mental health and substance use disorder parity, and determine areas that would benefit from further guidance.” We have met with members of the Task Force on several occasions and hope to see some of our recommendations included in its final report.

To say that parity is not being implemented and enforced is a misrepresentation. The law is complex, and so is the enforcement process. It is important to recognize the strides that have been made and work together to develop best practices to move forward.

#### **Ideas for Next Steps**

The parity analysis has become a strict one-way analysis with no recognition of the differences that do exist between behavioral health and physical health. Any flexibility that once existed has been taken away through rules and additional guidance. We believe that a one-way parity analysis does not always lead to the best quality of care for consumers and that there are times when a NQTL should not be imposed in the same manner it is imposed for physical health care. It is critical to recognize that differences do exist between behavioral health and physical health in order to ensure that the best quality, evidence based care is being provided to consumers. Parity is important, but so is quality; and we have to make sure that we are not so rigid with our implementation of parity that we end up compromising on quality care for consumers. Parity should not just be about the correct analysis being done; we should be asking, “Does this comparison result in good care for the patient?”

Another area that needs further discussion is disclosure. Consumer education and understanding was an important principle of the original legislation, and transparency and disclosure of information to

consumers is important. But we also have to keep in mind the results of a new research paper published in the Journal of Health Economics that found that 86% of participants could not define deductible, copay, coinsurance, and out-of-pocket maximum in a multiple choice questionnaire. The study leads us to believe that plan documents will also be difficult for a consumer to understand.

Recent legislative attention in the area of disclosure has contributed to the regulators issuing additional guidance on what information consumers have the right to ask for from their health plan. What is missing from this discussion has been the understandability of these documents once they are disclosed to an individual. We can provide consumers with thousands of technical papers that they may not have time to read and understand, or we can take the time to talk about what is the exact information a consumer needs in order to understand how a decision has been made or how parity has been applied. There needs to be a more concise option for consumers who want to understand how their health plan has implemented parity without burying them with hundreds of documents. We have begun this conversation with the three regulating agencies and members of the Task Force. Some ideas to consider include the development of a document that a plan would use to explain how they have performed the parity analysis; this would help guide the plan as to what information they need to provide and would not over burden the requesting party with an overabundance of documents. Another idea is to provide examples that would include scenarios of questions a consumer might have and documents that a consumer may want to request in order to have their questions answered. Additional information can always be requested but these alternatives would at least not immediately inundate someone, especially at a time that they or a loved one may be in treatment.

A third area that needs additional attention is education. This includes education to consumers, providers, employers and others as to what is and isn't included in MHPAEA, as well as additional education to states that are responsible for MHPAEA enforcement. HHS is working with states to educate them about the intent of the federal parity law and respond to their technical questions; they are engaged with the National Association of Insurance Commissioners (NAIC) to help ensure that all states have the same

understanding of the intent of the parity law and regulations. DOL has issued both a compliance assistance guide and a compliance check sheet to assist employers and their advisors with compliance. The Substance Abuse and Mental Health Services Administration (SAMHSA) also has educational information about MHPAEA on its website and recently issued [Approaches in Implementing the Mental Health Parity and Addiction Equity Act: Best Practices from the States](#). We commend these agencies for their work and recommend increasing education and guidance about MHPAEA to state officials who are enforcing the law and its accompanying regulations. Our member companies are currently faced with disparate interpretations by state agencies enforcing the federal law. In some cases, states' interpretations are inconsistent with other states and also with the express guidance issued by the federal departments. Often times, states are asking parity compliance questions that in reality will not inform the state as to whether or not the plan is properly implementing parity. Many of our members have also seen a lack of understanding at the state level that has led to attempts to incorrectly enforce the law. For example, at least four states have at various times interpreted the federal regulations to require that a plan use the primary care payment as the only permissible copayment for outpatient behavioral health services (despite the express language of the regulations and clarifying guidance in the form of FAQs laying out a mathematical formula that should be used to calculate copayments). We hope that additional materials, education, and training will lead to more consistent enforcement across the states and ensure that all Americans are provided with the parity benefit that Congress and the federal regulators intended for them to have.

Furthermore, ABHW supports the release of de-identified information related to compliance issues discovered by the regulating agencies. De-identified information that is released could also include best practice examples where plans have correctly implemented MHPAEA. The availability of this information will allow health plans and managed behavioral health organizations (MBHOs) to reexamine their compliance process to ensure that they are implementing parity according to the full intent of the

regulations. This information will also provide interested parties with a thorough picture of the intent of the final rule and will lead to improved compliance.

As I mentioned earlier, MHPAEA does not, and was not intended to, fix all of the problems impacting behavioral health. In that vein, there are two “parity” issues that I’d like to call your attention to as we look forward to 2017: the lack of parity in access to and disclosure of substance use disorder records (42 CFR Part 2) and the lack of meaningful use incentive payments for several categories of behavioral health providers. The separation of a patient’s substance use records from the rest of his or her medical records is not the privacy standard used for any other medical care (including mental health). This law is especially alarming in the current environment where the opioid addiction crisis demands closer coordination between medical providers and substance use treatment. Added to this is the fact that most behavioral health providers did not receive meaningful use incentive payments to encourage the use of electronic health records. As a result, integration of behavioral and physical health records and treatment is further obstructed.

#### **Conclusion**

Thank you again for the opportunity to testify before you today. As parity implementation continues, we welcome ongoing discussions with the Subcommittee. I believe we all share the same goal of access to quality mental health and substance use disorder care for all.

Mr. GUTHRIE. Thank you for testifying.  
Dr. Trangle, you are recognized for 5 minutes.

**STATEMENT OF MICHAEL A. TRANGLE**

Dr. TRANGLE. Thank you, Vice Chairman Guthrie, Ranking Member Green, and all the committee members.

I am Michael Trangle. I am a practicing psychiatrist and also a senior medical director for HealthPartners Medical Group, one of our hospitals, and have been really actively involved in kind of efforts we have been doing to make things better. I am very involved in quality improvement, leading initiatives to improve depression outcomes outpatient, reduce readmissions for people coming from psych units, trying to lengthen the lifespan of folks with serious mental illnesses in our State, and just work hard on that.

I am from an integrated organization where there is a health plan medical group of about 1,800 docs, hospitals. The health plan covers 1.36 million lives. We have got 22,500 employees. I know that we are all working hard to try to produce parity, both clinicians like me and administrators who know the details of the law and the policy in a way that I don't, to try to really make sure we understand and are fully implementing it.

I want to talk about some of the efforts we are doing in the real world at the ground level to try to make things better. One initiative that we have been very successful with is, with our public radio station and NAMI and other organizations, doing a campaign to reduce stigma called Make It OK, which actually helps access. There is so much shame involved and avoidance of getting involved in treatment that, if you can start conversations, people would be willing to either listen to their primary care doc or bring it up and get going. I know that, for our members, we measure closely and look for improvements. We are at a 96 percent member satisfaction of either very satisfied or satisfied for access to behavioral health resources in our system.

We have come up with ways that we have offered—we think it is so good to our employees as well as all of our patients, whether they have our health plan or not and are health plan members—where they can go online on the Internet and participate in a cognitive behavioral therapy treatment program at their leisure, at their own pace, to improve depression and anxiety care.

We have created an algorithm, based upon claims, to look at who is at high risk to not do well in the next 6 months. And I can give you an example of one of my patients who is a 44-year-old woman—married, three kids, lives in the burbs—who started seeing me as an outpatient for depression and anxiety and, despite my best efforts, wasn't getting better. Then I realized she was probably abusing substances. And then when I talked to her, she wasn't interested or willing to do treatment. She got worse. She ended up getting drunk, passed out while smoking in bed. Her house burned down. Thankfully, her kids and husband got out safely, but she had between 20 and 30 percent burns. She got hospitalized in a burn unit in a hospital that is not integrated with our system but part of our health plan network, was there for about 3 weeks, came out, and still was even worse than before. She was still depressed, anx-



ious. She had started abusing opiates, because she had pain now, as well as drinking.

And we had a healthcare coordinator that was working with this person because of our algorithm. And her job is to reach out and talk to all the various places and people involved in her care. She reached out to the hospital and found out that the patient was actively suicidal there and had been civilly committed and was under court order to undergo and participate in psychiatric care, supposedly under my direction. She had not filled out a release of information, lied to me about it, but this care coordinator discovered this. And then all of a sudden, I could have a real honest discussion with her. And we got her into a dual-diagnosis CD treatment facility. And it is about 2 years later now and she is still off opiates and alcohol and not really depressed, still struggles with anxiety, but her life is turned around. And it was all because of this kind of extraordinary care coordination that spanned different levels of care and systems of care that probably saved her life.

I agree with the workforce shortage. You know, we find that we are doing a lot of things to try and put psychiatrists and therapists in our primary care clinics. And there is a shortage of health psychologists. There is a shortage of psychiatrists. We have been taking efforts, in partnership with NAMI, to do extra training, to get physician's assistants and nurse practitioners and clinical nurse specialists to increase our pool of prescribers.

We are working hard to improve the flow of psychiatric patients. We have patients accumulating in the ED waiting to get into psych units, and people on psych units who can't get out waiting to get into group homes and residential treatment centers. And we need to partner with counties and States who are responsible for those things, and they have budget shortages, and there are not enough.

And I see I am going to run out of time. But one other thing that we have been trying to work on, but it is hard, is kind of payment reform so that we can flow our money to pay for outcomes and can then afford to have care managers in our clinics reaching out to patients between visits, reaching out to make sure, "It has been so long, you haven't rechecked, how are you doing with your depression," and making sure they come in and that they are getting into remission. And it requires partnerships in ways that I don't think is usually talked about. That is viewed as the public sector. We are viewed as the private sector. And we have got to work together. And when we do that, we can sort of get patients out of the hospital sooner into group homes and then our EDs. We are overflowing our safe space or locked space for psych patients. We can get them into the inpatient unit.

And a lot of what we are doing really involves kind of taking disparate partners and agreeing to a vision and then trying to work together, but it is very hard because the funding streams are not braided. I see I am going to be out of time pretty shortly.

Mr. GUTHRIE. If you could just summarize. I mean, I will be a little lenient, but if you could just summarize.

Dr. TRANGLE. You know, in a lot of ways, there are also new models of care where we are trying to sort of really truly integrate behavioral health resources with health plan resources, both delivery system—and this care coordination is another way of doing

this. We have programs where, if I have my patient and they don't get their refills for their antipsychotics, I will hear about it because of the health plan feeding that data to me. The patient hears about it. We can reach out and try to capture them so they don't get psychotic and really struggle. We do the same thing with depressed patients. And it really helps a lot.

We have initiatives where we have got people like me going or telemedicine going to primary care clinics. Primary care docs will talk about their depressed patients and their issues and their struggles. I will give advice. And for 2 hours a week, I can sort of leverage what primary care is doing for about 100 patients, so leverage the shortage of psychiatrists.

[The prepared statement of Dr. Trangle follows:]

**Mental Health Parity and Related Issues**

**By**

**Michael A. Trangle, M.D.**  
**Senior Medical Director, Behavioral Health Division,**  
**HealthPartners Medical Group, Regions Hospital**

**for the**  
**House Energy and Commerce Committee**  
**Subcommittee on Health**

**September 9, 2016**

**I. Introduction**

Chairman Pitts, Ranking Member Green, and members of the subcommittee, I am Dr. Michael Trangle, Senior Medical Director of HealthPartners' Behavioral Health Division. In my current position, I am responsible for the delivery of behavioral health care at Regions Hospital and within the HealthPartners Medical Group. These two settings are part of the HealthPartners family of care. HealthPartners is an award winning integrated health care system based in Minnesota with a team of 22,500 people dedicated to a mission to improve the health of members, patients and the community. Through our insurance plans, we cover about 1.36 million health and dental plan members in Minnesota and western Wisconsin. In my 16 years at HealthPartners, I have been active in regional quality improvement initiatives and collaboratives including depression guidelines, improving depression outcomes in primary care and in Behavioral Health clinics, and improving care for patients with mental illnesses and/or chemical dependency in emergency rooms, in crisis in the community or going through the commitment process. In addition to my clinical work, I have been fortunate to be a part of HealthPartners' work in partnership with NAMI Minnesota on our mental health anti stigma campaign "Make It OK." I'm also a practicing psychiatrist who cares for patients/members in our system.

I appreciate this opportunity to testify today on mental health issues, including the parity requirements established by the Mental Health Parity and Addiction Equity Act (MHPAEA). I thank the committee for focusing attention on these important issues.

My testimony today addresses the following topics:

- HealthPartners' commitment to implementing mental health parity and meeting the needs of patients with mental health conditions;
- Challenges associated with the treatment of patients who have mental health and substance use disorders;
- The role of medical necessity review in helping to ensure the safety and appropriateness of care for patients with mental health conditions; and
- Opportunities for improving access to and quality of mental health services.

## **II. Our Commitment to Implementing Mental Health Parity and Meeting the Needs of Patients with Mental Health Conditions**

HealthPartners strongly supports the protections established by mental health parity laws at both the federal and state levels. We have clinical and administrative personnel in our medical and behavioral departments who are working to promote a strong understanding and effective implementation of the parity rules.

In addition to complying with the parity requirements, we have pioneered innovative programs focused on ensuring that patients with mental health problems have affordable access to high-quality, evidence-based treatments. Several of these initiatives are highlighted in an issue brief<sup>1</sup> recently published by America's Health Insurance Plans (AHIP).

To identify individuals who are highly likely to be hospitalized with a mental health crisis within the next six months, HealthPartners has developed a U.S. patented predictive algorithm that uses claims data. By identifying these individuals early, dedicated behavioral health staff can proactively reach out to those members. With the patient's permission, care coordination staff helps members understand their behavioral health conditions, access care and help motivate them to stick to their mental health and/or substance abuse treatment plans before their condition worsens. This outreach is especially important for members who are in the early stages of a serious condition and for those who have never used behavioral health care before. Both of these groups benefit from guidance and assistance since they may not be aware of their benefits or how to access them.

Additionally, we have two initiatives that provide evidence-based, cost effective interventions as an alternative or supplement to psychotherapy or medication. Our members can access these services anywhere and anytime on a tablet, laptop, or personal computer.

- One of these services is "Beating the Blues". Beating the Blues consists of eight half-hour sessions of cognitive behavioral therapy that can either be self-guided or offered as an adjunct to treatment through a recommendation from primary care, behavioral health, or specialty care. Peer reviewed research indicates that Beating the Blues improves conditions such as depression, anxiety and stress – making it especially relevant for patients who are coping with a co-existing medical condition such as post-partum depression or chronic pain

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<sup>1</sup> Ensuring Access to Quality Behavioral Health Care: Health Plan Examples, AHIP, May 2016, <https://www.ahip.org/ensuring-access-to-quality-behavioral-health-care/>.

and for those engaged in cardiac rehabilitation. HealthPartners' behavioral health providers are using this online program as part of both individual and group psychotherapy, and specialty providers are beginning to offer it as well. More than 1,800 members and employees currently are using Beating the Blues cognitive behavior therapy. Early results suggest that completing even six sessions of the program leads to a statistically significant decrease in symptoms.

- We also offer emotional resilience group coaching to some of our employees and supplemented this group coaching with online virtual coaching on topics such as positive thinking, stress management, and healthy sleep. Among a group of employees who participated in three one-hour emotional resilience sessions, we found that improved well-being – when measured based on lifestyle, diet and exercise, quality of life measures, and missed work – persisted at least one year later. We are now in the process of offering this coaching to other employer groups and are piloting comparable content in an online approach.

One measure of our commitment to providing mental health services is our annual satisfaction survey of our members which measures our members' access to behavioral health care clinicians. These surveys consistently show very strong levels of satisfaction with access to network providers of psychotherapy or psychiatry services. In fact, HealthPartners most recent surveys show that 82% of members are satisfied or very satisfied the ability to get an appointment for behavioral health services which are convenient for them, which is not significantly different from the member satisfaction with access to primary care providers. We use a number of strategies to help make sure that our members have access to the mental health care they need. For example, we pre-purchase a limited number of appointment slots with psychiatrists and make them available to health plan members. This strategy allows our behavioral health navigators to search for appointments on a targeted basis to help members get appointments. For our members with the most complex or serious mental health and/or substance use disorders, our dedicated behavioral health care coordinators work to help each member access the type of care and level of care they need, often explaining and supporting the member in accessing care they have been avoiding. Our behavioral health care coordinators are in phone contact with these members many times over the course of a few months to encourage, assist and support members in accessing care and sticking to their treatment plans. Our satisfaction survey results show 96% are satisfied or very satisfied with this help.

Here's an example of how our behavioral health care coordinators made a huge difference in the life of one of my patients. My patient was a middle-aged married mother of 4 who struggled with

depression, anxiety, pain, and most recently began abusing alcohol. While drunk and smoking in bed she started a fire, was badly burned, and spent 2-3 weeks in the burn unit of a local hospital that was not part of our system. She was discharged and had the same symptoms and complaints as before and couldn't think clearly, function well as a parent and struggled in her marriage. Unbeknownst to me, she did not give permission for the hospital to send her records to me. When I strongly recommended treatment for her alcohol abuse (which now included addicting pain meds), she refused. Our dedicated care coordinator had permission to access the records and discovered that the patient was seen by psychiatry, was actually civilly committed and was under a court order to follow her psychiatrist's plan of care. I was then able to get her into chemical dependency treatment which was successful and she has been able to once again live an active enjoyable life and function adequately as a mom and have an improved marriage while staying free of addicting meds and alcohol.

### **III. Challenges in Treating Patients with Mental Health and Substance Use Disorders**

Despite health plan efforts, challenges exist in the treatment of patients who have mental health conditions, including: (1) the widespread national shortage of appropriately licensed behavioral clinicians; and (2) the lack of readily available information on the quality of behavioral health facilities.

#### Workforce Shortage

One of the most significant challenges is the shortage of appropriately licensed behavioral clinicians, particularly psychiatrists and psychologists to serve specific areas or specific population. For example, in Minnesota we face a shortage of psychiatrists, particularly those who specialize in treating children and young adolescents. The need is most acute in the inpatient psychiatry setting. The shortage of inpatient behavioral health clinicians leads to reduced numbers of staffed/available beds for many behavioral health inpatient facilities and more limited behavioral health services in some communities. The reduced capacity of the behavioral health workforce particularly focused on those with the most severe mental health and/or substance use conditions, paired with the scarcity of social services, affordable and supported housing and other community support options, is an area needing community-based solutions. As a first step toward addressing this issue, more loan guarantees and loan forgiveness for psychiatrists, psychiatrically trained nurse practitioners, physician assistants, and psychiatric clinical nurse specialists (all of whom can prescribe psychiatric meds) should be explored and

developed focusing especially on improving access to services in rural areas and for the most mentally ill no matter where they live.

Another significant concern is that we have too many patients accumulating in emergency departments for too long, waiting for an inpatient psychiatric bed. We have shortages of psychiatric inpatient beds (both for mental health conditions and substance use disorders) and an equally problematic shortage of group homes, residential treatment centers, supported housing and community supports that are necessary to safely allow these inpatients to leave the hospital and receive intermediate care. Our own organization has created hospital and community based care as part of our clinical continuum, and the services are nearly always at capacity. The solution also requires a much better partnership between state and county-based services and supports which currently are in short supply. I am appreciative of our state's leadership in convening a task force on mental health treatment that is currently studying these very issues.

#### Stigma

Another significant barrier to people accessing mental health or chemical health treatment is that these are still stigmatized conditions. Stigma is a barrier to making the choice to access treatment but there are several excellent programs which work to increase knowledge and eliminate stigma. For example, the "Make It OK" program is an online program at [MakeItOK.org](http://MakeItOK.org) which was created and is supported by HealthPartners, NAMI Minnesota and Minnesota Public TV. Some counties and cities in Minnesota have taken this further, promoting [MakeItOK.org](http://MakeItOK.org) in their communities to provide continuing local support to break the barrier of stigma.

#### Lack of Quality Information

The final challenge I'd like to highlight is the lack of available information on the quality of behavioral health facilities, including data on patient outcomes, to help consumers make decisions. Despite the emphasis on parity between medical/surgical services and mental health /substance use services, there is no similar evidenced based clarity and consensus in measuring or reporting information on the quality of inpatient psychiatric facilities or patient outcomes. To date, the National Quality Forum (NQF) has identified more than 700 health quality measures overall, but only 30 are directly linked to behavioral health care. Most behavioral health quality measures are clinical process of care measures; only a few which tend to be in the outpatient realm, are outcome measures. Depression measures are a great example of this. As a member of the Behavioral Health Committee of NQF, I know that there is tremendous interest in making this better. As more medical groups and hospitals use electronic medical records NCQA and the



Joint Commission will be able to efficiently and economically access patient outcomes data. This should be encouraged and supported. We will need this level of data to begin measuring whether we are effectively working with our patients who are most seriously mentally ill in ways that will allow them to live as long as their cohorts without mental illnesses. Currently they are dying up to 25 years earlier.. While the reporting of quality measures by inpatient psychiatric facilities through Hospital Compare is a step in the right direction, more needs to be done to make such quality information more robust and accessible.

#### **IV. The Role of Medical Necessity Review: Helping to Ensure Safety and Appropriateness of Care**

HealthPartners provides coverage for mental health services using a process – known as medical necessity review – through which we evaluate whether the care proposed for a patient, is necessary and appropriate, based on evidence-based clinical standards of care.

Medical necessity review is used for a range of medical and surgical services, such as non-routine outpatient services with a wide variation in cost and/or utilization, outpatient surgical procedures to ensure safety in the non-hospital setting, advanced radiology or imaging, and infusion therapy. Similarly, medical necessity review also is applied to mental health and substance use therapies where too often evidence for a particular service or condition is lacking or has conflicting results, safety concerns have been reported, or such services are delivered by unqualified clinicians practicing outside their licensed scope of practice. For patients with mental health conditions, such reviews are conducted in accordance with MHPAEA disclosure standards.

Non-quantitative treatment limits (NQTLs) are included among the strategies used by health plans in determining the medical necessity of mental health services. NQTLs are permitted with regard to mental health and substance use provided that the “processes, strategies, evidentiary standards and other factors” used in applying the NQTL are comparable to medical/surgical benefits and are not more stringent.

When performing medical necessity review, HealthPartners uses nationally recognized care criteria – medical, surgical, mental health or substance use – such as Milliman Level of Care Criteria, or American Society of Addiction Medicine (ASAM) criteria for chemical dependency,

the input of our pharmacy and therapeutics committee composed of specialty clinicians for specific medical protocols, and consideration of the best research on clinical outcomes. Prior authorization is used to ensure that care takes place in the most appropriate setting and at the most appropriate frequency for the specific clinical condition, particularly with respect to services prone to overuse or misuse. Prior authorization also can be used to make sure that drugs and devices are not being used for clinical indications other than those approved by the Food and Drug Administration.

