

30 Winter Street, Suite 1004
Boston, MA 02108
Telephone: 617-338-5241
Fax: 617-338-5242
www.healthlawadvocates.org

HealthLawAdvocates

Fighting for Health Care Justice

BOARD OF DIRECTORS

Wendy E. Parmet
Ellen A. Bruce
Jeffrey N. Catalano
Michael S. Dukakis
Paul W. Finnegan
Ruth Ellen Fitch
Daniel J. Jackson
Diane Bissonette Moes
John E. McDonough
S. Stephen Rosenfeld
Thomas P. Sellers
Eleanor H. Soeffing

LEGISLATIVE HEARING RELATIVE TO

HOUSE 1871

AN ACT RELATIVE TO MENTAL HEALTH PARITY

Before the
Joint Committee on Mental Health and Substance Abuse

October 1, 2007

EXECUTIVE DIRECTOR

Barbara Anthony

VOLUNTEER LEGAL DIRECTOR

S. Stephen Rosenfeld

STAFF ATTORNEYS

Matt Selig
Lorianne Sainsbury-Wong
Rebecca Rodman
Rebecca Brink
Mary Cyriac
Georgia Maheras

PARALEGALS

Elaine Griffin
Chris Haner

OFFICE MANAGER

Irene Nicolaides

ADMINISTRATIVE ASSISTANT

Laura Healey

**TESTIMONY OF
HEALTH LAW ADVOCATES, INC.**

Presented by
Clare D. McCorrian, Esq.

Thank you for the opportunity to testify in support of House 1871, “An Act Relative to Mental Health Parity.” My name is Clare McGorrian. I am an attorney in private practice, with a focus on representing individuals in health insurance disputes. I am testifying today on behalf of Health Law Advocates, where I served as Senior Staff Attorney from 1997 to 2005. In that capacity I led HLA’s efforts to expand the scope of the Mental Health Parity Law. I presently serve as of counsel to HLA on its MassHealth dental access litigation and other areas. This testimony was prepared with the able assistance of Rebecca Brink of Health Law Advocates.

Health Law Advocates is a non-profit public interest law firm affiliated with the statewide advocacy group Health Care For All. HLA provides free legal assistance to low-income Massachusetts residents who cannot access needed health care. Since 1996, HLA has represented many clients seeking adequate mental health services. Expanding insurance coverage of mental health treatment is one of HLA’s top priorities.

For many years, mental illnesses were subject to discriminatory treatment by health insurers. While most health plans did not set dollar or unit of service caps on treatment of physical conditions, mental disorders were routinely subject to such restrictions. The legislature recognized the need to address this wrongful discrimination in chapter 80 of the Acts of 2000, the Mental Health Parity Law. Under this law, an insurance plan is providing parity if it “does not contain any annual or lifetime dollar or unit of service limitation on coverage for the diagnosis and treatment of [certain designated] mental disorders which is less than any annual or lifetime dollar or unit of service limitation imposed on coverage for the diagnosis

and treatment of physical conditions.” This important act brought Massachusetts closer to ensuring fair insurance coverage for mental illness.

Unfortunately, the intervening years have revealed shortcomings in the 2000 law. A major limitation of the law is that adults are entitled to non-discriminatory insurance coverage only for a handful of mental illnesses deemed “biologically-based.” There is no clear scientific basis for identifying certain mental conditions as “biologically-based.”¹ Health Law Advocates applauds House 1871 and its chief sponsor Representative Ruth Balser for eliminating the unfounded “biologically-based” distinction among mental health conditions. The proposed legislation rightly establishes parity for *all* mental disorders included in the most recent edition of the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM) or in the most recent edition of the International Classification of Diseases and Related Health Problems (ICD).

Many conditions not deemed biologically-based under the 2000 law have just as adverse an impact as the so-called “biologically-based” disorders. For example, individuals who suffer from eating disorders, post-traumatic stress disorder and addictions – conditions not “biologically-based” under current law -- have equal need for appropriate treatment, free from arbitrary coverage limits. Under existing law, adults who do not have one of the few listed “biologically-based” disorders are entitled to no more than 60 inpatient days and 24 outpatient visits, regardless of medical necessity.

¹ The primary diagnostic tool of mental health professionals, the Diagnostic and Statistical Manual of Mental Disorders (DSM), does not categorize mental disorders by biological basis. Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 4th ed. 1994), at xxii.

