

RPTR BRYANT

EDTR SECKMAN

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, D.C.

The subcommittee met, pursuant to call, at 9:02 a.m., in Room 2322, Rayburn House Office Building, Hon. Joseph R. Pitts [chairman of the subcommittee] presiding.

Present: Representatives Pitts, Guthrie, Shimkus, Murphy, Burgess, Blackburn, Lance, Bucshon, Brooks, Collins, Green, Capps, Castor, Matsui, Lujan, Schrader, Kennedy, Cardenas, 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, Minority Staff Director; Tiffany Guarascio, Minority Deputy Staff Director and Chief Health Advisor; Samantha Satchell, Minority Policy Analyst; Andrew Souvall, Minority Director of Communications, Outreach and Member Services; Arielle Woronoff, Minority Health Counsel; and C.J. Young, Minority 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.

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 authorization 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.

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

[The prepared statement of Mr. Pitts follows:]

***** COMMITTEE INSERT *****

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.

[The information follows:]

***** COMMITTEE INSERT *****

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

[The prepared statement of Mrs. Blackburn follows:]

***** COMMITTEE INSERT *****

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.

[The prepared statement of Mr. Shimkus follows:]

***** COMMITTEE INSERT *****

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 follows:]

***** COMMITTEE INSERT *****

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

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.

[The prepared statement of Mr. Green follows:]

***** COMMITTEE INSERT *****

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.

[The prepared statement of Ms. Matsui follows:]

***** COMMITTEE INSERT *****

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.

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 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 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 essential 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:]

***** COMMITTEE INSERT *****

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 two 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 regulatory 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.

[The prepared statement of Mr. Kennedy follows:]

***** COMMITTEE INSERT *****

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, BEHAVIOR HEALTH DIVISION, HEALTHPARTNERS MEDICAL GROUP; AND MATT SELIG EXECUTIVE DIRECTOR, HEALTH LAW ADVOCATES, INC.

STATEMENT OF PAMELA GREENBERG, MPP

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 compliance 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 nonquantitative 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.

[The information follows:]

***** COMMITTEE INSERT *****

Ms. Greenberg. 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 differences 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:]

***** INSERT 1-1 *****

Mr. Guthrie. Thank you for testifying.

Dr. Trangle, you are recognized for 5 minutes.

STATEMENT OF MICHAEL A. TRANGLE, M.D.

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 Okay, 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, anxious. 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:]

***** INSERT 1-2 *****

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 --

Mr. Guthrie. We would request you pull the mike closer a little bit.

Mr. Selig. Oh, I'm sorry. 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:]

***** INSERT 1-3 *****

Mr. Guthrie. Thank you very much.

I want to thank each witness for your testimony, and I will begin the questioning and recognizing 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 copayments 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 okay, 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 okay, all of a sudden they can help us follow up and they can help us measure are they getting better or not.

Mr. Guthrie. Okay. 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. Okay. 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 midmorning, 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 unlikely 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 Government, 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. Okay. 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. Okay. 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. 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.

RPTR MELHORN

EDTR ZAMORA

[10:01 a.m.]

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. Yeah. 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. Yeah. 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. Yeah. 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, okay, 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 follows:]

***** COMMITTEE INSERT *****

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, okay, 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. Schrader'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. Lujan from New Mexico for 5 minutes.

Mr. Lujan. 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. Lujan. 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. Lujan. 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, another. 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 10:32 a.m., the subcommittee was adjourned.]