Although HealthPartners does not use step therapy, some health plans do use it as an important tool to prescribe recognized safe and cost-effective drugs before approval of a more complex, costlier or riskier drug or drug combination. Step therapy can help reinforce the American Psychiatric Association's recommendation that the use of multiple antipsychotic medications concurrently not be tried by clinicians until at least three attempts using a single antipsychotic medication have failed.<sup>2</sup>

#### **V. Opportunities for Improving Access to Mental Health Services**

Looking ahead, we believe there are several areas where policymakers and stakeholders can work together to improve access to services for patients with mental health conditions and achieve our shared goal of parity:

- Continuing to support and promote important, innovative programs, like Make It OK, to reduce stigma and encourage people to seek mental health care;
- Addressing workforce shortages, especially in rural areas and for cultural communities, by providing expanded roles and loan forgiveness for psychiatrists, psychiatrically trained nurse practitioners, physician assistants, and clinical nurse specialists, which is an issue on which we've worked directly with Minnesota NAMI;
- Facilitating better access to community resources including group homes, supportive housing and affordable housing, at both the state and local levels, to address gaps in services and supports and ensure that patients with serious mental illnesses are connected to social service supports that can help them thrive;

<sup>2</sup> <http://www.choosingwisely.org/clinician-lists/American-psychiatric-association-routine-prescription-of-two-or-more-concurrent-antipsychotics/>

- Considering grant programs to better streamline health and housing services through innovative community partnerships;
- Better integrating behavioral health care with primary care, while also providing support for collaborative care for chronic mental conditions and substance use disorders; and
- Advancing new payment models and standards that reimburse providers based on attaining best outcomes using a Triple Aim standard: simultaneous improvement in clinical outcomes or health, patient satisfaction or experience and cost to help keep healthcare affordable.

**VI. Conclusion**

Thank you again for this opportunity to present my perspectives on issues surrounding mental health parity. We appreciate the committee's interest in this critical issue.

Mr. GUTHRIE. We also have the chance to reiterate some of this during our question-and-answer period. We appreciate it very much. Thank you. Thank you for that testimony. It is very informative.

Mr. Selig, you are recognized for 5 minutes.

#### STATEMENT OF MATT SELIG

Mr. SELIG. Vice Chairman Guthrie, Ranking Member Green and members of the committee, thank you very much for the opportunity to appear before you today as you examine the parity law and regulations. I am grateful that you have convened this hearing.

My name is Matt Selig, and I am the executive director of Health Law Advocates. HLA is a nonprofit public-interest law firm with a mission to improve access to health care for low-income Massachusetts residents. We provide pro bono legal assistance to low-income clients who have been denied needed health care.

HLA has made mental health and substance use disorders parity a priority for more than a decade. We try to improve access to mental health and substance use disorders care by making the protections of the parity laws, both Federal and State, a reality for those we represent. HLA represents approximately 70 clients each year who have been denied coverage for treatment of mental illness or substance use disorder. This work gives us an up-close look at the problems consumers have when trying to access treatment. We also see how current parity laws and regulations are implemented and enforced. HLA works very closely with other advocates across the country with a strong interest in parity. As a result, we have a broader perspective on the insurance problems people face when they need treatment and how the parity laws are or are not addressing the problems.

While we and others believe there is much more important work still needed to achieve true parity, I want to express HLA's appreciation to you and as well as State legislators and regulators across the country who have made significant gains achieving parity already. We are particularly gratified that parity has been very much a bipartisan issue in Congress, and that has been true in Massachusetts as well.

In Health Law Advocates' experience with clients, individuals have more difficulty accessing mental health and substance use care than other types of care because of barriers created by many insurers. Our assessment corresponds with the findings of the National Alliance on Mental Illness report issued last year, which found that twice as many families reported that a member of their family was denied coverage for mental health care as for general medical care.

Our lawyers have identified certain types of mental health and substance use treatment that are particularly susceptible to coverage denials. I will mention some, but this is not meant to be exhaustive: residential treatment for substance use disorders, eating disorders, and other severe mental illness; applied behavioral analysis for autism spectrum disorder; medication-assisted treatment; and outpatient psychotherapy more than once per week.

HLA represents clients of all ages, but we devote particular resources to helping children access mental health and substance use

disorder care. Over the years, we have seen families struggle to obtain coverage for kids, especially for services such as neuropsychological evaluations, wraparound community-based care, autism services, and stepdown care from acute treatment.

In our work, we have witnessed many different ways insurance practices frustrate treatment for our clients that appear to run counter to the parity laws. For example, we have seen repeated early terminations of coverage for residential substance use treatment, regardless of the severity of our clients' symptoms; doctors being required to titrate medication-assisted treatment as a condition of coverage, even when mandatory titration is not the standard of care; treatment providers subject to onerous requirements to justify care; and termination of services arbitrarily based on age or alleged lack of parental participation.

These examples involve clients who were fortunate enough to have at least connected with a provider. We also represent clients of all ages but particularly children who have great difficulty finding a qualified and appropriate provider in their insurer's network.

In closing, I wish to offer a few recommendations to improve on current parity laws and their implementation. We strongly support H.R. 4276, Congressman Kennedy's Behavioral Health Coverage Transparency Act. There is no question that we need greater disclosure of information by insurers. Detailed information about how plans ensure that mental health and substance use disorder claims are treated equitably and the standards utilized to evaluate the medical necessity of treatment should be made public and written in language consumers can understand.

There should also be greater enforcement, including enhanced penalties of requirements to provide detailed information to members about the basis for coverage denials and comparative information on medical management of physical conditions. When HLA requests this information on behalf of our clients, we rarely receive it. This prevents us from determining whether our clients' parity rights have been violated. An explicit private right of action in the parity law would also allow consumers to enforce this right themselves.

Consumers should also have access to an easy-to-use process for filing complaints when their right to equitable mental health and substance use disorder coverage has been violated. This would help consumers access the treatment they need and identify trends in noncompliance. The complaint process and consumers' rights under the parity law should be broadly promoted by Government agencies to increase understanding among consumers.

The Federal Government should also assist carriers' compliance by publicizing and continually updating its adjudication of parity complaints to create an administrative common law for what constitutes a violation of the parity law. Neither insurers nor their members should have to guess what treatment limitation practices are illegal.

Finally, we recommend that Federal and State agencies conduct random audits of health plans to ensure parity compliance. These inquiries and other reforms will serve as a check on self-reporting by plans and identify problem areas where Federal or State enforcement is needed—more enforcement is needed. That targeted

enforcement will ensure that parity is not only the law of the land but a reality for people suffering with mental illness and addiction. Thank you again very much for the chance to testify.  
[The prepared statement of Mr. Selig follows:]



Testimony of

Matt Selig

Executive Director

Health Law Advocates, Inc.

Before the

United State House of Representatives Committee on Energy and Commerce;  
Subcommittee on Health

An Examination of Federal Mental Health Parity Laws and Regulations

September 9, 2016

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Chairman Pitts, Ranking Member Green and members of the Committee, thank you for the opportunity to appear before you today as you examine the parity law and regulations. I am grateful that you have convened this hearing.

**Background**

My name is Matt Selig and I am the Executive Director of Health Law Advocates (HLA). HLA is a non-profit, public interest law firm founded in 1996 with a mission to improve access to health care for low-income Massachusetts residents. We provide pro bono legal assistance to low-income clients who have been denied needed health care. We improve access to care primarily by addressing our clients' health insurance problems, including denials of coverage. We represent many clients who have commercial insurance through an employer or individual policy.<sup>1</sup>

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HLA represents approximately 70 clients each year who have been denied coverage for treatment of mental illness or a substance use disorder. This work gives us an up-close look at

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<sup>1</sup> It is critical that we offer these services for lower-income clients with commercial insurance because, in Massachusetts, more than sixty percent of those with household income between 138% and 299% of the federal poverty level (FPL) have commercial health insurance. In addition, more than thirty percent of those at or below 138% of the FPL have commercial health insurance. LAURA SKOPEC ET AL., CTR. FOR HEALTH INFO. & ANALYSIS, FINDINGS FROM THE 2015 MASSACHUSETTS HEALTH INSURANCE SURVEY 11 fig.4 (Dec. 2015), available at <http://www.chiamass.gov/assets/docs/tr/survey/mhis-2015/2015-MHIS.pdf>.



the problems consumers have when trying to access treatment. We also see how current parity laws and regulations are implemented and enforced. HLA works closely with other advocates across the country with a strong interest in parity, particularly those that represent consumers and health care providers. As a result, we have a broader perspective on the insurance problems people face when they need treatment and how the parity laws are (or are not) addressing these problems.

While we and others believe there is much more important work still needed to achieve true parity, I want to express HLA's appreciation to you, as well as state legislators and regulators across the country, who have made significant gains achieving parity already. We are particularly gratified that parity has been very much a bipartisan issue in Congress and that the same has been true in Massachusetts.

#### **Difficult to Access Treatment**

In Health Law Advocates' experience with clients, individuals have more difficulty accessing mental health and substance use care than other types of care because of barriers created by many insurers. Our assessment corresponds with the findings of the National Alliance on Mental Illness report issued last year, which found that twice as many families reported that a member of their family was denied coverage for mental health care as for "general medical care."

Our lawyers have identified certain types of mental health and substance use treatment that are particularly susceptible to coverage denials. I will mention some, but this is not meant to be exhaustive: residential treatment for substance use disorders, eating disorders, and other severe mental illnesses; applied behavior analysis for autism spectrum disorder; medication assisted treatment; and outpatient psychotherapy more than once per week.

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#### **Barriers to Treatment**

In our work, we have witnessed many different ways insurance practices frustrate treatment for our clients that appear to run counter to the parity laws. For example, we have seen: repeated early terminations of coverage for residential substance use treatment regardless of the severity of our clients’ symptoms; doctors being required to titrate medication assisted treatment as a condition of coverage even when mandatory titration is not the standard of care; treatment providers subject to onerous requirements to justify care; and termination of services arbitrarily based on age or alleged lack of parental participation.

These examples involve clients who are fortunate enough to have at least connected with a provider. We also represent clients of all ages, but particularly children, who have great difficulty finding a qualified and appropriate provider in their insurer’s network.

#### **Recommended Solutions**

In closing, I wish to offer a few recommendations to improve on current parity laws and their implementation. We strongly support H.R. 4276, Congressman Kennedy’s Behavioral Health Coverage Transparency Act. There is no question that we need greater disclosure of information by insurers. Detailed information about how plans ensure that mental health and substance use disorder claims are treated equitably and the standards utilized to evaluate the medical necessity

of treatment should be made public and written in language consumers can comprehend. There should also be greater enforcement, including enhanced penalties, of requirements to provide detailed information to members about the basis for coverage denials and comparative information on medical management of physical conditions. When HLA requests this information on behalf of our clients, we rarely receive it. This prevents us from determining whether our clients' parity rights have been violated. An explicit private right of action in the parity law would allow consumers to enforce this right themselves.

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The federal government should also assist carriers with compliance by publicizing and continually updating (in a de-identified fashion) its adjudication of parity complaints to create an administrative "common law" for what constitutes a violation of the parity law. Neither insurers nor their members should have to guess what treatment limitation practices are illegal.

Finally, we recommend that federal and state agencies conduct random audits of health plans to ensure parity compliance. These inquiries and other reforms will serve as a check on self-reporting by plans and identify problem areas where federal or state enforcement is needed. That targeted enforcement will ensure that parity is not only the law of the land but a reality for people suffering with mental illness and addiction.

Thank you again very much for the opportunity to testify.

Mr. GUTHRIE. Thank you very much.

I want to thank each witness for your testimony, and I will begin the questioning and recognize myself for 5 minutes for that purpose.

As Chairman Pitts discussed during his opening remarks, there have been continued discussions on the safeguards envisioned in previously enacted mental health parity laws.

Ms. Greenberg, one of the most recent documents ABHW published is a letter in response to the President's task force. You urge the administration's working group to engage with stakeholders on clinical differences, additional tools for States, release of the identified information, disclosure clarifying guidance and parity and confidentiality rules.

I would like to focus on the clinical differences in disclosure and confidentiality rules. In this letter, you write, and I quote: "Parity is important, but so is quality. We have to make sure that we are not so rigid with our implementation of parity that we end up compromising on quality care of consumers," unquote.

Please help me better understand how clinical autonomy to achieve improved quality outcomes in caring for patients with mental health and substance use disorders can be impeded by burdensome or, better yet, one-size-fits-all regulations.

Ms. GREENBERG. Sure. Thank you, Congressman, for that question. I think that our concern as we have moved forward with parity implementation is we have behavioral health and we have medical. And there are some things that are more clear-cut, like the co-payments and the coinsurance and things like that. But then there are other things about the treatment that is needed or when you check in with a provider to see how the treatment is going. And those are things that differ based on illness, and they are not so cookie-cutter that you say, oh, exactly what you are doing on the medical side should be the same thing that is done on the behavioral health side.

And we would just like to see some flexibility within the parameters of clinical guidelines. So it wouldn't just be because we say we should do it this way, then it is OK, but the clinical guidelines may justify a difference in some areas on behavioral health. And that language was included in the initial interim final rule and then was deleted in the final rule. And so I think just recognizing that there are some differences that do exist and, when clinically appropriate, those should be allowed.

Mr. GUTHRIE. Dr. Trangle, as a medical director, would you like to comment on that?

Dr. TRANGLE. You know, I am not a policy guy. I am still seeing patients, and I do a lot of quality stuff. So I can't comment on the details of the law. But I know that, clinically, all the time we are trying to improve talking to primary care docs, seeing their lab results, making sure they can see what we are doing. And in some sense, one of the things mentioned in the prelude had to do with chemical dependency. And we are struggling in our system with ED docs not seeing what meds or what is going on in CD treatment parts of our facility or what is going on in outpatient clinics and overmedicating people because we are not sharing some of that

data with each other. It is just really important to be able to talk together.

It is an interesting place where stigma plays out. We have primary care docs that, in some sense, will kind of be afraid to talk about somebody is depressed, you know, and shy away from it. But if they can see that we have talked about it, because we have a shared electronic medical record, they know it is OK, all of a sudden they can help us follow up and they can help us measure are they getting better or not.

Mr. GUTHRIE. OK. Thank you.

Let me get to my next question.

Ms. Greenberg, you note that certain transparency and disclosure efforts may be well-intentioned but inadvertently overwhelm patients with thousands of pages of documentation, but other advocates have asked for even more access to benefits details. Would you please share a more efficient and effective way to help patients better understand parity, fairness?

Ms. GREENBERG. Sure. The documentation that is available to patients or should be made available to patients includes a lot of information that health plans are using, either their analyses or the documents that they had to look at to get to what parity should include.

And while those documents are available, we would also like to see some type of summary of the analysis instead of—our concern is that if we hand the patient a box or two of documents, that will overwhelm them. And, also, they are very technical, and it will be a little bit difficult to go through. So if we can talk about a uniform analyses that people would hand out first to explain to patients how parity was determined and then kind of go from there as more documents are needed and/or provide guidance to patients as to what documents are appropriate to ask for for their situation—not that they couldn't have more but that at least at first they are getting just the documents that they need.

Mr. GUTHRIE. OK. You, also, in the coordination that Dr. Trangle was talking about—our committee is really looking at coordination. We know that that is important. But in regard to substance use disorders, you comment that multiple signed patient authorizations are necessary to achieve true coordination. How does this limit quality of care?

And then, Mr. Selig, would you comment on the fact that there are so many multiple signed documentation, is that a wall that the Federal Government should try to remove?

Actually, I am out of time. I don't want to go because we are kind of against votes.

Mr. SELIG. If you could clarify which signed documentations you are referring to.

Mr. GUTHRIE. Well, you know what, if I get into that, I am going to really get into that. I will put that in the record. We will give you a question for the record. Otherwise, it is going to take longer. We are running against—votes are going to come sometime mid-morning, I understand.

That concludes my questions.

I will recognize the ranking member, Mr. Green, 5 minutes for questions.

Mr. GREEN. Thank you, Mr. Chairman, Millions of Americans, as many as one in five, have a mental illness. One in 10 Americans will have a substance disorder in their lifetime. And 75 percent of them will not seek treatment. The lives of these individuals and their families and their communities will be significantly changed for the better with access to the treatment they need.

Congress did our part. We passed a parity law requiring health plans and Medicaid and Medicare and the private market to cover mental health and substance use treatment to the same extent as they do medical and surgical services. We passed the Affordable Care Act, which significantly expanded access to health coverage.

However, without strong enforcement of the parity law, millions of people continue to struggle to get the health care they need.

Mr. Selig, as a legal advocate, you are well aware of the importance of strong parity implementation and enforcement. I am sure you know how complicated and confusing insurance benefits can be and how hard it is to fight with an insurance company to get coverage for the benefits you need, especially when you are sick and need it the most.

My first question is, how hard is it for consumers to get the information they need in order to figure out whether their insurer is meeting the requirements of parity?

Mr. SELIG. Well, it can be very difficult, Mr. Green. As I mentioned in my statement, when we are working with consumers who have been denied coverage and they try to request information from their plan explaining why the service has been denied and providing the backup documentation comparing the medical management techniques for mental health and physical health, it is documents that really are rarely provided. And I recall Mr. Kennedy mentioning a member of his staff having the same experience.

So it is very difficult to get that information typically. It is clearly requested by our team members at HLA, and we don't get it. That being said, that information is difficult to understand. And we would favor information being made much clearer for the consumer. I think having boxes of information that indicate the process for determining when services are covered not only is complicated but it also I think speaks to the extreme scrutiny that services are given when people are trying to get coverage for them.

So we would definitely favor clearer information be given to consumers and also clearer information on where people can get help if they don't feel equipped to try to understand the materials that they are given, so, as Congressman Kennedy's legislation provides, a central portal where people can go and indicate that they feel as if they have been, generally speaking, unjustly denied coverage for care, and maybe they don't feel equipped to go through the documents and do the parity analysis themselves, but have an agency look at that complaint for them in a systematic and general and uniform way.

Mr. GREEN. And I know with our mental health bill we passed—it is still in the Senate—we didn't put that provision from Representative Kennedy in, but it is one we intend to do.

Since 2010, we know there are only 140 cases in which the Federal Department of Labor has found parity violations. It seems un-

likely that the parity has been implemented so comprehensively nationwide that there are only 140 violations. What steps can we take to ensure the law is fully enforced?

Mr. SELIG. Well, thank you for that question. I would say several things, and many of them are embodied in Congressman Kennedy's bill, which I think is on the mark in many ways. We do feel like Federal reporting requirements for health plans are important, for health plans to be required to demonstrate how they are complying with parity and have that information public.

We also think that random audits of health plans are important as a check on the self-reporting that insurance companies do. We also, again, believe strongly that there must be a simplified consumer complaint process and much greater public education that will help people understand what their rights are under the parity law and how to vindicate those rights and understand when a denial is inappropriate or maybe when it doesn't violate parity.

I also support some of the provisions for sure in the legislation that the committee did pass. The compliance program guidance document that was included in that legislation I think would provide a very valuable, as I said in my opening statement, kind of common law, a record of how the Government has interpreted certain limits by health plans and to give health plans and insurers a greater understanding of what are appropriate denials and what aren't.

Mr. GREEN. Thank you. We are out of time. But we even have problems with the physical health, because I have folks who think they have insurance, and they show up at the hospital that is on their network, and all of a sudden they find out—nowadays, the practice of medicine, there are different providers that are not part of that system. So when they leave, they find out they are out of network. And so it is confusing, both—the mental side probably worse than the physical side, but we have those problems there.

Thank you, Mr. Chairman.

Mr. GUTHRIE. Thank you.

I am going to try to stick to the 5 minutes as much as possible so we can get more questions in. There is actually a memorial service for 9/11 coming up this morning as well.

Dr. Bucshon from Indiana, you are recognized for 5 minutes.

Mr. BUCSHON. Thank you very much, Mr. Chairman.

First of all, I would just like to outline, you know, again, the problem, and it goes across all socioeconomic statuses. I have a high school friend in my class who recently died at age 54. She had schizophrenia. Their life expectancy is shortened. She had two children and her husband divorced her and changed the children's names. And she ended up on the street because of really probably a multitude of factors, but one of those was her ability to get treatment.

I also had a high school friend who came home for Christmas break in college and broke up with his girlfriend and a couple weeks later committed suicide at college. No other indication. But the question in my mind is, you know, on college campuses, was there any indication that he was struggling?

And that is true, because my son, one of his fraternity brothers who graduated in May and who had a job just committed suicide at age 22.

So this is really something we need to address. Twenty-two veterans a week we are losing. I just wanted to outline the problem, as we all know, but for the record.

And it is important to know that most mental health patients have other medical issues. In Indiana, there are a couple centers close to my district—Centerstone in Bloomington, Hamilton Center in Terre Haute—that coordinate both traditional medical problems and mental-health-related issues, including substance use disorder.

So, Dr. Trangle, this is a subject that is really—also, I was a medical doctor before I was in Congress. I was a surgeon. So I understand this.

Why do you think it has been so difficult to get mental health parity and treatment for mental health issues? I mean, they can be chronic problems, I understand. But, you know, diabetes, congestive heart failure, these are all chronic problems. Why? I mean, I think we all know probably the answer. But, in your experience, why are we still struggling to be able to have parity in how people are treated because they happen to have a mental health issue?

Dr. TRANGLE. I think the tradition in medicine is to have things siloed up, you know, and not thinking holistically, not having people be physically in the same place, not sharing the same EMR, and not talking about these things.

Some of the examples you mentioned—diabetes, cardiovascular disease, heart failure—have a significantly increased incidence of depression. If somebody has an AMI and they are depressed and you don't recognize it, they will have higher mortality, not because of the physiology, because they don't do their cardiac rehab. We need to screen for depression throughout all of primary care, throughout health plans' members, and then make sure for those that are screening positive we follow up. Ideally, you follow up in primary care clinics where you don't have to get somebody to get over their own stigma and go to a more embarrassing place of a mental health clinic. You need to be able to virtually talk to the primary care docs and help them with advice, with recommendations, with consults, things like that.

Mr. BUCSHON. Mr. Selig, maybe you can help, because you are involved in dealing with trying to help people get coverage. I mean, as a healthcare provider, still for years I have had this issue. I mean, I had patients that were inpatients that I did open heart surgery on that clearly had mental health issues. I diagnosed a number of people who were bipolar and depressed and everything and had a hard time getting—there is a physician shortage, which we can address.

But, in your mind, what is your opinion, what is the impetus for difficulty getting coverage for, say, depression versus diabetes? I mean, it doesn't make a lot of sense, really. I mean, do you have any insight into that?

Mr. SELIG. Well, I have a couple of thoughts about why the parity law, which is, you know, a landmark law, why it is hard to—has been hard to implement. First of all, there is a patchwork of agencies that have to enforce the law. So we have the Federal Gov-



ernment, which directly enforces it with self-insured plans and also can provide guidance to State agencies. And then you have 50 State agencies, divisions of insurance, and also Medicaid offices that all have to enforce the law in all different ways. So there is a patchwork of interpretations of the law.