While it is rare today for a patient to remain 60 consecutive days in an inpatient mental health setting, a serious mental illness – whether or not designated “biologically-based” – may require more than 60 days of inpatient treatment over the course of a year. The 24-visit limit for outpatient mental health treatment is also problematic. Many people have contacted HLA distraught that they can no longer see a therapist who is providing them with valuable treatment. HLA attorneys generally have to inform these clients that they have no legal recourse and must wait until the following year to obtain insurance payment for their therapy. Because HLA clients have limited incomes, they rarely can afford to continue treatment. Outpatient mental health services provide crucial support, allowing many individuals to function in the community and avoid expensive hospitalizations.

Children with mental illness also struggle to get appropriate services under current law. The 2000 law requires insurers to provide coverage on a non-discriminatory basis for children up to age 19 who have a designated “biologically-based” condition or a *non-biologically-based* mental, behavioral or emotional disorder described in the DSM which substantially interferes with or substantially limits the functioning and social interactions of the child.² Under this formulation, certain developmental disorders, such as autism, that meet the substantial interference test but are viewed as having biological origins, may fall outside the protections of the law altogether.

The proposed legislation raises the age of children protected to 21 years and broadens coverage by requiring that insurers cover the diagnosis and treatment of all mental disorders

² See, e.g., Mass. Gen. Laws ch. 32A, § 22(c).

in the DSM, ICD or the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood. Clarifying the scope of mandatory mental health coverage for children will reduce suffering and permit parents to focus on their child's healing instead of battling their insurance plan.

Another problem with current law is that the addition of new conditions entitled to full parity is left to the discretion of the Commissioner of Mental Health.³ In 2004, HLA's Eating Disorders Task Force petitioned the Commissioner to add eating disorders to the list of full parity conditions. The petition was supported by reports from a clinical expert demonstrating that eating disorders are "biologically-based." With no explanation, the Commissioner declined to extend full parity to eating disorders. Other groups have met with similar barriers. Legislators who passed the 2000 Mental Health Parity Law presumably expected the Commissioner to amend the "biologically-based" disorders list when presented with substantial clinical evidence. The legislation before us today makes clear that full parity must be afforded to all clinically recognized mental disorders, and will thus prevent unjustified denials of insurance coverage.

A number of studies have shown that comprehensive insurance parity for mental disorders, as proposed in House 1871, is affordable. Maryland's full parity law, for example, has resulted in premium increases of less than one percent.⁴ Furthermore, the severe psychiatric conditions deemed "biologically-based" under current Massachusetts state law, such as

³ The Commissioner of Mental Health makes the decision to expand the "biologically-based" list in consultation with the Commissioner of Insurance. *See, e.g.*, Mass. Gen. Laws ch. 32A, §22(a)(10).

⁴ According to one study, at most parity protections may raise insurers' costs by four percent. Mental Health America (formerly National Mental Health Association), *Mental Health and Substance Abuse Parity Fact Sheet* (www1.nmha.org/state/parity/parity_fact_sheet.cfm).

schizophrenia and bipolar disorder, account for the vast majority of cost increases after a parity law is implemented.⁵ Thus, Massachusetts should already have experienced the major anticipated cost impact of the parity law's passage.

Though some insurers will claim that full parity for mental disorders is too costly, lack of parity costs the state and nation more. The impact of inadequately treated mental illness on the patient, his family and friends, and society costs a great deal more in dollars and human suffering than any likely premium increase.

With the implementation of chapter 58 of the Acts of 2006, the Commonwealth has begun to make great strides in improving *access* to health insurance. It is incumbent on the legislature to also ensure that Massachusetts residents have meaningful *coverage* of mental health treatment. Too many people with mental illness suffer unnecessarily because their insurance plans do not pay for essential services. Health Law Advocates strongly supports House 1871. We urge you to report the bill favorably out of Committee and to work diligently for its passage. Thank you.

⁵ Sing, M., Hill, S., Smolkin, S., & Heiser, N. (1998). *The costs and effects of parity for mental health and substance abuse insurance benefits* (Department of Health and Human Services Publication No. (SMA) 98-3205). Rockville, MD: Substance Abuse and Mental Health Services Administration.