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Testimony on the Proposed House Bill for Mental Health and Addiction Treatment Parity

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Let me begin by sincerely thanking Representatives Kennedy, Ramstad, and Altmire for your leadership in addressing insurance issues for mental health and substance use related disorders. Your work is instrumental in bringing these misunderstood illnesses to the public's attention. I want to also thank Representative Tim Murphy and Brenda Lee of Allegheny County's United Mental Health Association for their work on this issue and making it possible for me to speak today. I offer this testimony based on my background as a clinical psychologist with over 30 years of daily experience in the assessment, treatment, research and policy development related to addictions. I am also a co-founder and current Board Member of Pennsylvania's largest Medicaid Behavioral Managed Care Company (CCBHO) and an advisor to many of Pennsylvania's insurers and policy leaders.

Along with my clinical practice in addictions, I direct the SAMHSA/CSAT funded Northeast Addiction Technology Transfer Center (NeATTC) and its parent organization, the Institute for Research, Education and Training in the Addictions (IRETA), a 501(c)3 located in Pittsburgh and serving providers and citizens in Pennsylvania, New York and New Jersey. IRETA seeks to align best practice, science and policy to improve accountability, efficiency and outcome in the substance use arena.

First, let me say that I believe your legislation can serve as a scientifically valid way to address the longstanding increased medical costs related to the historically poor integration between medical and behavioral health systems (Horvitz-Lennon, Kilbourne, & Pincus, 2006; Kathol, Saravay, Lobo, Ormel, in print). Science is replete with examples of behavioral and lifestyle issues leading to physical problems that, without the recognition of mind/ body integration, would not be treated correctly. This legislation offers a glimpse of what such "integrated" thinking can mean by creating a new understanding of and approach to health and the quality of each human life. Thank you.

I also would like to compliment you for amending earlier drafts of your bill to protect states with existing legislation protecting their citizens receiving behavioral healthcare services. In Pennsylvania, Act 106, passed in 1989, protects some 12,000 citizens each year.

However, I remain concerned that the proposed parity legislation still does not designate licensed and appropriately trained healthcare practitioners as the primary decision makers for the clinical decisions and determinations for the necessary "dose" of care. Too often the authorization of health benefits as you have proposed has had a negative impact on client care by creating a debate between the authorizer of benefits and the clinician as well as creating confusion in patient families as to the actual best course of treatment. This also means there is no room for clinicians to offer client-centered care, one of the six essential elements of high quality care as recommended by the Institute of Medicine (2006). If this legislation relies on the "plan

administrator" or "health issuer" to determine "medical necessity," you will have created a conflict of interest and inadvertently set health care back 10 years while practicing benefit management under the guise of healthcare.

Based on our experience in Pennsylvania implementing the Pennsylvania Client Placement Criteria (PCPC; Pennsylvania Department of Health Bureau of Drug and Alcohol Programs, 1999), we strongly recommend that your proposed legislation at least reference existing and nationally recognized criteria such as those by the American Society on Addiction Medicine (ASAM; Mee-Lee, Shulman, Fishman, Gastfriend, & Griffith, 2001), the Veterans Administration (Department of Veterans Affairs, 1996) and the American Psychiatric Association (2006). This would give all stakeholders a common language by which to make determinations for needed care. These criteria would also give a common foundation for any denials of care and a scientific basis for the ongoing evaluation your legislation proposes.

The Bill should also stipulate a process for patient or clinical appeal if care is not approved by the insurer. If the patient is already receiving care, the appeal should be conducted in a timely manner that does no harm to the patient's current recovery attempt, i.e. the patient should be allowed to continue in care until all parties are aware of the termination after appeal of benefits.

In addition to the concerns I just mentioned, I would like to note that there is no mention of parity of co-payments for services. Research has shown that treatment utilization is very sensitive to differences of even $10 in co-payments (LoSasso & Lyons, 2004). Therefore, I recommend that specific language limiting the amount of the co-payment for mental health or substance use related disorders or that stipulates parity of co-payments with physical illness services be included in the bill.

Finally, I would like to say that IRETA supports the proposed study on page 42 (line 9) but would suggest that a National Advisory Group of policy makers, providers, consumers, insurers, family members, and pastors be invited to work with the government to oversee the implementation of the proposed legislation. This would serve to effectively protect patient rights while ensuring fairness to all stakeholders involved in the study process. You could build real-time feedback to states and plans into the process which would avoid the two year wait associated with the Comptroller General's findings and reports. In addition, this real-time feedback could address concerns related to increased cost exemptions noted on page 12 (line 10). Any analysis of the actual cost of such "parity" will take time and must include a long term analysis of true total health cost savings after what might be initial increases to health plan costs (Varmus, 1998).

In conclusion, let me once again commend you on sponsoring this parity bill. It is an important beginning in the fight for equal and quality care for all Americans. The bill, as proposed, affirms the value of integrated care via a health benefit for a true medical illness – an illness that ranks among the very top of America's costliest, deadliest, most misunderstood and stigmatized illnesses in modern history (Robert Wood Johnson Foundation, 2001). Your bill, if enacted, will serve to change how we define healthcare while it brings together the interests of individual Americans through the might of its employers, insurers and public payers. Without the awareness that informed "parity" gives we offer no hope to individuals and families fighting

addiction. IRETA thanks you Representatives Kennedy, Ramstad, Murphy, and Altmire. Perhaps more importantly we stand ready to assist you further in all aspects of this work now and in the future. We offer our highest praise for your leadership in addressing this issue for those who often cannot advocate for themselves.

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