Mr. BUCSHON. I guess the question is, why would you need to have to interpret it? Why do you need a parity law in the first place? You see what I am trying to get at? I don't know if we can answer that question today.

Ms. GREENBERG. Dr. Bucshon.

Mr. BUCSHON. Yes, Ms. Greenberg, do you have any insight?

Ms. GREENBERG. If you don't mind for a second, Mr. Selig.

I think part of the issue too is that there is a great stigma associated with mental health and addiction. And so we have treated typically mental health and addiction in our healthcare system differently than behavioral health. That is not the right answer, not the right thing to do. But people are afraid to talk about their mental health and addiction for fear of being ostracized or—

Mr. GUTHRIE. We are going to have to get more questions in, so hopefully you will have the opportunity to answer further through some other questions moving forward.

But I would like to recognize Ms. Matsui from California.

Ms. MATSUI. Thank you very much. And I would like to thank all the witnesses for being here today to testify on such an important issue.

One of the main reasons that I have heard with parity enforcement stems from the fact that there are different Federal and State agencies responsible for overseeing and enforcing the parity law. This patchwork is a little bit of the nature of the game. The Federal law sets a standard, and States can make more strict parity laws, which California does. And States are also responsible in large part for making the rules for their own Medicaid programs.

Mr. Selig, can you give an overview of the patchwork of State and Federal enforcing agencies?

Mr. SELIG. Sure. I will pick up and repeat a little bit of what I was just speaking about and try to do it quickly. So there is a patchwork of enforcement agencies that enforce the parity law. So you start with the Federal Government, which enforces the law for self-insured plans directly, because those aren't under the regulatory purview of the States. Each State has a division of insurance and an office of Medicaid that enforces the law for those respective plans. You also have the TRICARE agency also, as Ms. Greenberg indicated, has a separate enforcement mechanism too. So there are several different agencies that have responsibility for making sure the parity law is implemented and enforced.

Ms. MATSUI. OK. Well, because much of the enforcement tends to be at the State level, especially for Medicaid, it follows that the States should learn from one another about best practices to ensure consistency for consumers. SAMHSA put out a report regarding best practices from seven States. For example, the California Insurance Commissioner's Office worked closely with California's exchange, Covered California, to design benefits under the parity law.

Ms. Greenberg, is the SAMHSA report helpful to your member companies? And what else can we be doing to share best practices, such as interagency coordination, across the country?

Ms. GREENBERG. Sure. Yes. The SAMHSA document, which was released quite recently, is very helpful. We were actually interviewed as a part of that report. And I think sharing of the best practices is one of the most helpful ways to assist with parity implementation. And one of the other things that can be done, as has been mentioned by I think all of us, is the sharing of the identified information.

So whether it be a problem that is found or something positive that is found by any of the agencies that Mr. Selig suggested that are doing the implementation, if they can let people know, this is a problem that we found, and this is how it should have been treated; or this is how the change was made to become parity compliant; or this is an instance where a plan is parity compliant, and these are the things that they are doing that we, the auditors, have found helpful. I think that information and those best practices or, in some cases, unfortunately, worst practices would be helpful to us.

Ms. MATSUI. But how can we encourage more sharing of information at a level where actually things get done?

Ms. GREENBERG. I think to talk—reports like the SAMHSA report, to talk with States and encourage them to release the information, and also to talk with the Federal agencies, which we and other stakeholders have, to encourage them to share that information.

Ms. MATSUI. OK. Well, thank you.

There are today up to 30 million Americans experiencing eating disorders during their lifetimes. However, one in 10 of these Americans will receive treatment due to a lack of early identification and treatment coverage.

You know, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act was designed to ensure health insurance plans covering mental disorders and substance use disorders would provide the same favorable level of coverage as they would for medical/surgical benefits. Since the law has been finalized, we have heard that there are still gaps in coverage for mental health disorders, especially for people with eating disorders.

With my colleague, Congressman Lance, we led the effort to include provisions to clarify coverage of eating disorders benefits, including residential treatment, within the mental health bill that passed the House before the August recess.

Dr. Trangle, in your experience, what is your understanding of how private health insurance contracts handle eating disorders?

Dr. TRANGLE. Thanks for the question. I think it is a great one. As my organization has grown, we combined with another organization, and we now own something called Melrose Eating Disorder Center. And our organization is really intent upon trying to simultaneously improve the measure of the quality, patient satisfaction, and making it more affordable.

As we kind of integrated this eating disorder place into our hospital, into our system, we looked at it from all different directions. What is the quality? Were they measuring outcomes? They weren't.

What was the expense? It turned out our employers were complaining about the expense and the number of high-buck cases and were thinking about excluding eating disorders from their benefit sets, the self-insured employers. We looked at it and basically said: We want to shift this a bit. And we created levels of care, like intensive outpatient treatment teams, to be mobile and work with them and much more intensive. It helped us reduce the length of days for inpatient. We created more outpatient resources. Ultimately, people are in care longer, but it is at less expensive levels of care. The cost has gone down, and the outcomes have gone up.

Mr. GUTHRIE. Thank you.

Ms. MATSUI. Thank you.

Mr. GUTHRIE. You might want to submit more of that to the record. If you want to answer more, you can submit that to the record. I appreciate it very much.

Mr. Collins of New York, you are recognized for 5 minutes.

Mr. COLLINS. Thank you, Mr. Chairman.

Dr. Trangle, if you could speak closer. When I ask you a question, I am going to maybe 4 inches from the mike, because that is how sensitive they are.

Anyhow, I want to thank the witnesses for coming, and I don't think there is a family in America that is not impacted by mental health at one stage or another. It is such a multifaceted problem, I think. Unlike some traditional medical issues, I actually believe mental health is almost individualized to so many contributing factors. It is hard to take six patients that may seem similar and say that it is all the same thing. So, again, I think this is a very useful hearing to kind of deep dive: What is going on? How we can do better?

Just as a point of interest, my district includes the only veteran suicide center in the United States. So every veteran who would have that unfortunate urge to commit suicide, when they call in, they end up at a call center in Canandaigua, New York. So I have spent a significant amount of time there talking to those who are answering the phone calls. And it just became clear that the problems ranged from opioid abuse to PTSD to then PTSD leading to more opioid abuse and substance abuse. It is such a tragic thing that is going on in this country and, in some cases, with the youth.

So, again, I appreciate all your testimony. But I also know there is a balance between State regulations, Federal regulations, more regulations that we have to address.

So, Dr. Trangle, I will just maybe ask my first question to you.

Mr. COLLINS. As a clinician, would more Federal rules, more Federal disclosures, and more Federal audits, because that is what we are here, the Federal Government, would this help in any way streamline care, or as a clinician do you feel that more regulations at the Federal level would potentially burden a system that is already pretty highly regulated, as Mr. Selig pointed out?

Dr. TRANGLE. Yes. Let me try and answer that. I almost feel like I am living in parallel universes. I think about what—

Mr. COLLINS. If you stand a little closer, like 4 inches—

Dr. TRANGLE. It feels like I have these conversations with patients and families—I am going to eat it while I talk.

Mr. COLLINS. That is—we will use that.

Dr. TRANGLE. I feel like I live in a world where I am talking with patients and families kind of in the clinic, and the kind of information they want is really sort of—like last week there was a social worker seeing someone. And the patient was someone who was chronically depressed and I think beginning to get a little bit manic and having some kind of thought disorder. And we talked about what do we need to do. You know, there was not necessarily a clear suicidal thought, a little vague thought about a bridge. And the discussion was, does this person need to be in an inpatient unit, which means being locked up and much more restricted? Do they need to continue to see somebody once a week? No. Ultimately, we came up with the idea this person should go to a partial hospital program where they would see a psychiatrist every day, they would get started on an antipsychotic, talk about suicide, make sure they were safe. And it was not all or nothing.

You know, you need to have some checks and balances, and people that are making the recommendations know what the resources are and what is the right care at the right level of care at the right time.

We have similar checks and balances that we struggle with. Somebody came to me and said: I read about Ketamine and I know it works for depression and I want you to change—and our depression scores showed that she was actually getting better but not fast enough for her. And she said: I want you to order Ketamine and I want the health plan to pay for it. And this didn't even go to the health plan review. I said: I am up on this literature. And Ketamine has a number of individual studies showing rapid response for depression, but it doesn't last. As soon as you stop getting the IV Ketamine, you get depressed again. It is not going to be a good solution long term.

You know, how do you have checks and balances to make those decisions and not have people like primary care docs who don't necessarily know all the details saying: This is what I am recommending, but somebody with more knowledge is involved and gets the right care at the right time for the patient? It is a separate issue. But more is not always better. It is what you share and what you communicate.

Mr. COLLINS. Yes. Thank you.

I guess, Ms. Greenberg, let me ask you kind of a similar question. There are so many State enforcement laws, as Representative Matsui, you know, alluded to a Federal, State, et cetera, et cetera. Do you think that the State enforcement laws at that level are adequate for the oversight and parity standards or do we need more Federal intervention?

Ms. GREENBERG. I think what we need is more uniformity in the enforcement. Whether you are a State or whether you are the Federal Government, the parity laws should be enforced consistently and uniformly. And if there can be some direction in that area in terms of education and what are the questions that an enforcer, no matter where they sit, should be asking to determine whether or not a plan is parity compliant, that would be very helpful. I don't know that it has to be legislative. I think the regulators are working to get there.

Mr. COLLINS. Yes. Well, again, my time has expired. I want to just thank all the witnesses. This is such a complicated issue. And I thank Representative Kennedy for asking that we hold this hearing. And I think it is being useful. And I yield back.

Mr. GUTHRIE. Thanks for that. I appreciate it.

Mr. Kennedy from Massachusetts, you are recognized for 5 minutes.

Mr. KENNEDY. Thank you. And I appreciate the kind words from Mr. Collins.

A couple of quick points here. First, for Mr. Selig, I want to thank you again for your tireless work on behalf of the patients and their families. We hear anecdotes time and again about patients who struggle to get access to the care that they need. In your experience, what is the greatest barrier to that care, and is it insufficient reimbursement, inadequate networks, shortage of suppliers? And we will start there.

Mr. SELIG. Thank you, Mr. Kennedy, very much. And thank you for your very hard work on this issue.

I think that there are many barriers to mental health and substance use services. And insurance barriers are certainly a leading one, and that is obviously the topic of today's hearing. That being said, there are other barriers to mental health and substance use care that I think are worth noting.

Workforce shortages, which has been mentioned today—

Mr. KENNEDY. Can I push you on that one.

Mr. SELIG. Sure.

Mr. KENNEDY. And I just ask just because the timing is brief, we have restrictions here. But all of you have mentioned workforce shortages in your testimony. And, Dr. Trangle, you went into this in some detail.

For programs that you put forth, loan forgiveness, reimbursement rates, would you support movement on all of those to address the workforce shortages issues? Ms. Greenberg.

Ms. GREENBERG. Would we support—yes.

Mr. KENNEDY. Yes. Dr. Trangle?

Dr. TRANGLE. Absolutely.

Mr. KENNEDY. And Mr. Selig?

Mr. SELIG. Oh, 100 percent. Absolutely. Loan forgiveness and better reimbursement would be critical for that.

Mr. KENNEDY. Great.

Ms. Greenberg, my cousin Patrick served in the House, and he worked tirelessly to pass a groundbreaking mental health parity law. And again, I want to thank you for your early support for that legislation and for ABHW's work. Years later, we worked to try to implement the spirit and the letter of the law. And the final rule for mental health parity clearly indicates that it, quote, "requires the criteria for planned medical necessity determinations with respect to mental health or substance use disorder benefits be made available to any current or potential beneficiary or contracting participant upon request in accordance with regulations," end quote.

One of the challenges we hear over and over and over again, including from my legislative director who spent, again, 2 hours on the phone with an insurance company whose folks, representatives, had no idea what she was talking about, to the extent that they

said: That information doesn't exist. And she said: Well, then you are not in compliance with Federal law. I can go through the minute-by-minute readout.

I understand the fact that this is very complex, and most experts in this room would still struggle with that level of complexity. But the complexity can't be the barrier to information for a patient to be able to get access to that care. So how can we—how can parity be strengthened—the enforcement of parity—and the legislation that we have authored doesn't try to touch the actual requirements around parity. It merely says: Shine a spotlight on it to make sure that the information is available so that we can ensure that parity is being complied with.

So if the issue is complexity, and it has been 10 years since this law has been passed, can't we find a way to simplify some of the information so that consumers can digest it?

Ms. GREENBERG. Yes. I would like to work with you and others that are interested in this topic to try to find what is that kind of concise document that we can give out. And I think that would help insurers understand, OK, what are the components that should and need to be given and also help with consumers, because they would have then an understandable document.

I will say that I agree with you, the medical necessity criteria should be disclosed. That is part of the law. Many of our member companies have it up on their Web site. And in that specific situation, if that is still an issue, I would like to help with that as well.

Mr. KENNEDY. Great. And great that that was one specific company. And, you know, there is obviously many plans and challenges out there. But one of the challenges that we also hear over and over and over again is that there should be a central clearinghouse for—essentially, a database for issues and complaints that arise so that information again can come in a centralized location so that regulators, advocates, patients can understand what services they can get, what is covered, what isn't, given the complexity of this law, and the challenges for it. That is part of what is contemplated in our legislation.

And I would love to get your thoughts on, again, how we can ensure that the transparency requirements—we shine a greater light on that transparency.

Ms. GREENBERG. Sure. And we do support the idea of a consumer portal that I know is in your legislation. And also we would say, and I think you do as well, deidentified information.

Mr. KENNEDY. Of course.

Ms. GREENBERG. And people always remind me to say not just the problems but also deidentified but show the good things that have happened and where there have been success stories in parity, because there are some of those as well.

I don't know, Congressman, whether legislation is necessary to do this. I think, you know, that strict and strong conversations with the regulators. And, frankly, we have already seen, as a result of the attention you have brought to this issue, guidance issued in the last few months on the—more guidance issued on the disclosure topics. So you are shedding a sunlight on it.

Mr. GUTHRIE. Thanks. We are going to—I hate to—

Mr. KENNEDY. No, Mr. Chairman.

Mr. GUTHRIE. Mr. Kennedy, do you have other things—

Mr. KENNEDY. I have a number of documents I would like to introduce for the record. And, again, I appreciate the time. But a letter from a number of advocacy organizations, testimony from former Representative Patrick Kennedy, and a couple of letters from other advocacy organizations that I would like to submit for the record.

Mr. GUTHRIE. Without objection, so ordered.

Mr. KENNEDY. Thank you.

[The information appears at the conclusion of the hearing.]

Mr. GUTHRIE. Thank you, Mr. Kennedy. And I will compliment you on your passing of this as well.

Mr. Schrader from Oregon is recognized for 5 minutes.

Mr. SCHRADER. I yield my time to Representative Kennedy.

Mr. GUTHRIE. Representative Kennedy is recognized.

Mr. KENNEDY. Mr. Schrader, you are a good man.

So let's focus a little bit, since I have a couple more minutes, on the reimbursement issues.

My understanding—again, Mr. Selig, we can start there—well, actually, Dr. Trangle, we can start with you. Particularly issues around Medicaid. If you could talk a little bit about how low reimbursement rates affect, in your opinion, the access to care that professionals are able to provide for the poor.

Dr. TRANGLE. You know, I know I read an article that came out just this past week, I think it was in JAMA, where they talked about—it did document some variability there, as well as sort of variability in how many psychiatrists were participating in what plans. So I know there is data out there nationally of how that plays out.

In our area, I don't think we necessarily—what we have are psychiatrists that opt out of the system totally and will take cash only and take nobody with insurance, is the bigger issue in our area versus not taking one versus the other.

Mr. KENNEDY. Generally—

Dr. TRANGLE. Workforce issues for general population, especially the mentally ill.

Mr. KENNEDY. So generally speaking, looking at insurance rates, reimbursement rates, private insurance generally reimburses at a higher rate than Medicaid would. Fair?

Dr. TRANGLE. Correct.

Mr. KENNEDY. So one of the challenges that we have faced, even over the course of the past couple years, is that we have been searching for information about Medicaid's reimbursement rates for mental health services. Not the joint Federal/State program, CMS actually doesn't compile a national database of what those rates are.

So I was wondering, Ms. Greenberg, is there some information that, given the companies that you represent and the scope that—the number of States that your companies practice in, that data clearly exists, it is just that the Federal Government doesn't have access to it because, in our conversations even with CMS, they have indicated the nature of a joint Federal/State program, that information is lodged in the States and many of those States aren't—

they are not required at all to divulge that reimbursement rate information to CMS or to the Federal Government.

You guys obviously deal with those issues on a daily basis. Is there a way that we can try to ascertain, that this committee can ascertain, what reimbursement rates look like for Medicaid across the country? Can you help with that?

Ms. GREENBERG. I would be happy to try. To be honest, it is not an issue that I have—or the question that I have asked before of our member companies. But I certainly would be happy to ask them that question and see—or maybe they don't—they don't have it or can't give it out, but maybe they know someone in the State level that can help with that. So yes, I would be happy to look into that.

Mr. KENNEDY. It just strikes me as we have heard some of the challenges of parity, but we have also heard from all of you today the struggles with workforce. If we are looking at struggles with workforce and Medicaid is the largest payer of mental health services in this country, that if we are not looking at reimbursement rates as one of the drivers for workforce shortage, then it is tough to address that issue for workforce if we are not looking at the compensation mechanisms for those professionals.

Ms. GREENBERG. Sure. Yes.

Mr. KENNEDY. Do you want me to keep going?

Mr. SCHRADER. Sure.

Mr. KENNEDY. Great.

So if I can continue, Ms. Greenberg, so insurance companies often state that they are making efforts to comply with the law. And in your testimony with mental health parity, your testimony, you indicated that. Why is it that given a good-faith effort to comply with the law, why is it that 10 years on we are still struggling with the actual receipt of that information and struggling with patients being able to gain access to the care that they need when they need it and even understand what services are available to them?

Ms. GREENBERG. There are so many reasons. You know, it is, as I think everybody knows, it is a complex law and regulation. The regulations came much later than the actual law did. So enforcement of the law began—or, sorry—of the final regulations began in 2014. So while the law passed in 2008, the regulations haven't been in effect for as long a period of time.

I think also we have seen some things, like some of the larger disclosure issues have come later through guidance that has been issued by the regulators versus the initial disclosure that specifically was around medical necessity criteria and reasons for denial. And through guidance we have seen that expand a little bit. So trying to get our head around, OK, what are those documents that you are talking about, what format, you know, as we have discussed here today, are you looking for that information? And it is—as I mentioned in the testimony, we have had dozens of meetings with regulators. There are gray areas, as there are with all regulations, that we have spent countless hours trying to understand.

Mr. PITTS [presiding]. Thanks.

Mr. Kennedy's time has expired. Dr. Schrader, we have a 9/11 memorial service at 10:30 I know some of us are trying to get to.



But Ms. Castor from Florida, you are recognized.

So I apologize for cutting you off.

Ms. CASTOR. Thank you, Mr. Chairman. I want to thank Congressman Kennedy and Congressman Green and all of my colleagues for continuing to focus on mental health parity for our neighbors back home. And thank you to the witnesses.

There have been many significant changes to mental health parity and substance abuse parity over the past decade. And as a legislator, it is important to know what is happening in the real world, how does this play out for families.

Mr. Selig, your organization, Health Law Advocates, represents Massachusetts residents in mental health and substance abuse disorder parity cases. You also communicate with other advocacy groups across the country that are engaged in similar work. Based upon your experience, what is the most common type of potential parity violation you encounter? Or are there a few different ones?

Mr. SELIG. Thank you for the question. There is no question, as I said, that among the people we represent, mental health and substance use care is harder to access than other types of care. That is our experience, and that is the experience that is communicated to us by other advocates and providers out across the country.

The insurance limits that we see most frequently are things like arbitrary limits on things like residential stays for substance use disorders. You know, we have seen several patients, for example, who have lost their coverage for residential substance use treatment, regardless of their condition, after 2 weeks. It is like a hard stop and then that is it and then services are stopped. So that is something that we see as a significant barrier.

The full range of scope of services is also something that we see not being provided to consumers. So especially intermediate services, intensive outpatient services. Again, residential care and other types of services that aren't acute and aren't outpatient are very common.

As I mentioned, we also see unusual limits on medication assisted treatment that seem to be arbitrary and don't necessarily align with what our review of the medical necessity requirements are. So those are some. Also—

Ms. CASTOR. But when you raise the issue with insurance providers, typically is it remedied or is it a fight?

Mr. SELIG. So, you know, it really runs the gamut. When we talk to health plans on behalf of our consumers, sometimes we are able to remedy the problem. We will be able to provide a certain amount of information or provide some clarity on the situation or an analysis of the parity law, in some cases, where we may say we think that this process counters the parity law and the health plan will change its course. In other situations, we will go to appeals internally with the health plan, externally, and we will raise the issues that way. And in a good portion of the cases, those appeals do result in an overturning of the decisions that are made by the health plan.

So we have a pretty good record, I think, a very good record, actually, when insurance denials occur in changing the outcome.

Ms. CASTOR. It is really too bad that folks need an advocate at all, because they are dealing with the personal issues every day. And thank you for what you are doing.

Congressman Kennedy raised the point of Medicaid reimbursement rates. And I know my colleague, Mr. Green from Texas, would agree that the fact that Texas and Florida have not expanded Medicaid at all is a real barrier to so many of our families receiving the care they need. Do you have an opinion on what Medicaid expansion has meant for families and mental health treatment across the country?

Mr. SELIG. Well, I think the Medicaid expansion really has provided just incredible financial stability and support for State Medicaid programs which enable them to support the, you know, really the entire range of services that members are entitled to, but specifically mental health and substance use services, which are typically, you know, and historically shortchanged. So I think it has been just hugely successful in that way.

More people are enrolled in insurance, obviously, because of the expansion. People have better coverage. And so I would—you know, undeniably, the expansion has, in all sorts of different ways, helped people throughout the country access mental health and substance use services.

Ms. CASTOR. I hope they hear that back home in my State capital. The most important thing for the mental health of a lot of my neighbors would be for the State of Florida to expand Medicaid. So thank you very much.

And I yield back.

Mr. GUTHRIE [presiding]. Thank you, Ms. Castor.

I recognize Mr. Luján from New Mexico for 5 minutes.

Mr. LUJÁN. Thank you very much, Mr. Chairman.

Well, I am a cosponsor of Congressman Kennedy's legislation and I applaud all the work that Congressman Kennedy is doing in this space to continue much of the work that has been done by the Kennedy family and carrying on with the work that was done by both Senator Paul Wellstone and Senator Pete Domenici, senior Senator from my home State of New Mexico.

In New Mexico, right now, we have an issue before us where the State of New Mexico under Governor Susana Martinez unnecessarily suspended payments to 15 behavioral health providers, claiming fraud. And the system was thrown into chaos. Now, even though every provider has been exonerated by the attorney general of the State of New Mexico, many of these providers have been forced to close their doors. And we all know who is left out. It was patients. It was the people that needed help the most.

And so, Mr. Selig, can you talk to us about what such a disruption means for someone struggling with mental health issues? If their provider is suddenly gone, the trust that is established to try to get back in that door, what does that mean to someone that is struggling with mental health issues to try to get the support they need?

Mr. SELIG. Well, that sounds like a very regrettable situation, and I am sorry to hear about that situation in New Mexico. We represent, again, a lot of people who have mental health services. And when they are denied coverage, their services are interrupted.

And we have seen really catastrophic effects for people. Their conditions get much worse. Someone with a eating disorder, for example, which is a high priority for us, who needs a particular level of treatment and is denied that level of treatment and is only provided access to a much lower level of care, really, their life is going to be in danger. And that person is really gravely at risk. Also, there is absolutely a connection between lack of addressing mental health and substance use services and deterioration of other health conditions. So when people aren't getting mental health services, other health conditions will suffer too. So people aren't as able to attend to situations like perhaps heart disease or diabetes.

So really, there is a cascading effect when people aren't able to access mental health and substance use care that I think is really life threatening and disruptive, you know, to their lives and livelihoods for sure.

Mr. LUJÁN. Well, along the same questions that Congresswoman Castor was asking that Congressman Green had put on the table with concerns of States that did not have Medicaid expansion. In New Mexico right now, what we are seeing is the State recently made a decision to cut provider Medicaid reimbursement by \$400 million. And especially with the shakeup with the mental behavioral health system, we have grave concern and we are looking for some support.

But specific to the reimbursement rates, Mr. Selig, is a low reimbursement for behavioral health providers in the Medicaid program an impediment to ensuring robust access? And how can we encourage more participation of behavioral health providers in the Medicaid program?

Mr. SELIG. I mean, I think there is no question. I mean, that is what we hear from providers. They would love to be able to provide the services, be reimbursed through insurance. I think the rates are an important factor alongside the other burdensome kind of criteria that health plans place upon them.

But going back to the rates, I think that it is absolutely connected to the inability of consumers to access providers because they are not in the network, because providers choose not to accept insurance because of low reimbursement rates. In Massachusetts, we have recently been able to increase, actually, reimbursement rates for outpatient providers. So we really applaud our State government for doing that. I think there is more work to do in that area, but that has been very well received by the provider community in Massachusetts. And I think it is going to have some impact going forward. So we would encourage other States to do the same.

Mr. LUJÁN. I appreciate that. And, Mr. Selig, the other question I had for you you actually addressed, which was the impact to someone's physical health if they are not able to get the mental health care that they need. And you described exactly that impact. So I appreciate you addressing that.

And, Mr. Chairman, you know, while I hope that the committee and the Congress will move forward to support Congressman Kennedy's legislation, I think the aspects that Congressman Kennedy also raised, which was brought up by our panelists today, about the importance of making sure that we have enough providers available to see everyone that needs care is something else that we need

to take seriously. And the mental and behavioral health bill that passed the United States House of Representatives currently still needs to be funded. And I think everyone on this panel would support full funding of that legislation. And so I look forward to working with our colleagues to get that done.

Mr. GUTHRIE. Thank you.

And Mrs. Capps from California, you are recognized for 5 minutes for questions.

Mrs. CAPPS. Thank you, Mr. Chairman. And thank you all for your testimony. And I want to echo the thanks to our colleague Joe Kennedy for making sure this topic is received in this hearing. I hope it won't be the last one. I hope it is the first of really getting into this issue and doing some of the work we haven't done yet. Because for too long we have artificially looked at behavioral health as totally separate and unrelated to physical health. My previous questioner just made that point. But I want to go into it.

Because we know that the two are so intrinsically linked, we need to ensure that our public policy recognizes the important fact that if we ever really want to help our Nation become more healthy and productive, this topic needs to be addressed. I am proud of the work that Congress has done over the years to address parity between the behavioral health and physical health services. And I want to be clear. We have come a long way, but that is not enough. What we have done is not enough.

Too many individuals are still falling through the cracks. Too many communities, as we have heard, are unable to support those in need of affordable behavioral health services, even though the treatments are there and the results have been documented. I believe we have missed an opportunity to take the next necessary steps to address this issue in mental health legislation we considered here in this committee earlier this year.

So today's hearing is a chance to reinvigorate this conversation, help guide this committee to do what is necessary to ensure that individuals get the care they need when they need it.

Mr. Selig, I know you have been questioned, but you see the shortcomings in this current system so well. And while we know that these issues affect all in need in one way or another, I wonder if you would speak a minute about the compounding effects on more vulnerable and underserved populations like children.

It is estimated that at least 13 percent of children are affected by mental disorders in a given year. Unfortunately, we know that pediatric specialists are few and far between. So in your experience, how does this lack of coverage affect children? Are there any unique access issues faced by children? You mentioned eating disorders, and that is just one. Is there a difference for children in Medicaid and CHDP and those with private insurance?

Mr. SELIG. Well, thank you for raising that, and particularly, Mrs. Capps, for highlighting the needs of children. There is, you know, no higher priority for our organization than trying to access mental health and substance use services for children. We do see specific types of services that are harder—that children have difficulty accessing. I mentioned a couple of them.

Children with autism, very difficult to access, especially applied behavioral analysis services. Eating disorders you mentioned, an-

other. And there are also, I would mention, many children, simply there is a long wait for services. Authorization for coverage may be in place, but—and this particularly speaks to children on Medicaid in our State. There can be lengthy waits for services, and I think that also connects to the issue of the availability of providers.

So I would say that, you know, children, as much as any other population, are impacted by this kind of thing. They have very special needs. They see different providers than other people, obviously, and their needs are complex and they are intermingled with school concerns and family concerns. And so we are very cognizant of the needs of children and pay very close attention to them.

Mrs. CAPPS. Thank you. You know, I so agree. I noticed so many—the many years that I worked as a school nurse, having a child on a waiting list is—in Congress in so many ways, because they change so dramatically over the months. Sometimes it is years. And by the time they can be treated and seen, those symptoms they had have exacerbated and become so much worse. And so the impact is so much more than their health. It affects their education, their ability to learn and work. It sets them on a pathway that is destructive, not opportunity challenging.

And it is clear to me that any barriers to getting the care they need are not only harmful for the child, they really impact our society as a whole. The whole family is affected by it. It is really an urgency. And that is why we have to make sure that these services become more available.

Again, I want to salute my colleague Joe Kennedy, and pledge my support for making sure this topic stays on the table and that it actually goes somewhere further. Thank you very much.

And I am yielding back.

Mr. GUTHRIE. Thank you.

I also want to thank Mr. Kennedy and Chairman Upton and Vice Chairman Pitts for working together to make this hearing come together. I thank the witnesses for being here. I think that concludes all of our questions.

Mr. KENNEDY. I will take them if I got time.

Mr. GUTHRIE. Well, no, the 9/11 memorial is coming, and as of now—I want to remind members they have 10 business days to submit questions for the record. And I ask the witnesses to respond to the questions promptly. Members should submit their questions by the close of business on Friday, September 23.

So you have an opportunity to submit more questions, Mr. Kennedy.

And the subcommittee stands adjourned. Thank you for being here.

[Whereupon, at 10:31 a.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

#### PREPARED STATEMENT OF HON. BEN RAY LUJÁN

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act was a signature achievement of New Mexico's longest sitting Senator, Pete Domenici. It was through his perseverance and that of Senator Ted Kennedy and Representatives Ramstad and Patrick Kennedy that Congress finally passed The Parity Act.

But it was just a first step. I thank my colleague and friend, Congressman Joe Kennedy, for his efforts to build on his family's legacy and I look forward to working

together to secure passage of more robust legislation that expands coverage for some of our most vulnerable citizens.

As we all know, parity laws are undoubtedly a crucial step, but laws mean very little without access to mental health service providers and mental health facilities.

In my State, we do not have a functioning mental and behavioral health system. When the State of New Mexico decided to unnecessarily suspend payments to 15 behavioral health providers claiming fraud, the system was thrown into chaos. Now, even though every provider has been exonerated of the charges leveled against them, the damage has been done—providers have been forced to close their doors and continuity of care has been disrupted for vulnerable New Mexicans.

I hope today's hearing will bring light to the many challenges faced by our mental health system and will serve to educate all of my colleagues on the importance of strengthening mental health parity laws and expanding access. Everyone deserves to live their healthiest lives, and mental health is no exception.

This should not be a partisan issue—it is simply the right thing to do.

**America's Health  
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August 31, 2016

Ms. Cecilia Muñoz, Chair  
Mental Health and Substance Use Disorder Parity Task Force  
c/o Domestic Policy Council  
The White House  
1600 Pennsylvania Ave. NW  
Washington, DC 20500

*Submitted electronically via parity@hhs.gov*

Dear Ms. Muñoz:

On behalf of America's Health Insurance Plans (AHIP), I am writing to address issues surrounding mental health and substance use disorder parity.

AHIP is the national association representing health insurance plans. Our members provide health and supplemental benefits to the American people through employer-sponsored coverage, the individual insurance market, and public programs. AHIP advocates for public policies that expand access to affordable health care coverage to all Americans through a competitive marketplace that fosters choice, quality, and innovation.

In this letter, we highlight our industry's commitment to parity and to meeting the needs of patients with mental health and substance use disorders. We also address some of the challenges associated with treating patients with mental health and substance use disorders, most notably the national shortage of clinicians who are qualified to treat patients with behavioral disorders, and we offer recommendations for the Task Force. Additionally, we offer comments on guidance the Administration has issued addressing: (1) whether insurers can rely on data for their entire book of business in testing whether a plan passes the "substantially all" and "predominant" level testing required under federal law for testing financial requirements and quantitative treatment limitations; and (2) disclosure obligations under federal law for medical necessity determinations with respect to mental health and substance use disorder benefits.

**Health Plans Promote Access to Quality, Affordable Behavioral Health Care**

Our members support the protections established by the federal Mental Health Parity Act (MHPA), and as amended by the Mental Health Parity and Addiction Equity Act (MHPAEA), as well as state requirements. Health plans have worked diligently to ensure compliance with parity

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requirements – involving clinical and administrative personnel across both medical and behavioral departments to promote understanding and implementation of parity rules. A 2013 report prepared for the Department of Health and Human Services found that “...employers and health plans have made substantial changes to their plan designs in order to comply with MHPAEA...”<sup>1</sup>

Beyond parity, our members have been leaders in pioneering innovative programs focused on ensuring that patients have affordable access to high-quality, evidence-based treatments. We recently conducted a series of interviews with some of our member plans to document the range of creative and comprehensive approaches to meeting the needs of patients with mental health and substance use disorders. Our issue brief, *Ensuring Access to Quality Behavioral Health Care*, describes a number of these plan-specific initiatives.<sup>2</sup> The following are key components of these programs:

First, these programs rely on *proactive identification and outreach*. Because of the oftentimes close link between physical and behavioral health, health plan medical care managers working with patients with chronic medical conditions screen for behavioral health concerns and, if any potential issues are identified, they work with the plan’s behavioral health care managers to help these patients navigate the system and coordinate ongoing care. This process runs parallel to the processes used to assist patients with chronic medical conditions.

Second, these programs are founded on *quality, evidence-based care*. Using nationally-recognized external sources supplemented with internally-utilized evidence-based criteria, health plans develop clinical guidelines for behavioral health conditions in the same way they do for medical conditions. As with medical conditions, recognized quality metrics are used to track and improve behavioral health care quality.

Third, just as with medical conditions, *coordination and integration* are essential to securing follow-up care, managing medications, and identifying community support resources. Some plans have created behavioral health home models; others have embedded behavioral health clinicians in primary care practices or trained primary care physicians to identify behavioral health conditions in their patients. These approaches are consistent with and integral to health

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<sup>1</sup> Consistency of Large Employer and Group Health Plan Benefits with Requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. Prepared for the Office of Disability, Aging and Long-Term Care Policy, Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. November 2013.

<sup>2</sup> Ensuring Access to Quality Behavioral Health Care: Health Plan Examples, AHIP, May 2016, <https://www.ahip.org/ensuring-access-to-quality-behavioral-health-care/>.



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plans' overall efforts to implement delivery system reforms that improve value and outcomes for patients.

Fourth, health plan programs strive to provide *timely access* to behavioral health care. In addition to meeting state and federal network adequacy requirements, health plans actively recruit behavioral health clinicians, monitor the availability of appointments, help members get appointments when needed, and many plans are also using telemedicine to augment network capacity.

#### **Workforce Shortages and Other Challenges Undermine Access**

It is important to note that challenges exist in all of these areas. For example, federal rules limit the sharing of substance use information among clinicians, affecting coordination and integration of care. A lack of behavioral health outcomes measures makes it difficult to effectively track quality and measure improvement. And the uniqueness of behavioral health conditions can sometimes make a direct crosswalk with medical conditions difficult. However, one of the most significant challenges is the widespread shortage of appropriately licensed behavioral clinicians, particularly psychiatrists and psychologists who specialize in caring for children and adolescents. This shortage of behavioral health clinicians is an issue that must be addressed separately from MHPAEA as it spills over into reduced hours of operation for many behavioral health facilities and more limited behavioral health community resources. The reduced capacity of the behavioral health workforce, paired with the scarcity of community support options, is an area needing community-based solutions that could greatly improve plans' ability to provide timely access to behavioral health care.

Further exacerbating the workforce shortage is the number of behavioral health clinicians who refuse to participate in health plan networks, resulting in patients having to pay out-of-pocket for behavioral health treatment or forgo treatment altogether.<sup>3</sup> Our members continue to actively recruit behavioral health clinicians for their provider networks. We also recognize the importance of timely and accurate information in health plan provider directories to assist consumers in accessing care. In April 2016, AHIP kicked off a six-month intensive pilot to explore joint health plan-provider solutions to making provider directories more accurate and up-to-date.<sup>4</sup>

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<sup>3</sup> Bishop, Tara F et al. Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care. *JAMA Psychiatry*. 2014;71(2):176-181. Accessed on June 24, 2016 at <http://archpsyc.jamanetwork.com/article.aspx?articleid=1785174>.

<sup>4</sup> Provider Directory Pilot: Program Overview and FAQ, AHIP, <https://www.ahip.org/wp-content/uploads/2016/03/Provider-Directory-FAQ-1.pdf>.

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Another challenge to improved access and consumer awareness relates to the multiple jurisdictions and perspectives on the laws and regulations applicable to mental health and substance use disorder treatment. The overlap of jurisdiction is one area that has caused confusion for consumers as well as health care entities in determining what law or regulation governs. For example, states may have regulations that meet the federal standards and add state requirements, as long as they do not conflict with or prevent the application of federal standards, but some of that guidance or interpretation about the application of federal parity requirements, or whether federal regulators retain the “final say” in interpreting laws, regulations, or sub-regulatory guidance may not be clear to all parties. And situations where several requirements that may apply (e.g., HIPAA, the federal “Part 2” confidentiality regulations, a state law that is more stringent than federal requirements) create complexity as well. We believe that expanding the ability of consumers and stakeholders to share examples of these types of challenges, with information and scenarios shared with the Mental Health Parity Task Force and other state and federal regulators in public events can promote a better understanding of the legal requirements and how they apply in a variety of real-life contexts.

#### **Information Lacking on Quality of Behavioral Health Facilities**

Another significant challenge is the lack of readily available information on the quality of behavioral health facilities, including data on patient outcomes to help consumers make decisions. According to a 2012 HHS report, there are 256 private psychiatric hospitals, 1,292 non-federal hospitals with separate psychiatric facilities, and 672 other facilities with adult residential treatment capacity.<sup>5</sup> Yet, in contrast to medical and surgical facilities where there are well documented quality measures and well established certification/accreditation programs, there is little information on the quality of psychiatric facilities or patient outcomes.

Despite recent efforts, quality measurement for even the more common behavioral health conditions is less well developed than for comparable general medical conditions.<sup>6</sup> Measurement and reporting of quality data on inpatient stays through Hospital Compare, for example, have led to significant improvements in quality and patient safety.<sup>7</sup> Additionally, the American Heart Association, the American Diabetes Association and the American Cancer Society have collaborated to promote the use of evidence-based treatment guidelines, performance measurement tools, and quality improvement strategies. These collaborations have

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<sup>5</sup> Behavioral Health, United States, 2012, U.S. Department of Health and Human Services, <http://media.samhsa.gov/data/2012BehavioralHealthUS/2012-BHUS.pdf>

<sup>6</sup> Institute of Medicine: Improving the Quality of Health Care for Mental and Substance-Use Conditions. Washington, DC, National Academies Press, 2006.

<sup>7</sup> <https://blog.cms.gov/2016/05/25/cms-continues-progress-toward-a-safer-health-care-system-through-integrated-efforts-to-improve-patient-safety-and-reduce-hospital-readmissions/>

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resulted in programs for stroke, arterial fibrillation, heart attack, and resuscitation that allow facilities to measure performance based on nationally recognized quality measures. Such an effort is lacking in behavioral health, even for the most common conditions such as anxiety disorders, bipolar disorder, dementia, schizophrenia, and substance use and addiction. Further study is needed with respect to treatment guidelines for behavioral health and the evidence basis for quantitative and non-quantitative limits.

To date, the National Quality Forum (NQF) has identified more than 700 health quality measures overall, but only 30 are directly linked to behavioral health care. Most behavioral health quality measures are clinical process of care measures; only a few, such as depression remission, are outcome measures. The absence of a broadly accepted set of key evidence-based quality and outcome measures for behavioral health impedes the identification of effective clinicians and facilities. While the reporting of quality measures by inpatient psychiatric facilities through Hospital Compare is a step in the right direction, more needs to be done to make such quality information more robust and accessible.

A recent study<sup>8</sup> determined that the collection and use of functional outcome measures present new opportunities for behavioral health care. Broad outcome measures facilitate practice innovations that lead to quality improvement, increase incentives for coordination with other parts of the health and social service system, and provide a basis for comparisons of facilities and clinicians.

The lack of widespread adoption of validated, evidence-based quality standards and certification/measures for behavioral health facilities, particularly inpatient or 24-hour residential care facilities, adds to the difficulty of identifying for consumers and payers which facilities may provide services that will be most effective and reinforces the need for tools and strategies to ensure the safety and appropriateness of treatments. The current landscape of facilities is such that there is a great deal of ambiguity and wide variation in residential treatment facilities.<sup>9</sup> As a result, loose definitions (e.g., residential facilities may include group homes, spas, etc.), an undefined scope of service, lack of evidence supporting effectiveness, and often very long duration treatment options that can isolate the patient from family support and involvement in treatment plans create challenges for improved outcomes, continuity and coordination of care, and patient satisfaction.<sup>10</sup>

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<sup>8</sup> Measuring Performance in Psychiatry: A Call to Action, *Psychiatric Services* 66:8, August 2015.

<sup>9</sup> Marketing Residential Treatment Programs for Eating Disorders: A Call for Transparency 67:6, March 2016.

<sup>10</sup> *Ibid.*

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Certification and accreditation organizations that complement state licensure and certification standards are developing programs for behavioral health residential treatment facilities, including:

- Joint Commission - [https://www.jointcommission.org/accreditation/behavioral\\_health\\_care.aspx](https://www.jointcommission.org/accreditation/behavioral_health_care.aspx)
- Commission on Accreditation of Rehabilitation Facilities - <http://www.carf.org/Programs/>
- Council on Accreditation – <http://coanet.org/about/behavioral-health-roadmap/>
- National Integrated Accreditation Healthcare Organization - <http://www.achc.org/programs/behavioral-health>

The Joint Commission introduced its program in the 1970s and it has evolved over time; as of 2016 they have accredited more than 2,200 behavioral health organizations. The Council on Accreditation released its program in 2012 and has accredited 700 behavioral health organizations. The Commission on Accreditation of Rehabilitation Facilities (CARF) expanded to include mental health programs in the mid-1990s, including community mental health programs, and substance use treatment programs. However, these programs are not widely adopted and many in the field are not yet aware of them.

Additional resources devoted to the development of quality standards and the addition of required certification/accreditation, coupled with evidence-based behavioral health quality measures – particularly outcome measures – are needed to capitalize on the opportunity to identify best practices, quality clinicians and facilities, and drive quality improvement.

#### **Tri-Agency FAQ<sup>11</sup> on “Book of Business” Testing (Q8)**

We appreciate the work that the Administration has undertaken over the past eight years in implementing the MHPA/MHPAEA. Health insurance plans have modified their products and state filings, which can include benefit and plan designs, to incorporate the MHPA/MHPAEA “tests.” Based on a common understanding of how to measure parity under these tests, plans have designed co-payments and benefits and moved forward in making their required state filings, designing marketing materials, and having an actuarially-sound basis for their premiums.

Frequently Asked Question Number 8 (Q8), published by the Administration in April 2016, addresses whether insurers can rely on data for their entire book of business in testing whether a

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<sup>11</sup> Tri-Agency FAQ# 31 question number 8. <https://www.dol.gov/ebsa/faqs/faq-aca31.html>

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plan passes the “substantially all” and “predominant” level testing required under the MHPAEA for testing financial requirements and quantitative treatment limitations. After noting that the MHPAEA regulations permit “any reasonable method” to be used to determine the dollar amount of all plan payments for the substantially all/predominant analysis, the agencies determined in Q8 that “book of business” testing is not a “reasonable method” for those purposes.

The FAQ goes on to recognize each self-insured plan separately and then suggests that each insured group plan offered on an experience-rated basis should be evaluated on a plan-level basis. This fails to recognize that many “large” groups may have fewer than the number of enrollees needed for actuarial credibility for the “reasonable” analysis that Q8 purports to propose. The underlying regulation calls for a demonstration of parity in each of the categories listed, including inpatient, in-network; inpatient, out-of-network; outpatient, in-network; outpatient, out-of-network; emergency care; pharmacy. Because of this, each category should have enough utilization to be credible. This could mean, for example, that thousands of members may be necessary to ensure credibility. Book of business level data is almost always going to be more credible. Use of plan level data would not lead to sufficient volume for all but the very largest of groups leading to testing results that are driven by statistical variation rather than being an indication of a plan with a design that is not in parity. This would seem to be contrary to the intent of the law.

In addition, this FAQ would apply the same plan test standard for insured small group and individual market plans. Recognizing that there may be insufficient data to calculate the substantially all and predominant tests at the plan level, Q8 does allow an issuer to use data at the product level to inform its projections of expected spending in the benefit classification at issue (provided that the issuer can demonstrate the validity of the projection method). However, while product level data allow for a larger data set over which to aggregate, it may not be sufficient to allow for actuarial credibility if enrollment in a product is insufficient.

Additionally, this guidance for the individual and small group markets is inconsistent with how plans are required to rate those products: since plans must rate products based on the experience of the total individual risk pool, and the total small group risk pool. Determining financial quantitative requirements and non-quantitative treatment limitations on a different basis –at each separate plan level, introduces significant inconsistencies that complicate managing premiums.

As drafted, this FAQ creates significant structural change to prior guidance on “reasonable approaches” to determine financial quantitative requirements and non-quantitative treatment limitations. Testing at the plan level can create distortions due to outliers and variance that can skew the data and produce an inaccurate picture of plan spending when a single year is reviewed.

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Such a plan level review would harm consumers especially if variation causes significant swings from year-to-year in deductibles and copays as a result of a single year's experience.

There are additional areas of concern. Even under the testing guidance prior to this FAQ, there have been issues with regard to the testing approach. The testing methodology may result in the same benefit design having different parity testing results when employed in the individual, small group, fully insured large group, and self-funded group markets because of the different populations. Under the FAQ guidance, a plan by plan approach may cause a standard Exchange plan design in the individual market to meet parity testing for one issuer but not meet it for another issuer based on the enrolled population. The agencies may also wish to consider whether alternative methods should be considered that are consistent with the spirit of the parity law, including safe harbors that carve out from testing cost sharing for mental health services that have the lowest level of cost sharing, so as to prevent the counter-intuitive result of requiring deductibles to be increased so as reach parity with medical services/visits.

Another issue raised by this FAQ is the administrative challenge posed by a plan level analysis. A single carrier may have thousands of large group plans (in addition to its many small group and individual market plans) which would require very time consuming plan level analysis – and would have little utility given the distortions presented by the lack of credibility.

Finally, this FAQ does not provide any type of relief in terms of being applied on a prospective basis, and hence, without more clarity, this FAQ could expose prior-year testing results to audit challenges, if such testing was done on a "book of business" basis. For these reasons, we are recommending that Q8 be retracted or revisited which is a consensus recommendation by the industry developed by AHIP, the Blue Cross and Blue Shield Association and the Association for Behavioral Health and Wellness.

If not retracted, we recommend that the FAQ be revised to read as shown below (with the red text representing new language):

**Q: When performing "substantially all" and "predominant" tests for financial requirements and quantitative treatment limitations under MHPAEA, may a plan or issuer base the analysis on an issuers entire overall book of business for the year?**

No. Basing the analysis on an issuer's entire overall book of business expected to be paid for the year or book of business in a specific region or State is not a reasonable method to determine the dollar amount of all plan payments under MHPAEA. While each unique plan of benefits would ideally be tested against the data specific to that plan, an employer/group health plan or issuer may aggregate data to the necessary level, which may be line of

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business, market segment, entity, or product, to assure sufficient data to make projections, based on the standards of actuarial analysis of credibility.<sup>12</sup> To the extent group health plan-specific data is available, each self-insured group health plan must use such data in making their projections. For large fully-insured group health plans, for which the premiums are determined on an experience-rated basis, the issuer should generally have group health plan-specific data to make projections. If the large, fully-insured plan does not have sufficient group health plan-specific data to make projections, data from other similarly-structured group health plans with similar demographics can be utilized for the analysis.

For insured small group and individual market plans, the health insurance issuer should use data at the “plan” level (as opposed to the “product”) to perform the substantially all and predominant analyses, as such terms are defined in 45 CFR 144.103.<sup>13</sup> If an issuer does not have sufficient data to calculate the substantially all and predominant tests at the plan level, it can use data at the product level or aggregate data consistent with the ACA’s single risk pool requirements to inform its projections of expected spending in the benefit classification at issue (provided that the issuer can demonstrate the validity of the projection method based on the best-available data standards of actuarial credibility<sup>14</sup>).

**Q. How will the Departments enforce compliance with the “substantially all” and “predominant” tests for financial requirements and quantitative treatment limitations under MHPAEA?**

The Departments recognize that there has been some uncertainty about prior requirements relating to the relevant level of aggregation to determine the dollar amount of all plan payments for purposes of conducting the “substantially all” and “predominant tests” under MHPAEA. With regard to enforcement, the Departments will take into account good faith efforts to comply with a reasonable interpretation of the MHPAEA regulations in analyzing whether enforcement action is appropriate under these tests.

<sup>12</sup> Standards of actuarial analysis that provide for the recommended basis are outlined in the Actuarial Standard of Practice No. 25 (ASOP #25) Developed by the Actuarial Standards Board ([http://www.actuarialstandardsboard.org/wp-content/uploads/2015/03/asop025\\_143.pdf](http://www.actuarialstandardsboard.org/wp-content/uploads/2015/03/asop025_143.pdf)).

<sup>13</sup> 45 CFR 14404.103 states “product means a discrete package of health insurance coverage benefits that a health insurance issuer offers using a particular product network type within a service area, and “plan” means, with respect to an issuer and a product, the pairing of the health insurance coverage benefits under the product with a particular cost-sharing structure, provider network, and service area.”

<sup>14</sup> Op cit. ASOP #25.

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**Tri-Agency FAQ<sup>15</sup> on Disclosure and Non-Quantitative Treatment Limits (Q9)**

The Administration has issued FAQ guidance pertaining to disclosure obligations under the MHPAEA for medical necessity determinations with respect to mental health and substance use disorder benefits. Health plans have been meeting those obligations under the MHPAEA standard for the past 18 months, and will continue to assure they provide the necessary disclosure to consumers and clinicians when there are requests or appeals.

While we recognize that the intent of the additional guidance is to build on existing disclosure requirements, we are concerned that the changes will not result in the availability of meaningful, consumer friendly information. The disclosures required by FAQ 9 are intended for consumers to provide documentation to help them understand what services may not be covered and associated reasons, however in its current form easy to understand information to assist consumers is not available. Health plans are developing communications on mental health services that are consumer friendly, and we recommend that the guidance focus on developing in layman's terms general information on processes and tools plans use to make medical policy decisions, such as:

- Description of process
- Who is involved
- How decisions are made
- Define medical management tools (prior authorization, concurrent review, etc.)

In addition, we recognize that questions have been raised as to the use of non-quantitative treatment limits (NQTLs) for mental health and substance use and the variation of such limits when applied to medical and surgical benefits; and it is important to understand where and when health plans apply such limits and the challenges pertaining to mental health and substance use disorder services. Health plans, employer-sponsored plans, and government-sponsored health care programs have long utilized medical necessity review for medical and surgical procedures to ensure that patients are receiving optimal care based on well-established evidence of efficacy and safety, while providing benefits to the individual patient. NQTLs are permitted with regard to mental health and substance use provided that the "processes, strategies, evidentiary standards and other factors" used in applying the NQTL are comparable to medical/surgical benefits and not more stringent.

Medical necessity review is generally done when there is a lack of or conflicting evidence supporting a particular therapy or drug, safety concerns especially for specific populations, questions pertaining to a therapy's effectiveness for a specific population, licensure

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<sup>15</sup> Tri-Agency FAQ# 31 question number 9. <https://www.dol.gov/ebsa/faqs/faq-aca31.html>



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requirements, and questions regarding benefit design. As the preceding discussion about measuring quality makes abundantly clear, there is less information on the quality of behavioral-related outcomes, more gaps in evidence, and therefore may be more safety and effectiveness concerns than with respect to medical/surgical care where there are well documented and evidence based quality measures. Health plans use nationally recognized care criteria for all therapies – medical, surgical, mental health or substance use – such as Milliman Level of Care Criteria, or American Society of Addiction Medicine (ASAM) criteria for chemical dependency, the input of a plan’s pharmacy and therapeutics committee composed of specialty clinicians for specific medical protocols, and consideration of the latest medical evidence based on the highest standards of care. Such review is used for a range of medical and surgical services, such as non-routine outpatient services with wide variation in cost and/or utilization within a clinician’s practice utilizing peer-peer comparisons, outpatient surgical procedures to ensure safety in the non-hospital setting, advanced radiology or imaging, and infusion therapy, to name a few. Such review is also applied to mental health and substance use therapies where too often evidence for a particular service or condition is lacking or has conflicting results, safety concerns have been reported, and/or such services are delivered by unqualified clinicians, practicing outside their licensed scope of practice.

Prior authorization is an important tool in medical necessity review for both medical/surgical and behavioral health conditions. As medical evidence traditionally links efficacy of drugs and services to a specific population or subpopulation, it is important that the prescribed therapy is safe and effective for the patient’s specific condition, provides the greatest value, and is a covered benefit. Particularly with respect to services prone to overuse or misuse, prior authorization can be used to ensure that care takes place in the most appropriate setting and at the most appropriate frequency. Prior authorization can also be used to make sure that drugs and devices are not being used for clinical indications other than those approved by the FDA. Often off-label drug use requires the prescriber to confirm the use for which the off-label drug was prescribed and the rationale for its use over other recommended drugs for that condition. Such action helps ensure the patient is not placed at risk and allows for monitoring of the drug’s use. In addition, prior authorization can help ensure that prescribing access to select medications is limited to specific physician specialists, such as those that have a high level of expertise in prescribing and monitoring treatment. In fact, prior authorization is a tool used and/or endorsed by many state Medicaid programs with respect to the prescribing of the addiction recovery drug Suboxone (buprenorphine-naloxone) as a way to reduce the risk of misuse, further addiction and diversion of the medication. As an additional example, given the FDA’s black box warning regarding the use of anti-depressants in the pediatric population and the increased risk of suicidal thinking, prior authorization can also help ensure that an appropriate psychiatric evaluation has

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been conducted by a provider certified in pediatric mental health. In sum, prior authorization offers the clinician the opportunity to provide the medical rationale for the service and ensure that it will be provided by a clinician practicing within his or her licensed scope of practice.

Step therapy may also be used for prescription drugs used to treat both medical and behavioral conditions. Step therapy involves prescribing a recognized safe and cost-effective drug before approval of a more complex, costlier or riskier drug or drug combination. For example, there is limited evidence on the safety and efficacy of using two or more antipsychotic medications concurrently, yet the prescribing of multiple antipsychotic drugs occurs in as much as 35 percent of outpatients and 50 percent of inpatients. The professional society of psychiatrists advises clinicians that use of multiple antipsychotic medications concurrently not be tried until at least three attempts using a single antipsychotic medication have failed.<sup>16</sup> Health plan step therapy policies can help reinforce this professional society recommendation.

In addition, certain medical or surgical services are frequently only covered if performed at a recognized and contracted Center of Excellence (COE). These facilities have a proven record of offering high quality care with minimal to no complications and utilize experienced qualified clinicians. Centers of Excellence are often used for solid organ transplants, some cancer therapies, especially pediatric cancer, bariatric surgery, etc. Unfortunately, most mental health and substance use facilities lack standard quality requirements, as previously discussed, thus limiting the use of COE for these services. In addition, needed services exceed the current capacity for residential treatment centers, inpatient psychiatric centers, and clinics.

Medical necessity review, prior authorization, step therapy, and Centers of Excellence are traditional tools used by health plans across their medical and surgical benefits and are applied similarly to mental health and substance use. The individual needs and risk factors associated with each patient are considered during the review and as such a simple checklist is not feasible. Such tools help to improve patient access to the most effective and beneficial therapies, improve patient outcomes, and reduce overall health care costs.

While the unique nature of behavioral health conditions can preclude a direct comparison of the medical necessity criteria for these conditions to the criteria for medical and surgical conditions, disclosure of those services requiring medical necessity review and/or prior authorization as well

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<sup>16</sup> <http://www.choosingwisely.org/clinician-lists/american-psychiatric-association-routine-prescription-of-two-or-more-concurrent-antipsychotics/>

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as any medical documentation required is available to clinicians, either through health plans' websites or other methods of communication, as part of their medical policies, clinical utilization management guidelines, and pre-certification requirements – and is directed to the clinician as the prescribing authority. Specific instructions are included with respect to the process and forms to be completed to expedite approval. It is important to note that in all cases, review is expedited for emergencies.

Insurers understand the importance of disclosing information to consumers, even when it can be challenging, as they may not be able to address the specific requirements for services requiring review before approval, such as licensing requirements, safety issues or confirmation of specific medical needs that prohibit the use of other therapies. In addition, areas such as participation in networks and reimbursement are based on the geographic availability and supply of clinicians, state licensure and negotiations between the payer and the provider.

In regard to clinicians licensed and skilled in managing mental health and substance use disorders, the number of clinicians in a specific geographic area may be limited, many clinicians choose not to contract with commercial payers, and their office hours are often limited thereby creating additional access problems for patients. As the plan of care is discussed between the clinician and the patient, payers focus their efforts on ensuring that clinicians are aware of medical necessity review, use of preferred facilities, pharmacy limitations, and other pre-certification requirements.

### **Conclusion**

Promoting parity between medical and behavioral health conditions is an ongoing, enterprise-wide endeavor to which health plans are strongly committed. Essential to the successful implementation of parity is health plans' ability to use reasonable medical management to promote appropriate, safe, evidence-based care. Additionally, because a "one-size-fits-all" approach is particularly misplaced in the area of behavioral health, there must be sufficient flexibility in implementing regulatory guidance to allow for continued innovation and customization to address specific needs and ample opportunities for public input. Unlike much of medical and surgical care where treatments are focused on objective signs of dysfunction and improvements can be measured by objective tests, treatment of many behavioral health conditions involves often extensive periods of time to address symptoms that may be subjective with treatments that may not be standardized. Being able to conduct reviews for ongoing treatment allows health plans to ensure that members are receiving safe and appropriate, evidence-based treatments from qualified providers.

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Lastly, we encourage federal regulators to either provide guidance for states that review compliance with benefits and parity, or provide more information and expand awareness of federal jurisdiction and state roles, so we can achieve the goal of consistent interpretations across oversight agencies, provide a level of regulatory certainty, minimize variation in interpretations, and help consumers understand when and which federal and/or state laws apply to their individual health needs and health care services.

Our members recognize that behavioral health conditions, particularly with their often close relationship to chronic medical conditions, have a significant impact on individuals, families, our society, and our economy. Access to evidence-based services, coordination with primary medical care, and assistance with finding community support services to meet basic needs such as housing, transportation and job training all contribute to the overall well-being of individuals with behavioral health conditions. For these reasons, our members will continue to implement innovative programs that improve access to quality, affordable, evidence-based care and work with policymakers to remove barriers to further innovations and improvements in meeting the needs of those with behavioral health conditions.

Thank you for considering our perspectives on these important issues. We stand ready to provide further information as the Task Force continues its deliberations.

Sincerely,



Carmella Bocchino  
Executive Vice President



Julie Miller  
General Counsel

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The Emily Program  
The Emily Program Foundation  
Kantor & Kantor, LLP  
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The Eating Disorders Center at Rogers Memorial Hospital  
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Gurze Books  
International Federation of Eating Disorders Dietitians (IFEDD)  
McCallum Place Eating Disorder Centers  
The National Association of Anorexia Nervosa and Associated Eating Disorders  
Theravive

September 7, 2016

The Honorable Fred Upton Chairman House Energy & Commerce Committee 2183 Rayburn House Office Bldg. Washington, DC 20515	The Honorable Frank Pallone Ranking Member House Energy & Commerce Committee 237 Cannon House Office Bldg. Washington, DC 20515
The Honorable Joseph Pitts Chairman House Energy & Commerce Committee, Health Subcommittee 420 Cannon House Office Bldg. Washington, DC 20515	The Honorable Gene Green Ranking Member House Energy & Commerce Committee, Health Subcommittee 2470 Rayburn House Office Bldg. Washington, DC 20515

Dear Chairman Upton, Subcommittee Chair Pitts, Ranking Member Pallone, and Subcommittee Ranking Member Green:

On behalf of the Eating Disorders Coalition for Research, Policy, and Action, we want to thank you for holding a hearing examining Federal Mental Health Parity Laws and Regulations, as well as for your support of the Helping Families in Mental Health Crisis Act of 2016 (H.R. 2646), which includes provisions from the Anna Westin Act of 2015 (H.R. 2515) intended to clarify the availability of eating disorder benefits, including residential treatment (Section 808), in our nation's parity laws. The Eating Disorders Coalition is a Washington, DC-based nonprofit organization comprised of eating disorder treatment providers, advocacy organizations, and patient advocates across the nation, devoted to improving federal policies to help better the lives of people experiencing eating disorders.

Eating disorders are classified as mental disorders in standard medical manuals including the International Statistical Classification of Diseases and Related Health Problems (ICD-10) and the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-5), and include specific disorders such as anorexia nervosa, bulimia nervosa, and binge-eating disorder.



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Eating disorders affect the lives of over 30 million Americans during their lifetimes and are among the most lethal of all psychiatric illnesses. Despite the high prevalence and severity of these mental disorders, persons with eating disorders frequently face remarkable barriers in pursuit of life-saving treatment. These vulnerable citizens are too often the victims of imprudent treatment denials by health insurance companies—casualties of payors' violations of the Paul Wellstone and Pete Domenici Federal Mental Health Parity and Addictions Equity Act of 2008 (Parity Act). Many people—be they adults or children—are affected by Parity Act noncompliance, with mental illness and/or addictions. The Act requires fairness—or, as its name implies, parity—between mental health and substance use benefits on the one hand and medical/surgical benefits on the other. The Parity Act was a groundbreaking piece of legislation aimed at ending ongoing discriminatory practices by insurance companies against those suffering from eating disorders, as well as all mental health issues.

We encourage the Energy and Commerce Committee to look into noncompliance issues related to medical necessity, chronicity, and transparency from health insurance plans on top of other related noncompliance issues. Below provides some detailed information on the specific concerns within these topic areas as it relates to eating disorders:

**A. Medical Necessity**

The place providers run into the most trouble is the accessibility of the medical necessity standards that insurance companies use. Difficulties arise when providers and reviewers disagree on interpretation of medical necessity. What occurs is that the providers will be working in-person with the consumer and their family and the provider believes it is the best interest of a consumer to receive a particular level of care. However, upon discussion with the health plan reviewer, who has never met or interacted with the consumer and their family, the reviewer believes it is in the best interest of the consumer to not receive that level of care. While this doesn't always happen, it is particularly distressing when it does. The provider is then left to tell the consumer and family, "We believe you need this level of care, yet your insurance company disagrees and will not authorize the care. You can choose to have your loved one in this level of care at your own expense."

Medical necessity criteria used by insurance companies are often only available online and are often difficult to locate. When providers ask some insurance company representatives to explain the criteria, they are often unable or unwilling to do so. Enrollers can try to access the criteria online, but the criteria are



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confusing and often impossible to meet. Denial letters are confusing and are not tied to the standard of care in the community or insurance company criteria.

**B. Chronicity**

Some insurance companies speak often about "chronic" eating disorders, despite the fact that there is no standard in the field of eating disorders that defines "chronic". There is no agreed upon definition and no treatment guidelines that say that providers should definitively treat those with an eating disorder for a long time period differently than those with a short time of illness. In this way, there are some insurance companies that are essentially creating a requirement to determine something that cannot be determined.

Anecdotally, our provider Members have had clients who have been told at the age of 17, after having anorexia for under 2 years, that they are "chronic" and treatment should focus on helping them adapt to this chronic illness and facilitate return to "baseline level of functioning" at this "chronic" place rather than providing coverage for treatment that would support and facilitate full recovery, which we know to be possible.

**C. Transparency**

A frustrating element for treatment providers, consumers and their families is the limited information health plans and insurance companies provide to providers and consumers when coverage for their eating disorders benefit is denied. Oftentimes the information is so limited that both the provider and consumer are not able to determine the exact reason that a benefit was denied- i.e. medical necessity.

Denial letters are confusing and are not tied to the American Psychiatric Association Guideline for the Treatment of Eating Disorders, which is the standard of care in the industry. Even when insurers use their own guidelines, they often do not cite to those guidelines in the denial letters. Often insurers use template denial sentences which are not individualized to the patient's condition. Insurers often do not accurately reflect the information provided by the treating experts, and sometimes do not even consult with the experts before making life and death decisions about treatment.

Recently, a large insurer in Iowa provided written authorization to families for treatment at the residential level of care. After the family member finished their treatment, families got letters stating that the care was not authorized and would not be paid for. Denial letters included reasons for denial as lack of medical

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necessity, despite prior authorization based on medical necessity, and incomplete documentation, despite thorough documentation submitted to the company. Families are left with enormous bills that they believed would be covered by their insurance company.

In conclusion, we applaud the Energy and Commerce Health Subcommittee for opening this dialogue on mental health parity, and going forward, the Eating Disorders Coalition would love to continue this dialogue and work with you to better help the coverage provided by Federal mental health parity, particularly as it pertains to eating disorders. We welcome the opportunity to provide further insight on noncompliance for people with eating disorders as you continue this dialogue.

Sincerely,

Katrina Velasquez, Esq.  
 Policy Director  
 Eating Disorders Coalition



September 8, 2016

Dear Member of Congress:

The undersigned organizations—representing providers, professionals, patients, family members and consumers are united in support of strong implementation and enforcement of the parity protections in the landmark Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). We write to urge you to enact mental health reform legislation with strong parity protections before Congress adjourns this year.

The Helping Families in Mental Health Crisis Act (H.R. 2646), passed by the House of Representatives on a near unanimous vote (422-2), and the Mental Health Reform Act (S. 2680), unanimously approved by the Senate Health, Education, Labor and Pensions Committee (HELP), both include provisions for better enforcement of the MHPAEA. These bicameral, bipartisan bills promote mental health and substance use parity by requiring better federal agency collaboration to enhance compliance through issuance of clarifying guidance, the reporting to Congress on federal parity investigations, and the development of an action plan to improve federal and state enforcement. In addition, the Government Accountability Office will study parity compliance by health plans covered by the law and clarify parity requirements for eating disorders.

Since the MHPAEA was enacted in 2008, insufficient state and federal enforcement, health plan non-compliance, including lack of disclosure of medical management information, and other implementation barriers to accessing mental health and substance use services on par with physical health services have stifled the full promise of the law for many Americans. The adoption of parity reforms in H.R. 2646 and S. 2680 is an important next step. If this legislation is coupled with state and federal implementation and oversight, including the randomized auditing process detailed in the Behavioral Health Transparency Act (H.R. 4276), the letter and spirit of the 2008 law will be realized and non-discriminatory access to treatment and recovery will ultimately become available.

We salute the bills' sponsors, cosponsors, HELP Committee Senators and all the Representatives who have already expressed by co-sponsorship and vote to move these important parity provisions closer to enactment through mental health reform legislation.

We also applaud the Administration for prioritizing mental health and substance use disorders parity implementation through the establishment and work of the Mental Health and Substance Use Disorder Parity Task Force and urge issuance of strong parity implementation and enforcement action by October 30, 2016.

We now seek your full support to ensure mental health reform legislation is enacted this year, and that congressional attention continues on the parity enforcement and implementation effort in the future.

Sincerely,

The American Association on Health and Disability  
The American Foundation for Suicide Prevention  
The American Psychological Association  
The American Society of Addiction Medicine  
BasicNeeds US

The Coalition For Whole Health  
 Depression and Bipolar Support Alliance  
 Health Equity Leadership & Exchange Network  
 Human Services Research Institute  
 The Kennedy Center for Mental Health Policy & Research  
 The Kennedy Forum  
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 State Representative Lou Lang (Illinois-16)  
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Written Testimony of Former U.S. Representative Patrick J. Kennedy (D-R.I.) for Energy and Commerce Committee Hearing: "An Examination of Federal Mental Health Parity Laws and Regulations"

I would like to thank the Energy and Commerce Committee for holding today's hearing on Federal Mental Health Parity Laws and Regulations. Few things are more critical to the health and wellbeing of all Americans than a strong and fully-enforced federal parity law.

As the lead sponsor of the bipartisan Mental Health Parity and Addiction Equity Act of 2008, I am hopeful that the federal government's renewed commitment to ensuring that this law is fully implemented is real, and not just window dressing.

President Obama's creation of the Mental Health and Substance Use Disorder Parity Task Force demonstrates that parity remains a priority for his administration, but the real test will be in how its findings are communicated and implemented. While few issues garner bipartisan support, the near unanimous vote on the Helping Families in Mental Health Crisis Act (H.R. 2646) demonstrates that both Democrats and Republicans agree that we need to do something to increase access to lifesaving treatments for individuals with behavioral health disorders. Furthermore, the relatively meager appropriation of \$22 million by CCIIO to increase regulatory capacity to enforce ACA market reforms, including parity, provides what I consider an initial financial commitment critical to ensuring implementation.

Despite this movement, more needs to be done, especially as it relates to enforcement of the parity law.

Individuals are continually denied medically necessary treatment or must fail at lower levels of care before receiving appropriate services. Throughout the country, inequitable reimbursement rates contribute to a shortage of in-network behavioral health providers and, subsequently, poor access to mental health and addiction services — which include medication-assisted therapies to address the opioid crisis. These likely parity violations must be addressed to curb the preventable suicides and drug overdoses impacting all American families.

The adoption of parity reforms within H.R. 2646 are a good start, but do not go far enough. I applaud my cousin, Representative Joseph P. Kennedy III, for his leadership in this area and keeping the pressure on for real parity reforms through his bill, H.R. 4276. While the provisions in the final House bill passed earlier this summer will promote parity by requiring further regulatory guidance, transparent federal investigations, and the development of an action plan to increase enforcement by federal and state agencies, clearly more needs to be done to strengthen parity overall. Nothing could be more critical to the millions of Americans with a mental health condition or an addiction seeking treatment.

I further expect that the Mental Health and Substance Use Disorder Parity Task Force will issue a strong set of recommendations to increase compliance and bolster enforcement. We hope these recommendations include parity-focused market conduct exams by state insurance departments, state certification requirements tied to parity compliance, the development of streamlined appeals processes, the expansion of consumer and provider complaints registries, and public education for consumers and providers.

However, the federal response to this medical civil rights issue will be incomplete if the Departments of Health and Human Services, Labor, and Treasury fail to conduct random audits, as specified by the Behavioral Health Transparency Act (H.R. 4276). We need proactive

enforcement of the law rather than the complaints-driven system that is currently in place. Every day, 250 people die from suicides and drug overdoses, many of whom were denied coverage or faced medically inappropriate and unethical restrictions of coverage. We don't need any complaints to tell us that something is wrong. We need assertive monitoring and enforcement to protect our communities that have been ravaged by this epidemic. While I will never allow perfect to be the enemy of good, I also will never yield until we can say that we did the right thing. H.R. 2646 is a first step, but let's not lose sight of the fact that this is an ongoing struggle that demands continued efforts on both the legislative and regulatory fronts.

The recent momentum around parity is only paralleled by the passage of the Federal Parity Law in 2008, and the expansion of its protections in 2010 through the Affordable Care Act. I hope that the federal government, and this committee, takes advantage of this opportunity to ensure that mental health legislation is enacted this year and that Congress remains focused on parity implementation and enforcement going forward.

I thank the committee for the opportunity to provide these comments.



1000 Wilson Blvd., Suite 1825  
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December 16, 2015

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The Honorable Joe Kennedy III  
US House of Representatives  
306 Cannon House Office Building  
Washington, DC 20515

Dear Representative Kennedy,

On behalf of the American Psychiatric Association (APA), the national medical specialty society representing more than 36,000 physicians specializing in psychiatry, we are writing in support of your Behavioral Health Coverage Transparency Act. This legislation would strengthen enforcement of established parity law to more fully realize the promise of access to equitable and comprehensive insurance coverage of mental health and substance use disorder (MH/SUD) services.

The need for improved access to psychiatric care is great. 43.8 million adults experienced mental illness in 2013 and 1 in 5 teens ages 13–18 have experienced a severe mental disorder.<sup>1,2</sup> The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) was landmark bipartisan legislation that barred most private health plans from engaging in discriminatory activities targeting beneficiaries with mental illness, including substance use disorders. While insurance companies have largely eliminated discriminatory and differential copays and deductibles in accordance with the law, plans creatively circumvent other parity requirements through opaque policies and harmful practices that effectively limit beneficiaries' access to needed psychiatric care and increase the cost of care for patients in need of MH/SUD treatment services.

Your legislation addresses these continued challenges through the authorization of random audits and public reporting that would bring further scrutiny of plans' parity compliance analyses. These added tools will aid robust federal, state and consumer access to insurance data, and in turn better identify violations and promote compliance.

We applaud your leadership as well as that of others in Congress who are undertaking efforts to make meaningful and comprehensive reforms to our nation's broken mental health system, including through addressing gaps in enforcement of the historic mental health parity law. We look forward to working with you to enact this legislation. If you have any questions, or if we can be of further assistance, please contact Jeffrey P. Regan, Deputy Director, Federal Affairs at [jregan@psych.org](mailto:jregan@psych.org).

Sincerely,

Renée Binder, M.D.  
President

Saul Levin, M.D., M.P.A.  
CEO and Medical Director

---

<sup>1</sup> Any Disorder Among Children. (n.d.) The National Institute of Mental Health. Retrieved December 11, 2015, from <http://www.nimh.nih.gov/health/statistics/prevalence/any-disorder-among-children.shtml>

<sup>2</sup> Any Mental Illness (AMI) Among Adults. (n.d.). The National Institute of Mental Health. Retrieved December 11, 2015 from <http://www.nimh.nih.gov/health/statistics/prevalence/any-mental-illness-ami-among-adults.shtml>



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Addiction Medicine

January 28, 2016

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The Honorable Joseph Kennedy  
United States House of Representatives  
306 Cannon House Office Building  
Washington, DC 20515

Dear Representative Kennedy,

On behalf of the American Society of Addiction Medicine (ASAM), the largest medical society representing physicians and allied professionals treating addiction, I am writing to thank you for your bill, the Behavioral Health Coverage Transparency Act (HR 4276). This important act supports ASAM's efforts to increase patients' access to quality addiction treatment by strengthening parity in mental health and addiction benefits. Specifically, your bill would require issuers to disclose the analysis they perform in making parity determinations; require federal regulators to conduct random audits; and require the federal parity agencies to review denial rates for mental health versus medical claims. Moreover, it would create a central online portal so that consumers can access all information as a one-stop shop, and submit complaints and violations.

The morbidity and mortality statistics related to addiction, and in particular opioid addiction, are astounding. According to the Centers for Disease Control and Prevention (CDC), drug overdoses are the current leading cause of accidental death in the US, with 47,055 lethal drug overdoses in 2014. Of these drug overdoses, 18,893 deaths were related to prescription opioid analgesics, and 10,574 overdose deaths related to heroin.<sup>i</sup> These alarming statistics are driven by a very large treatment gap in this country. Nearly 90% of Americans with addiction do not receive treatment and 80% of individuals with opioid addiction are not treated.<sup>ii,iii</sup> Those that take the first step towards recovery by seeking treatment often face immense barriers from insurance companies. For example, medications for the treatment of opioid addiction are often subject to onerous utilization management practices by public and private payers, including prior authorization requirements, fail first policies and requirements for psychosocial

services that may either be unavailable or not covered by a patient's insurance provider.

Your leadership and attention to ensuring greater oversight and transparency in parity implementation is much appreciated. ASAM was a part of the broader public health community that championed the passage of the Mental Health Parity and Addiction Equity Act of 2008, which secured strong federal rules for ensuring addiction and mental health treatment benefits are covered at parity with other health benefits. Since the law was passed in 2008, ASAM has been advocating for full implementation and enforcement of the law to end health insurance discrimination for mental health and addiction coverage.

Strengthening parity protections for patients with addiction will have a long-term, positive impact on increasing access to quality addiction treatment and ultimately improved public health. The Behavioral Health Coverage Transparency Act details a thoughtful and actionable approach that supports this outcome. ASAM supports the goals of your bill and looks forward to working with you to secure its passage as we continue to advocate for adequate coverage of addiction and mental health treatment in order to save the lives of those in need of it.

Sincerely,



R. Jeffrey Goldsmith, MD, DLFAPA, DFASAM  
President, American Society of Addiction Medicine

<sup>i</sup> Center for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System, Mortality File. (2015). Number and Age-Adjusted Rates of Drug-poisoning Deaths Involving Opioid Analgesics and Heroin: United States, 2000–2014. Atlanta, GA: Center for Disease Control and Prevention. Available at [http://www.cdc.gov/nchs/data/health\\_policy/AADR\\_drug\\_poisoning\\_involving\\_OA\\_Heroin\\_US\\_2000-2014.pdf](http://www.cdc.gov/nchs/data/health_policy/AADR_drug_poisoning_involving_OA_Heroin_US_2000-2014.pdf)

<sup>ii</sup> Legal Action Center. (2015). Confronting an Epidemic: The Case for Eliminating Barriers to Medication Assisted Treatment of Heroin and Opioid Addiction. Washington, D.C: Legal Action Center. Available at <http://lac.org/wp-content/uploads/2014/07/LAC-The-Case-for-Eliminating-Barriers-to-Medication-Assisted-Treatment.pdf>

<sup>iii</sup> Saloner PhD, Karthikeyan MPP. Changes in Substance Abuse Treatment Use Among Individuals with Opioid Use Disorders in the United States, 2004–2013. *The Journal of the American Medical Association*. 2015;314(14):1515-1517





The Emily Program  
FOUNDATION

January 2016

The Honorable Joseph P. Kennedy III  
United States House of Representatives  
306 Cannon House Office Building  
Washington, DC 20515

Dear Congressman Kennedy III,

The Emily Program Foundation applauds you for introducing The Behavioral Health Coverage Transparency Act (H.R. 4276). We would like to offer our full support of the bill which will save lives by strengthening parity in mental health benefits for eating disorders and providing support to the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act intended to cover all mental health treatment equally to medical/surgical health.

So many Americans seek treatment for eating disorders, and are invariably denied recommended treatment. Not only is the process of covering initial intake services complicated, but when higher levels of care are needed the denial rates skyrocket. Vague explanations are given from the insurance companies as to why they denied recommended treatment, leaving eating disorder sufferers and caregivers confused and deeply discouraged. Holding insurance companies accountable for covering recommended eating disorder treatment procedures set in The Mental Health Parity and Addictions Equity Act of 2008 will restore hope to those who feel powerless in their financial battle against insurance companies.

Thank you for championing The Behavioral Health Coverage Transparency Act and for your dedication to helping the 30 million people who suffer from eating disorders in the United States. It is leaders like you who give us all hope for a future where eating disorders are treated equal to medical/surgical health care.

With deep respect,



Kitty Westin	Larry Espel	Kiki Schmit
Member of the Board	President	Community Organizer
The Emily Program Foundation	The Emily Program Foundation	The Emily Program Foundation



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August 31, 2016

To the Mental Health and Substance Use Disorder Task Force:

On behalf of the Jewish Federations of North America (JFNA), thank you for this opportunity to comment on the equal coverage of and access to mental health and addictive disorder treatment through the Mental Health Parity and Addiction Equity Act (MHPAEA) and its broader application under the Affordable Care Act (ACA). We thank you for your sustained effort to solicit input from organizations nationwide, and for your continuing work to ensure that individuals with mental illness and addictive disorders get the services to which they are entitled.

JFNA is one of the largest philanthropic networks in the country, serving as the umbrella organization for 151 Jewish federations and over 400 partner agencies. Our network includes 125 Jewish family & children's agencies that provide extensive mental health and addictive disorder treatment and, therefore, are on the front lines of mental health parity implementation.

Although our nation has come a long way in recognizing the need for and the importance of mental health treatment, JFNA believes that the promise of mental health parity is not being fully realized. We are concerned that the breadth and complexity of mental health parity under the current regulations and guidance make it difficult for individual patients to determine whether they truly are being provided coverage for mental health and addictive disorder treatment equal to their general medical coverage. The process seems to require extensive and detailed analysis of both a plan's stated benefits and actual coverage decisions. JFNA believes that this complexity necessitates federal action or study of mental health parity to assess the level of parity compliance throughout the country.

A recent inquiry of our Jewish family & children's agencies also has revealed two important findings related to mental health parity compliance. First, our agencies report that access to covered mental health and substance use treatment is being impeded by narrow networks of behavioral health providers and long wait lists for in-network providers, a situation that is forcing patients to choose between paying out-of-pocket for out-of-network providers or foregoing needed care. Second, our agencies report that their patients increasingly are unable to afford their copayments for services, particularly when combined with the higher deductible plans which are becoming much more prevalent according to recent reports. As one agency said, "If people can't afford co-pays, they don't seek treatment." Mental health care simply is becoming out of reach for too many Americans.

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Eight years after the MHPAEA's enactment, it is time to ascertain whether the promise of the mental health parity law is being realized for the patients who are in dire need of mental health and addictive disorder treatment. Thank you for this opportunity to offer the perspective of our broad network of social service agencies on this important matter.

Sincerely,

A solid black rectangular box redacting the signature of William C. Daroff.

William C. Daroff,  
Senior Vice President for Public Policy  
& Director of the Washington Office



September 8, 2016

The Honorable Joe Pitts  
 Chairman  
 Health Subcommittee  
 House Energy and Commerce Committee  
 420 Cannon House Office Building  
 Washington, DC 20515

The Honorable Gene Green  
 Ranking Member  
 Health Subcommittee  
 House Energy and Commerce Committee  
 2470 Rayburn House Office Building  
 Washington, DC 20515

Dear Representatives Green and Pitts:

On behalf of the National Alliance on Mental Illness (NAMI), thank you for your leadership in conducting this important hearing examining implementation of the federal Mental Health Parity and Addictions Equity Act (MHPAEA). NAMI is the nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness. NAMI and its members have worked for many years at both the state and federal levels to advocate for equitable coverage of mental health and substance use disorder treatment relative to coverage of medical/surgical treatment in health insurance plans.

The enactment of the Paul Wellstone and Pete Domenici Mental Health Parity and Addictions Equity Act (MHPAEA) in 2008 was a landmark step forward in addressing pervasive inequities in coverage of mental health and addictions disorders in health insurance. Today, eight years later, while significant progress has been made, people living with mental illness continue to encounter significant barriers in accessing necessary mental health services covered in health insurance.

In 2015, NAMI released a report entitled "*A Long Road Ahead: Achieving True Parity in Mental Health and Substance Use Care.*" The report, which was based on a survey of people living with mental illness and their families concerning their experiences with health insurance, revealed that these individuals continue to encounter numerous obstacles in their efforts to access and obtain quality mental health or substance use disorder treatment. These barriers include:

- Serious problems in finding mental health providers in health insurance plan networks;
- High rates of denials of authorization of inpatient and outpatient mental health and substance use disorder care by insurers;
- Barriers to accessing psychiatric medications in health plans;
- High out-of-pocket costs for prescription drugs that appear to deter participation in both mental health and medical treatment;

- High co-pays, deductibles and co-insurance rates that impose barriers to mental health treatment;
- Serious deficiencies in access to information necessary to make informed decisions about the most appropriate health plans.

NAMI is currently analyzing responses to an updated survey of people living with mental health conditions and families concerning coverage of mental health and substance use care in health insurance policies. Although our analysis is not yet complete, it appears that many respondents are continuing to encounter these kinds of barriers.

For example, one survey respondent talked about the difficulties of getting accurate information even when he calls his insurance company.

*“Calling the insurance company to find mental health and/or substance abuse providers is a JOKE. Their website gives no help. Call representatives should be knowledgeable about their own plans! So hard to navigate insurance requirements – and I have a Masters’ degree! What is it like for others?”*

Another respondent talked about disincentives for mental health providers to participate in her health insurance plan’s network and how she has chosen to seek care out of network, even at the risk of foregoing some of life’s other necessities.

*“I don’t even try to use the mental health benefits anymore provided by my insurance company. It requires pre-authorization by one of their providers. My psychiatrist isn’t in any network. I have been going to her for over 20 years. She is part of the reason I am still on this earth. I would spend less on food, if I had to, rather than stop seeing her.”*

NAMI is pleased that the “Helping Families in Mental Health Crisis Act” (HR 2646) passed by your Committee, and by the full House in a nearly unanimous vote, contains important provisions addressing these barriers. We are particularly appreciative of the inclusion of provisions requiring:

- Development and issuance of guidance to help improve compliance by health insurers with MHPAEA, including examples of non-discrimination in the clinical criteria used to evaluate mental health and substance use claims, relative to medical/surgical claims;
- Development of an action plan for improving enforcement of MHPAEA at the federal level, including input from mental health and substance use disorder advocates and providers;
- Annual reporting by federal agencies charged with enforcing MHPAEA summarizing the results of all completed Federal investigations involving findings of serious violations of the federal parity law;
- A comprehensive GAO study on parity in mental health and substance use disorder benefits, with specific focus on coordinated enforcement activities and on compliance with requirements concerning non-quantifiable treatment limitations; and
- Development of resources on the application of the federal parity law to eating disorders.

These provisions would be a significant step forward in helping to realize the potential of MHPAEA as a vehicle for eliminating discrimination towards mental illness and substance use disorders in health insurance.

NAMI is also on record as supporting the Behavioral Health Transparency Act (H.R. 4276). We support provisions in H.R. 4276 that clarify disclosure requirements for plans and for the collection and public publishing of denial rates. These latter provisions are necessary to not only enhance enforcement of the federal parity law, but to level the playing field for plans that are improving mental health care and striving to meet the intent of the law. Without greater transparency requirements, well-intentioned plans are disadvantaged by plans that offer weaker, or even disparate, mental health coverage.

We also strongly support provisions in that bill authorizing randomized audits of health plans for compliance with parity and establishing a one-stop internet portal for submitting parity violation complaints and forwarding these complaints to relevant federal and state agencies charged with parity enforcement.

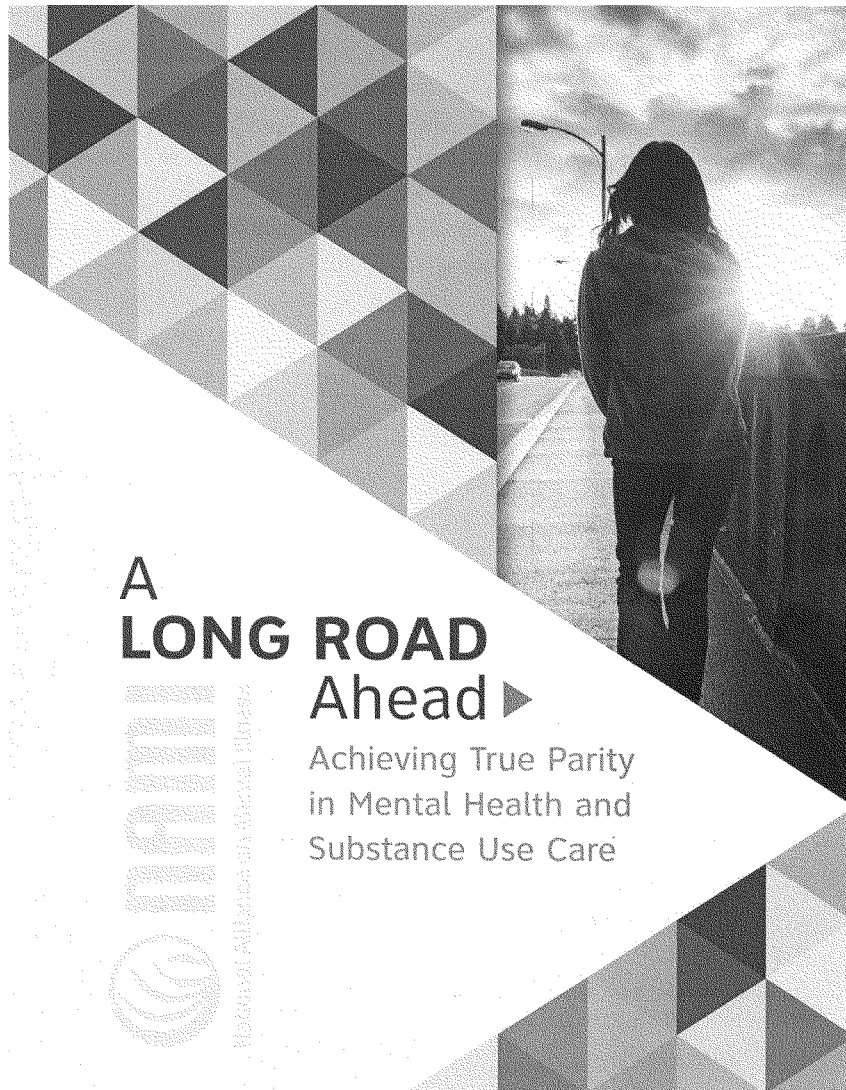
NAMI's ongoing efforts to assess stakeholder experiences with parity have made us aware that people are confused about what constitute parity violations and what to do if they believe their rights have been violated pursuant to MHPAEA. We believe this illustrates the importance both of conducting ongoing educational efforts on parity and implementing clear and simple procedures for filing parity complaints. Although H.R. 2646 did not include the two aforementioned provisions regarding randomized audits and a one-stop portal for filing complaints, we hope that these very helpful provisions will be considered for adoption in the future.

NAMI applauds the sponsors, co-sponsors and supporters of H.R. 2646 for including important provisions to improve implementation of federal mental health and substance use disorder parity. We also applaud HELP Committee Senators for their support of parity provisions in the Mental Health Reform Act (S. 2680). We stand ready to work with you in any way we can to ensure that the goals of equity in health insurance are realized.

Respectfully,

A solid black rectangular box used to redact the signature of Mary T. Giliberti.

Mary T. Giliberti, J.D.  
Chief Executive Officer



A  
**LONG ROAD**  
Ahead ▶

Achieving True Parity  
in Mental Health and  
Substance Use Care

MHI  
Mental Health Institute



Copyright April 2015, the National Alliance on Mental Illness (NAMI)

NAMI is the National Alliance on Mental Illness, the nation's largest grassroots mental health organization. NAMI provides advocacy, education, support and public awareness so that all individuals and families affected by mental illness can build better lives.

**Acknowledgements and Gratitude**

This report was prepared by the staff at NAMI including Ron Honberg, Sita Diehl and Dania Douglas. NAMI expresses sincere gratitude to Avalere Health for analysis of Qualified Health Plans in the Exchanges and to Christina Van Regenmorter, Centerstone Research Institute, for assistance with the Coverage for Care survey data analysis. We also offer our thanks to public policy interns Jeffrey Roberson, Corinne Ruth and Everly Groves for preparing and implementing the survey. This report is made possible by the leadership of Mary Gilliberti, Executive Director. Thank you to Jessica Hart, Emily Cepla, Darcy Gruttadaro, Katrina Gay, Bob Carolla and the others who provided helpful review and comments during the preparation of the report. We deeply appreciate the 2,720 individuals and family members affected by mental illnesses or substance use disorders who responded to the survey, sharing their experience of health insurance coverage.

This report was made possible by generous support from Eli Lilly and Company, Genentech, Otsuka Pharmaceutical, and a generous NAMI donor who does not wish to be identified.

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## INTRODUCTION

### A Long Road Ahead – Achieving True Parity in Mental Health and Substance Use Care

For too long, people who need mental health and substance use care have been subjected to pervasive discrimination in health insurance. Health plans for people with pre-existing mental illness, if they included mental health benefits at all, have historically been more expensive, with limited benefits and significant administrative hurdles to obtaining care.

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) enacted by Congress in 2008, was designed to remedy a major piece of the problem.<sup>1</sup> This landmark law applies to employer-sponsored health plans with more than 50 employees, including self-insured and fully insured plans.<sup>2</sup> MHPAEA does not require insurers to cover mental health and substance use treatment benefits, but if a plan includes these benefits, coverage must be on par with medical and surgical benefits.<sup>3</sup>

The Patient Protection and Affordable Care Act of 2010 (ACA) strengthened parity requirements set forth in MHPAEA by extending federal parity requirements to individual and small group plans. Further, mental health and substance use disorder services were mandated as one of ten categories of Essential Health Benefits required for all plans sold through the federal health insurance marketplace, or state exchanges.

These two important laws represent a monumental step forward in the long fight to end discriminatory coverage

of mental illness and substance use disorders in health insurance policies. However, it is well known that efforts to achieve meaningful social change are far from over when laws are passed. Achieving true equity in accessing mental health and substance use disorder care requires vigilant attention by advocates and public agencies responsible for enforcement.

This report describes a survey conducted by NAMI to assess the experiences of people living with mental illness and their families with private health insurance. The findings of the survey are supplemented with an analysis of 84 health plans in the top 15 states by projected 2014 exchange enrollment. Our findings reveal that while progress is being made in law, we have a long way to go to achieve true parity in mental health and substance use care.

The report describes a number of barriers that people with mental illness and substance use disorders encounter in their efforts to obtain quality care. Some of these barriers appear to be worse for mental health or substance use treatment, while others apply equally to medical care. These barriers include:

- Serious problems in finding mental health providers in health insurance plan networks;
- High rates of denials of authorization for mental health and substance use care by insurers;

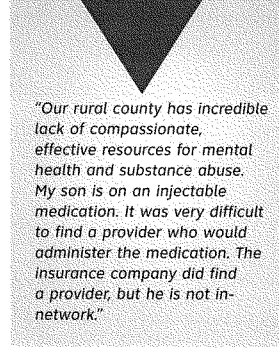
- Barriers to accessing psychiatric medications in health plans;
- High out of pocket costs for prescription drugs that appear to deter participation in both mental health and medical treatment;
- High co-pays, deductibles and co-insurance rates that impose barriers to mental health treatment;
- Serious deficiencies in access to information necessary to enable consumers to make informed decisions about the health plans that are best for them in ACA networks.

Although people living with mental illness and substance use disorders are grateful for the steps Congress and the Administration have taken to increase fairness through MHPAEA and the ACA, the problems described in this report must be addressed for the great promise of these landmark laws to translate into improved access to quality care.

**REPORT FINDINGS**

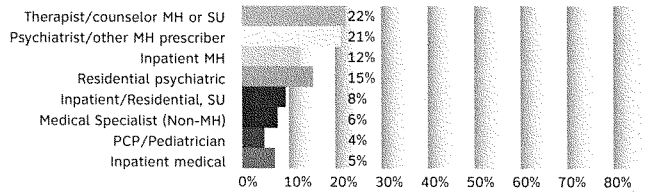
**1. Consumers and family members report serious problems with finding mental health providers in their health plans.**

Whether health insurance is obtained through employment or purchased by individuals through health insurance marketplaces, a significant percentage of respondents to our survey reported problems in finding mental health providers in their health plans. The most significant problem identified was difficulty accessing therapists or counselors for outpatient mental health or substance use disorder treatment, followed closely by difficulties accessing psychiatrists. Respondents also reported higher rates of difficulty accessing inpatient psychiatric or residential treatment than they did for accessing medical specialty services, primary care services, or inpatient medical

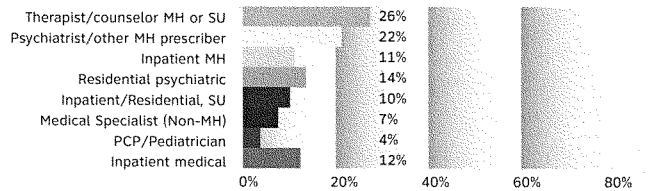


treatment. Consumers clearly face more significant barriers to accessing inpatient and outpatient psychiatric or mental health care than they do in accessing inpatient or outpatient medical specialty or primary care.

**Cannot find a provider in the plan's network: all private insurance**



**Cannot find a provider in the plan's network: ACA only**



Most likely, these barriers are attributable both to severe shortages in qualified mental health professionals in most parts of the country and to inadequate provider networks maintained by health insurance plans. The nationwide mental health workforce shortage is well documented, and these problems are particularly acute in rural regions. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), 55% of U.S. Counties have no practicing psychiatrists, psychologists or social workers.<sup>34</sup>

Making matters worse, concerns have emerged that a significant number of mental health professionals included in networks of Qualified Health Plans (QHPs) included in health insurance exchanges may not actually be available to plan participants. For example, in January, 2015, the Mental Health Association of Maryland published a study which revealed that only 14% of the psychiatrists listed in QHPs in the Maryland exchange were actually accepting new patients and available for an appointment within 45 days.<sup>35</sup>

*"My insurance will pay my primary care doctor more for a 10-minute appointment for the flu, than it will allow my psychiatrist for an hour-long treatment session. For this reason, my own psychiatrist along with many others, no longer accepts insurance."*

Compounding the problem of mental health workforce shortages is the reality that many practicing psychiatrists do not accept health insurance, confining their clientele to people with the resources to pay out of pocket. A recent study published in JAMA Psychiatry revealed that only 55% of psychiatrists accepted insurance in 2009-2010 as compared

to 88.7% among physicians in other medical specialties. The data further revealed significantly lower Medicare and Medicaid acceptance rates among psychiatrists than physicians in other medical specialties.<sup>36</sup>

A number of reasons are cited for the distressingly low rates of psychiatrists accepting insurance, including lower payment rates for psychiatrists (although the study cited above reveals comparable payments for psychiatrists and other medical specialties), the longer duration of therapy sessions versus medical appointments and the burden of documentation requirements for solo practitioners.<sup>37</sup>

The difficulties respondents reported accessing mental health therapists and counselors is more surprising. Psychologists, social workers and mental health counselors provide vital psychotherapy and counseling to people with mental illness and/or substance use disorders. The finding that so many respondents had trouble obtaining a therapist who would take their health plan, suggests that these individuals, despite having insurance, may have little or no access to needed services and supports.

A recent report issued by the Commonwealth Fund revealed that premiums on average are significantly lower for people purchasing health insurance through the Marketplaces than originally anticipated. A primary reason for this is that beneficiaries are selecting lower cost plans that also have far more limited provider networks.<sup>38</sup>

Whatever the reason for the reported difficulties in accessing providers, the goals of mental health and substance use parity will be frustrated

by insufficient access to providers qualified and willing to serve people with mental illness or substance use disorders. In fact, problems with access to services may be exacerbated as demand increases due to more people having insurance through the ACA.<sup>8</sup>

**2. Insurers are denying authorization for mental health care at higher levels than they are for other types of medical care.**

The parity requirements in MHPAEA apply to both Quantifiable Treatment Limits (QTLs), such as cost sharing, visit limits, or deductibles, and to Non-Quantifiable Treatment Limits (NQTLs), such as medical necessity criteria used by insurance companies and managed care organizations to approve or deny care. "Medical necessity" is a managed care tool intended to evaluate whether care proposed by a provider for a given patient is reasonable, necessary and appropriate, based on evidence-based clinical standards of care. Consumers, family members and providers often complain that mental health or substance use treatment is denied as not medically necessary arbitrarily and without reasonable explanation.<sup>9</sup>

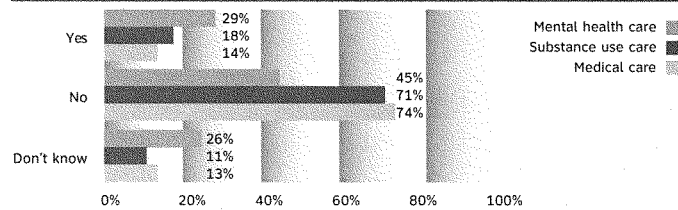
NAMI asked respondents whether their health plan has denied mental health, substance use and/or medical services recommended by their clinician because they were deemed

*"Our health insurance denied all claims for one year retroactively, asking all of my and then all of my husband's providers to refund monies paid, putting my health, my psychiatric health, and my husband's health at risk."*

"not medically necessary." Because of MHPAEA's application to NQTLs such as medical necessity, the reasonable expectation is that reported denials of care for mental health, substance use, and medical care would be roughly equal.

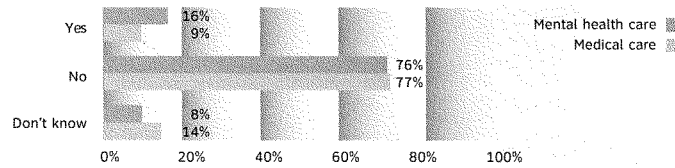
However, nearly one third (29%) of respondents reported that they or their family member had been denied mental health care on the basis of medical necessity, more than twice the percentage who reported being denied general medical care. 18% of respondents reported being denied substance use care and 14% denied general medical care. For ACA plans, rates of reported denials based on medical necessity were lower, but denials for mental health care were still nearly twice the rate of denials for general medical care.<sup>1</sup>

**Service denials based on medical necessity criteria: all private insurance**



<sup>1</sup> Only four of the ACA respondents reported seeking substance use care. This was too few to accurately compare responses with other types of care.

Service denials based on medical necessity criteria: ACA only



Historically, there has been lack of clarity about the medical necessity criteria used by insurance companies and managed care organizations for mental health and substance use disorder care. <sup>xi</sup>In the absence of uniform criteria, insurers have adopted their own standards and have often not been forthcoming about informing beneficiaries about these standards.<sup>xii</sup> This in turn has sparked concerns that insurance companies and managed care organizations deny claims for mental health care at far higher rates than for other medical care. The results obtained in our survey would appear to reinforce these concerns.

In fact, as this report was being finalized, news broke that Beacon Health Options of New York has agreed to change the way it handles mental health and drug and alcohol claims and will be fined \$900,000. The settlement resolved allegations that the company denies mental health claims at twice the rate it does for

medical/surgical claims and denies drug and alcohol claims at 4 times the rate.<sup>xiii</sup> Other media stories have also portrayed exceedingly high rates of claims denials for mental health care.<sup>xiv</sup>

The common use of medical necessity criteria and other utilization management tools to limit care for mental illness is particularly concerning because it is very difficult, if not impossible for consumers and family members to find information on the criteria used to make such decisions. Health insurance policies typically do not include information about medical necessity criteria regarding specific types of care.

This lack of transparency exists as well for summary documents used to provide information about specific plans included in state health insurance marketplaces under the ACA. Without transparent, easily available information, the ability of mental health consumers to make informed choices about plans - or to assert their rights in the face of adverse decisions - is severely hamstrung.

*"Our health plan for medical is great. Their behavioral health arm for prescriptions is not great. They have an appeal process but they never even respond to your appeal and even if the doctor shows that the generic didn't work, they still won't approve branded. Luckily, we can pay out of pocket for the medication, but we, his parents, pay for our 20 year old's medication. He could never afford it. Thank God for the Affordable Care Act; at least he is covered on parent's insurance until age 26."*

**3. There appear to be significant barriers to accessing psychiatric medications in health insurance plans.**

Insurance plans generally cover prescription drugs on a tiered basis. Tier one medications are most easily available and most affordable. Higher tier medications are more expensive and are frequently not available except through specific requests for exceptions or authorizations.

The imposition of specific limitations on psychiatric medications is particularly problematic because these medications are frequently not interchangeable. The National Institute of Mental Health (NIMH) explains that psychiatric “medications work differently for different people.” Factors affecting variability include diagnosis; age, sex and body size; genetics; physical illness; diet and others. “Some people get side effects from specific medications, others don’t.”<sup>xx</sup>

In view of this, decisions about psychiatric medications must be made carefully between the treating clinician and his or her patient. The effectiveness and side effects of the prescribed medication must be carefully monitored. Restrictions imposed by insurance companies through tiered formularies can deprive individuals of these safeguards and upset the often delicate balance of a psychiatric medication regimen.

NAMI contracted with Avalere Health to conduct a review of drug formularies in plans provided through health insurance marketplaces in selected states. Formularies for 84 health plans were analyzed to assess coverage of three

classes of psychiatric medications, Antipsychotics, Antidepressants, and SSRIs/SNRIs (selective serotonin reuptake inhibitors [SSRI] and selective norepinephrine reuptake inhibitors [SNRI]) used commonly to treat depression.

The results were troubling, particularly for coverage of antipsychotic medications used in the treatment of schizophrenia and other disorders characterized by psychosis.

For antipsychotics, more than half of the health plans (47) covered fewer than 50% of analyzed drugs, meaning that the majority of antipsychotic medications weren’t available to plan participants at all.<sup>xx</sup> Additionally, although a number of plans covered a higher percentage of anti-psychotic medications, a significant proportion of these medications were available only on a restricted, non-preferred basis with high out of pocket costs. For example, a third (28 health plans) placed at least half of covered antipsychotic medications on Tier 3 of the drug formularies, meaning that these drugs could not be prescribed without being subject to higher cost sharing than generic or ‘preferred’ branded products.

Coverage of antidepressants was somewhat better, with 22 plans covering at least 70% of these medications. Over half (46 health plans) placed at least 50% of these medications on Tier 1 preferred status. Even so, a number of plans placed a significant number of covered drugs on higher cost tiers, with 13 plans placing at least half of the covered antidepressants on Tier 3 and 11 plans placing more than 20% of antidepressants on Tier 4.

More than a quarter (22 plans) covered at least 70% of SSRIs and SNRIs. Nearly half (42 health plans) placed at least 50% of these drugs on Tier 1, while 16 plans placed at least half on Tier 3, and 13 plans placed more than 20% on Tier 4.

There were broad variations in coverage among specific companies administering these plans. Nearly two thirds (48) of the plans were considered “more restrictive” for at least one class of drug, 21 plans were considered more restrictive for at least two of the three analyzed classes, and 12 plans were considered more restrictive for all three classes. Two companies in particular stood out for the restrictiveness of their plans. Nine of eleven Anthem plans included in the analysis were more restrictive for antidepressants and antipsychotics, the other two Anthem plans were more restrictive for all three classes. Further, all seven Humana plans included in the analysis were more restrictive in all three classes.

In a more positive vein, 12 of the analyzed plans covered 100% of all drugs included in the three classes

There were variations across states as well. In Arkansas, three of the four assessed plans covered fewer than 65% of medications in each class. By contrast, in New Jersey, three of four plans covered 100% of the drugs in each class.

Do the restrictions described above constitute a violation of the federal MHPAEA law? As described earlier in this report, this law applies to all ACA plans offered through state health insurance marketplaces. If an ACA plan covers psychiatric medications at levels lower than medications for other health conditions, this may constitute a violation of MHPAEA. However, we do not have sufficient information to so conclude at this point.

**4. Even when covered, the out of pocket costs of medications may pose a barrier to participating in care.**

NAMI’s survey asked respondents whether their health plan covered the cost of medications fully or partly. For those with private coverage, medications for mental health care

**Criteria for Identifying Restrictive Plans**

Antidepressants and SNRIs/SSRIs	Antipsychotics
1. Plan covered 33% or fewer of analyzed drugs within the class.	1. Plan covered fewer than 30% of analyzed drugs within the class.
2. At least 70% of analyzed drugs within the class were not covered, or placed on Tier 3 or Tier 4.	2. At least 90% of analyzed drugs within the class were not covered, or placed on Tier 3 or Tier 4.
3. At least 70% of analyzed drugs within the class were not covered, or required Prior Authorization, Step Therapy, or both Prior Authorization and Step Therapy.	3. At least 90% of analyzed drugs within the class were not covered, or required Prior Authorization, Step Therapy, or both Prior Authorization and Step Therapy.

analyzed. None of the four Aetna plans or the two Cigna plans were assessed as having more restrictive coverage.

were slightly more likely to be covered fully (10%) or partly (87%), when compared with medications for

*"Once I aged out of my parents' plan (which was very good coverage) the cost of my medications tripled. I could no longer get a three-month supply for meds I had been on for years, only a one-month supply. I chose the plan because of the low advertised cost of prescriptions, but they have yet to be those prices. Increased cost was the reason I stopped all four of my psychiatric medications within two months of each other."*

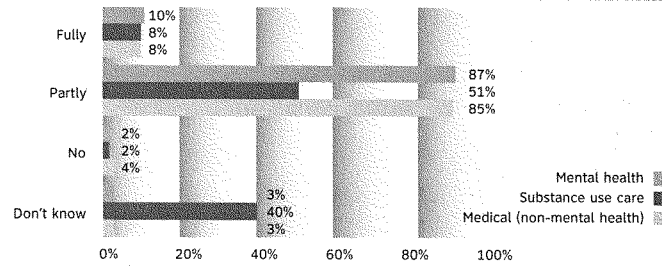
medical care (fully, 8%; partly 85%). Participants were less likely to know about substance use medications, though full cost coverage lagged slightly behind mental health (8%) and partial coverage was far lower (51%).

Medication cost coverage under ACA plans was similar with medications for mental health care slightly more likely to be covered fully (12%) or partly (88%) when compared with medications for other types of medical care (fully, 11%; partly 83%).

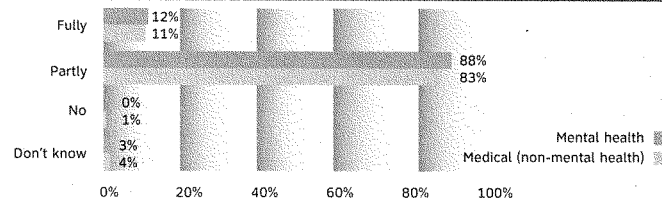
However, partial coverage of medications can result in significant out of pocket costs for beneficiaries, costs that are sometimes so high that people choose to forego needed prescription drugs. This proved to be the case for a number of respondents to our survey.

When asked whether, due to cost, they had been unable to fill a prescription for mental health, substance use, or medical care, 17 percent of respondents reported that they were unable to fill prescriptions for mental health care, 30 percent

Coverage of medication costs: all private insurance



Coverage of medication costs: ACA only





reported that they were unable to fill prescriptions for substance use disorder care and 33 percent reported that they were unable to fill prescriptions for other medical care.

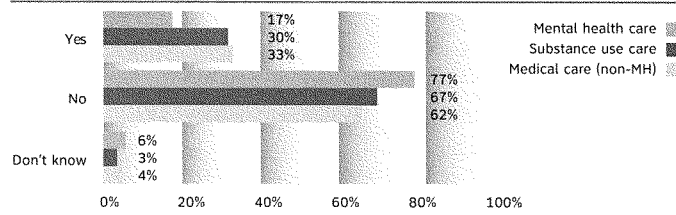
These percentages were even higher with ACA marketplace plans than for insurance plans in general (mental health 32%; general medical 33%). Since the income profiles of respondents in both groups were similar, this suggests that out of pocket costs for prescription drugs are higher in ACA plans than other types of insurance plans.

Co-insurance requirements in health plans can be particularly problematic for consumers. Co-insurance requires beneficiaries to pay a fixed percentage of the costs of the service or medication. Medications on higher tiers in ACA plans are often subject to co-insurance as opposed to a flat fee, or copayment. Consumers who purchased ACA plans may not have been aware of the difference between these two practices, which can mean widely varied out of pocket costs. When the cost of a prescription drug is \$900 per month, as is the case

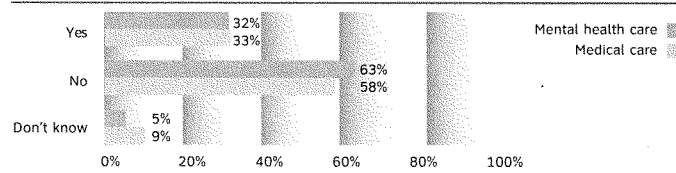
with some antipsychotic medications, a 40% co-insurance requirement requires the person to pay \$360 per month out of pocket. Such costs are unsustainable for many consumers and thus may serve as a major barrier to taking needed psychiatric or other types of medications.

**5. Out of pocket costs may present a greater barrier to inpatient and outpatient mental health care than inpatient or outpatient medical specialty care.**

**Not able to fill prescription due to costs: all private insurance**



**Not able to fill prescription due to costs: ACA only**

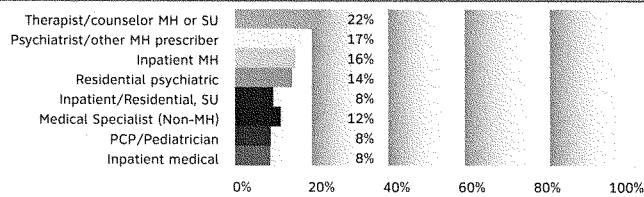


*"My income per month is \$860. My co-pays for medical and mental health are often \$120-\$160. If I cancel mental health appointments because I am broke, the therapist or psychiatrist notes state that I am non-compliant. I pay \$120 to \$180 on past hospital stays, which had fees before I met my deductible. I pay \$400 a month to rent a room. I choose to stay on my meds so I skimp on nutrition."*

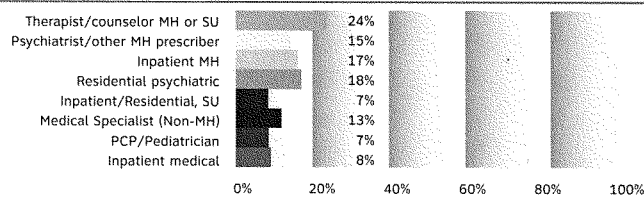
More respondents cited out of pocket costs (deductibles, co-pays, coinsurance) as barriers to seeking inpatient or outpatient mental health care than for primary care or inpatient or outpatient medical specialty care. This was true as well for ACA plans. More information is needed to determine whether these differences reflect higher out of pocket costs for inpatient and outpatient mental health care than for other types of medical care, which could constitute non-compliance with the federal parity law.

Also noteworthy is that many of our survey respondents reported having to pay sizable deductibles in their health insurance policies. These deductibles apply to the costs of all care, whether mental health, substance use, or medical care. Although deductibles in ACA plans did not exceed \$10,000 as was the case with a few non-ACA plans, 20% of the ACA plans carried deductibles from \$2,500 to \$5,000, while 22% had deductibles between \$5,000 and \$10,000. Out of pocket costs of this magnitude may deter people from participating in needed care.

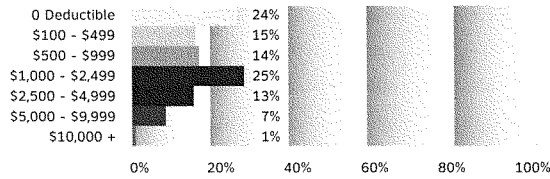
**Cost as barrier to care: all private insurance**



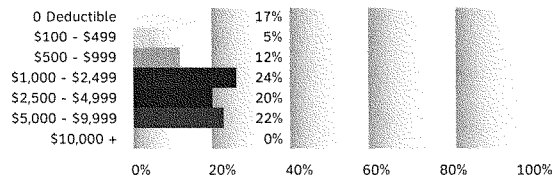
**Cost as barrier to care: ACA only**



Annual deductible: all private insurance



Annual deductible: ACA only



**6. When selecting health plans available in State Marketplaces, consumers and family members generally do not have access to information needed to make informed decisions.**

The ACA requires each Marketplace plan to publish a Summary of Benefits and Coverage (SBC) with cost sharing

and coverage information. These documents do not include the kind of detailed information about coverage that mental health consumers need to make informed decisions about the plans that are best for them. For example, these documents typically do not include information about provider networks, meaning that a consumer would be unable to determine if his or her psychiatrist is part of the network.<sup>111</sup> Additionally, even when provider information is available, for example through the shopping function in Healthcare.gov, the provider directories provided by plans are often inaccurate and outdated.

More detailed information about provider networks, out of pocket

*"It is impossible to figure out the best way to get coverage for the services I know I need. It's always a crapshoot, and the people at the state exchange are too busy signing people up to help me figure out how to get the subsidy that I think I am entitled to. But the rules are so complicated and have so many exceptions. The ACA is a better solution than the system we had before, but it is still too hard to afford, too complicated, and people are still going to fall through the cracks."*

costs, and specific services covered may be found in documents known as Evidence of Coverage (EOC) or Certificates of Coverage. However, these documents are frequently not publicly available. The Avalere analysis of 84 plans revealed that these more detailed plan documents were publicly available for only 15 of the 84 plans analyzed.<sup>299</sup> Eight of the 15 plans for which detailed documents were available were in California, which has a state law requiring the publication of detailed documents about plans.<sup>300</sup>

Even when more detailed documents are available, they are generally quite complicated and may not contain the level of detail required. As noted by

Avalere, the more detailed documents are written in different formats and with varying levels of detail. For example, some "plan documents contained broad statements (e.g. 'prior authorization may be required, or services not covered') without additional information."<sup>301</sup>

The lack of specificity in Summary of Benefits and Evidence of Coverage documents is problematic not only for consumers trying to make informed choices about plans that are best for them. Lack of specificity in these documents also inhibits conducting a detailed assessment of whether plans are complying with requirements of the federal parity law.

A recent study conducted by researchers at Johns Hopkins University illustrates this difficulty. The researchers analyzed plan offerings on the health insurance marketplaces in two states. When trying to assess parity in non-quantitative treatment limits, they observed that, "summary documents do not provide information on how medical management protocols (for example, provider network admission standards, fee schedules, step therapy protocols and medical necessity determinations) are applied to covered benefits."<sup>302</sup>



## POLICY RECOMMENDATIONS

### 1. Strong enforcement of MHPAEA is needed.

The enforcement scheme for MHPAEA is complicated. States have primary authority over implementation. However, the U.S. Department of Labor has primary enforcement responsibility for self-insured employee plans (the majority of employees in plans subject to MHPAEA). Further, the U.S. Department of Health and Human Services, through its Center for Medicare and Medicaid Services (CMS) has enforcement authority when states fail to exercise this authority.<sup>xxx</sup>

A complex, multi-faceted enforcement scheme of this kind creates confusion, both among consumers and agencies responsible for enforcement. Federal and state agencies responsible for enforcement should work with consumer and family organizations and other stakeholders to develop an easily accessible mechanism to report incidents of non-compliance with the federal parity law. The two agencies with federal oversight must establish a procedure for monitoring these reports for patterns of non-compliance and develop procedures to help ensure enforcement.

### 2. Insurers should be required to publish the clinical criteria they use to approve or deny care.

Respondents to our survey revealed that insurers deny authorization for mental health care at higher levels than they do for other medical care. It is difficult to prove that disparate levels of denials for mental health care relative to other medical care violate MHPAEA. To do so requires comparisons of the clinical protocols used by insurers for mental health

care with those used for medical-surgical care. It also requires assessment of whether insurers are accurately applying these clinical protocols to decisions in individual cases.

It is currently very difficult to access clinical protocols such as medical necessity criteria for purposes of review and comparison. HHS should require all plans participating in health insurance exchanges to publish these clinical protocols in publicly accessible sites such as HealthCare.gov and exchange websites established by states. Additionally, the Substance Abuse and Mental Health Services Administration (SAMHSA), in consultation with the National Institute of Mental Health (NIMH), the Assistant Secretary for Planning and Evaluation (ASPE) and other relevant HHS agencies, should promulgate guidance to health plans on appropriate clinical criteria for insurers to use in approving or denying mental health and substance use care.

### 3. Health plans should be required to publish accurate lists of providers, including mental health providers, participating in plan networks and to update those lists regularly.

Narrow, limited provider networks have been identified nationally as a problem in health insurance exchanges and our survey revealed that this is a problem for mental health care in all types of insurance plans, whether employer based or through the ACA. In recognition of this, the final rule published by CMS establishing Benefit and Payment Parameters for 2016 requires Qualified Health Plans participating in health

insurance marketplaces to publish up-to-date, accurate and complete plan specific provider directories, including information on which providers are accepting new patients.<sup>xxxii</sup>

The National Association of Insurance Commissioners (NAIC) is currently drafting model state network adequacy legislation. This model legislation should include similar requirements as the federal Benefit and Payment Parameters for 2016, with specific focus on ensuring adequacy for specialties that have been historically under-represented in health insurance networks, such as psychiatrists, psychologists and other mental health professionals. NAIC model legislation is not binding on states but frequently serves as a model for state laws.

**4. HHS should require all health plans to provide clear and understandable information about benefits and should be required to make this information easily accessible.**

Health plans should be required to provide sufficiently detailed information in easily understandable language to enable consumers and advocates to compare health and mental health benefits in plans offered through state and federally-facilitated health insurance exchanges. Detailed plan documents should include all information necessary for consumers and advocates to make informed decisions about the best coverage to purchase. At a minimum, information disclosed should include the following:

- an accurate up-to-date provider network listing;
- quantifiable limits on coverage including inpatient and outpatient treatment;

- medical necessity criteria or other utilization review practices;
- prescription drug formularies and the policies for approval;
- information to calculate out-of-pocket costs; and
- types of mental health and substance use benefits covered.

Health plan information should be accessible to consumers before enrollment, through health plan websites or by telephone. Finally, HHS should develop a uniform system for health plans to report this information to consumers and advocates and make it easy to find.

**5. Congress and the Administration must work together to decrease out of pocket costs in the ACA for low income consumers.**

Out of pocket costs include deductibles, copayments, and co-insurance for covered services. They do not include the costs of insurance premiums. Although individuals or families with incomes below 250% of the Federal Poverty Level<sup>xxxv</sup> who purchase Silver Plans are eligible for subsidies to defray out of pocket costs, these costs can still be very high.<sup>xxxvi</sup> Many respondents to our survey reported very high out of pocket costs, so high that they or their family member sometimes chose to forego needed mental health or medical-surgical care. As implementation of the ACA moves forward, careful consideration must be given to lowering out of pocket limits, particularly for low income individuals. Otherwise, the goal of increasing access to care, including mental health and substance use care may be frustrated.



## APPENDIX 1: Methodology and Coverage for Care Survey Sample Characteristics

Information for this report derives from two primary sources, a NAMI survey on the experience of health coverage and an analysis of Health Insurance Marketplace and State Exchange Plan benefits performed by Avalere Health under contract with NAMI.

### NAMI Coverage for Care Survey

In September and October of 2014, NAMI released a nationwide online survey of individuals and families of adults or children in need of mental health and/or substance use care. The survey inquired about access to, and out of pocket costs for, services and medications to treat general medical, medical specialty (non-mental health), mental health or substance use conditions. Eligible respondents could have any type of private or public health coverage including insurance obtained through health insurance marketplaces established under the Affordable Care Act (ACA).

### Avalere Health Analysis

Analysis of formularies offered in the Qualified Health Plans relied on the Avalere Health proprietary PlanScape database and examined formulary coverage of mental health drugs by 84 selected Marketplace plans offered in 15 states. Avalere also performed a review of Summary of Benefits and Coverage (SBC) and Evidence of Coverage (EOC) documents to compare coverage of mental and physical health benefits.

### Coverage for Care Survey Respondents

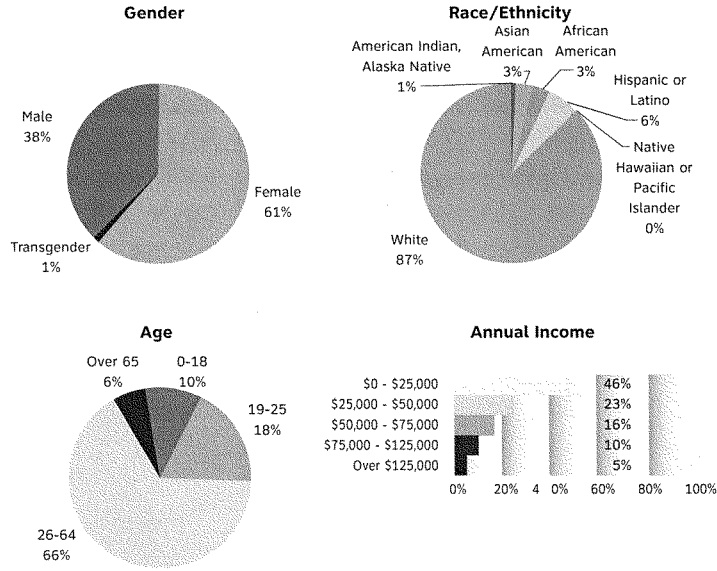
The 2,720 respondents were individuals and family members of adults or children who need mental

health or substance use care. Of those who started the survey, 70% followed through to completion. Nearly half (48%) answered for themselves, while 40% answered for a child, including adult children, and less than 5% answered for someone else. Persons who were the subject of responses were typically female, white, non-elderly adults with annual incomes below \$25,000. Every state was represented, though most lived in California (577), Colorado (105), Florida (194), Massachusetts (102), Michigan (98), Oregon (105) and Tennessee (108).

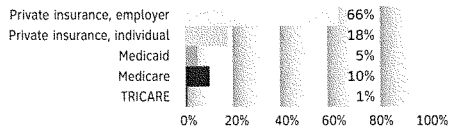
A majority of the survey sample (90%) had health coverage, either through private insurance or public programs. The higher than normal overall insured rate, compared to the average insured rate among people with mental illness (76%),<sup>xxvi</sup> is likely because the survey invited respondents to describe their experience of health coverage, rather than enrollment. Mental health and substance use benefits were covered for 2,059 (88%) of the survey population. Almost all children and elderly adults were insured (98%) as were most young adults (90%) and other adults (88%).

Respondents with private insurance coverage (1,225, 45%) are the subject of this report because the final parity rule for private insurance took effect July 1, 2014. Small percentages of the survey sample had Medicaid (5%) or Medicare (10%) in addition to their employer sponsored or individual plan. 220 respondents obtained coverage under the ACA, either through a Qualified Health Plan (121, 4%) or Medicaid expansion (99, 4%).

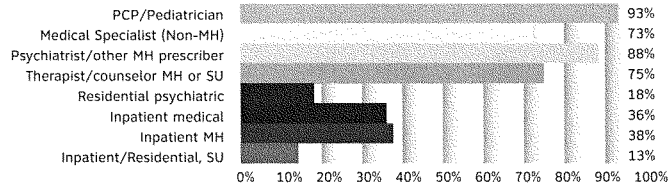
Demographic Characteristics



Type of Health Coverage



Type of Services Used







## APPENDIX 2: How do Parity Laws Apply to Types of Health Plans?

Two recently enacted federal laws strengthen health insurance coverage for mental health and substance use disorder (MH/SUD) services with the intention of making care more available to those who need it.

- **The Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008** does not require insurers to provide MH/SUD benefits. However, if such benefits are provided, the financial requirements and treatment limitations for MH/SUD benefits must be equal to medical and surgical care.

- **The Patient Protection and Affordable Care Act (ACA)** extends parity by requiring some health plans to provide ten categories of Essential Health Benefits (EHB). Under the ACA, MH/SUD benefits must be provided through certain types of plans in compliance with MHPAEA.

While these policies represent an important step forward, gaps remain. The chart below shows which types of health plans are subject to parity requirements under MHPAEA and the ACA.

	Type of Plan	Subject to parity under MHPAEA	Subject to parity under ACA: Essential Health Benefits*
Exchange Plans	Individual	No	Yes
	Small group	No	Yes
Non-Exchange Plans	New Plans	Self-insured	Yes**
		Large group	Yes**
		Small group	No
		Individual	No
		Government plans: Non-Federal Small or self-funded++	No
	Grandfathered Plans+	Self-insured	Yes**
		Large group	Yes**
		Small group	No
		Individual	No
		Government plans: Non-federal Small or self-funded++	No

\* Patient Protection and Affordable Care Act, Section 1302 (a) and (b); <http://www.hhs.gov/healthcare/rights/law/index.html>

\*\* MHPAEA applies to employer-sponsored health plans with more than 50 employees, including self-insured and fully insured plans; <http://www.dol.gov/ebsa/newsroom/fsmpaea.html>

+ MHPAEA does not apply to non-federal governmental plans that have 100 or fewer employees or large self-funded non-federal governmental plans that choose to opt out of MHPAEA; [http://www.cms.gov/CCHO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea\\_factsheet.html](http://www.cms.gov/CCHO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html)

++ Grandfathered plans are those that were purchased before March 2010 and remain largely unchanged.



### APPENDIX 3: Population of Marketplace-Eligible People with Mental Illness

State	Total Marketplace eligible population <sup>2</sup>	% Marketplace eligible with any mental illness (AMI) <sup>3</sup>	# Marketplace eligible with AMI
Alabama	463,000	19.2%	88,896
Alaska	84,000	17.4%	14,616
Arizona	647,000	18.4%	119,048
Arkansas	251,000	21.0%	52,710
California	3,263,000	11.0%	358,930
Colorado	574,000	13.5%	77,490
Connecticut	236,000	11.1%	26,196
Delaware	45,000	7.6%	3,420
District of Columbia	32,000	10.1%	3,232
Florida	2,502,000	10.6%	265,212
Georgia	1,073,000	4.9%	52,577
Hawaii	53,000	20.0%	10,600
Idaho	229,000	21.6%	49,464
Illinois	966,000	14.6%	141,036
Indiana	673,000	15.9%	107,007
Iowa	224,000	11.3%	25,312
Kansas	244,000	15.0%	36,600
Kentucky	265,000	12.7%	33,655
Louisiana	506,000	16.7%	84,502
Maine	124,000	11.2%	13,888
Maryland	462,000	6.4%	29,568
Massachusetts	400,000	16.2%	64,800
Michigan	699,000	14.8%	103,452
Minnesota	277,000	15.6%	43,212
Mississippi	293,000	16.6%	48,638
Missouri	632,000	13.4%	84,688
Montana	125,000	16.5%	20,625
Nebraska	237,000	20.1%	47,637
Nevada	266,000	13.5%	35,910
New Hampshire	129,000	13.9%	17,931
New Jersey	586,000	15.7%	92,002
New Mexico	153,000	6.1%	9,333
New York	1,214,000	10.0%	121,400
North Carolina	1,098,000	11.8%	129,564
North Dakota	80,000	18.8%	15,040
Ohio	962,000	15.1%	145,262
Oklahoma	381,000	20.8%	79,248
Oregon	339,000	13.8%	46,782
Pennsylvania	1,171,000	13.7%	160,427
Rhode Island	73,000	28.7%	20,951
South Carolina	444,000	15.1%	67,044
South Dakota	100,000	13.4%	13,400
Tennessee	602,000	14.6%	87,892
Texas	3,079,000	13.3%	409,507
Utah	385,000	15.4%	59,290
Vermont	44,000	22.2%	9,768
Virginia	816,000	20.9%	170,544
Washington	517,000	14.1%	72,897
West Virginia	111,000	17.9%	19,869
Wisconsin	474,000	20.4%	96,696
Wyoming	67,000	15.0%	10,050

<sup>2</sup> Kaiser Family Foundation (April, 2014) Marketplace Enrollment as a Share of Potential Marketplace Population.

<sup>3</sup> SAMHSA (2013) Enrollment under Medicaid Expansion and Health Insurance Exchanges: 2008-2010 National Survey of Drug Use and Health.



## APPENDIX 4: Glossary

**Coinsurance:** When the beneficiary, the person who has health insurance, shares the cost of a covered service. This is calculated as a percent (for example, 20%) of the allowed amount for the service. For example, if the allowed amount for an office visit is \$100 and the beneficiary has met their deductible, the co-insurance payment of 20% would be \$20. The health plan pays the remaining allowed amount. (<http://www.cms.gov/CCIIO/resources/files/downloads/uniform-glossary-final.pdf>)

**Copayment:** A fixed amount (for example, \$15) the beneficiary pays for a covered health care service, usually at the time of service. The amount can vary by the type of covered health care service. (<http://www.cms.gov/CCIIO/resources/files/downloads/uniform-glossary-final.pdf>)

**Deductible:** The amount the beneficiary owes for covered health care services before the health insurance begins to pay. For example, if the deductible is \$1,000, the plan will not pay for anything except preventive services until the beneficiary has paid \$1,000 for covered health care services. The deductible does not apply to preventive services such as annual check-ups or mental health screening, meaning that the plan will pay regardless of whether the deductible has been met. (<http://www.cms.gov/CCIIO/resources/files/downloads/uniform-glossary-final.pdf>)

**Depression Screening Tools:** Brief questionnaires designed to detect the presence of depression. These tools are not diagnostic, but are used as preventive care to help determine whether the person could benefit from assessment by a mental health professional.

**Formulary:** A list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits. Also called a drug list. (<https://www.healthcare.gov/glossary/>)

**Out of Pocket Limit:** The amount owed by a beneficiary during a policy period before the health insurance plan begins to pay 100% of the allowed amount. This limit does not include the premium, balance-billed charges or costs for benefits not covered under the plan.

**Network:** The facilities, providers and suppliers the health insurer has contracted with to provide health care services. (<http://www.cms.gov/CCIIO/resources/files/downloads/uniform-glossary-final.pdf>)

**Preventive Care:** Routine health care that includes screening, check-ups and patient counseling to prevent illnesses, disease or other health problems. Under the ACA, all Marketplace plans and many other plans must cover a list of preventive services without charging a copayment or coinsurance. This is true even before the deductible is met. Depression screening is an example of preventive mental health care.

**Prior authorization:** A decision by the health insurer that a health care service, treatment plan or prescription drug is medically necessary. Sometimes called preauthorization, prior approval or precertification. (<https://www.healthcare.gov/glossary/>)

**Medically Necessary:** Health care services or supplies needed to prevent, diagnose or treat an illness or condition and that meet accepted standards of medicine. (<https://www.healthcare.gov/glossary/>)

**Non-Quantitative Treatment Limits (NQTL):** Procedures to limit the scope or duration of benefits that do not involve a numerical value in terms of visits, days or costs. NQTLs may include such practices as prior authorization, step therapy and other utilization management techniques to determine whether a given service is medically necessary. Under the ACA, NQTL may be no more restrictive for mental health or substance use care than for medical or surgical care.

**Prior Authorization (also called Prior Approval):** A cost-containment procedure that requires a physician, facility or program to obtain permission from an insurance company or managed care organization before commencing treatment or prescribing a medication.

**Quantitative Treatment Limits (QTL):** Procedures to limit the scope or duration of benefits that involve a numerical value in terms of visits, days or costs. Examples include the number of visits or inpatient days, copays, coinsurance or annual dollar limits. Under the ACA, QTL may be no more restrictive for mental health or substance use care than for medical surgical care.

**Step Therapy:** Step therapy is a type of prior authorization. With step therapy, in most cases, you must first try certain less expensive drugs that have been proven effective for most people with your condition before you can move up a "step" to a more expensive drug. For instance, your plan may require you to first try a generic prescription drug (if available), then a less expensive brand-name prescription drug on its formulary, before it will cover a similar, more expensive brand-name prescription drug. (<https://www.medicare.gov/Pubs/pdf/11136.pdf>)

**Tier:** A health insurance term to indicate a level of coverage for a given type of care. For example, beneficiaries would pay more out of pocket costs for prescription drugs placed on higher tiers.

**Utilization Management:** Practices used by insurers to evaluate whether requested care is medically necessary, efficient and in line with accepted medical practice. Examples of utilization management practices include prior authorization and step therapy.



## APPENDIX 5: References

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- <sup>54</sup> R. Karlin, "Attorney General, Insurance Company Reach Settlement on Mental Health Coverage," *Albany Times Union*, 3/5/2015, <http://www.timesunion.com/news/article/Insurer-fined-900-000-in-settlement-6115886.php>
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- <sup>62</sup> Berry, K.N., et al, "A Tale of Two States: Do Consumers See Mental Health Insurance Parity When Shopping on State Exchanges," *Psychiatric Services in Advance*, March 2, 2015, pp2-3; <http://ps.psychiatryonline.org/doi/pdf/10.1176/appi.ps.201400582>, accessed 3/3/2015; See also, Mental Health America, "Parity or Disparity: The State of Mental Health in America 2015," <http://www.mentalhealthamerica.net/sites/default/files/Parity%20or%20Disparity%202015%20Report.pdf>, accessed 3/21/2015
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- <sup>66</sup> Out of pocket limits for individuals with incomes between 100 and 200% of FPL are no more than \$2,250. Out of pocket limits for individuals with incomes between 200% and 250% of FPL are no more than \$5,200.
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