

November 20, 2019

The Honorable Frank Pallone
Chairman
Committee on Energy & Commerce
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Bobby Scott
Chairman
Committee on Education & Labor
2176 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Pallone and Chairman Scott,

We are writing to respectfully request that your respective committees hold hearings on health insurance coverage of mental health and substance use disorders. As you know, the landmark Mental Health Parity and Addiction Equity Act (Federal Parity Act), which was enacted more than a decade ago, was a watershed in mental health and addiction coverage. Because of the Federal Parity Act, inequitable financial requirements for consumers and quantitative limits for mental health and addiction care have largely been eliminated. However, despite the law, health plans continue to use discriminatory managed care practices – known as “non-quantitative treatment limitations,” or NQTLs – to wrongfully deny needed care.

We believe your committees can play a critical role in shining a light on how this unacceptable rationing of mental health and addiction treatment through coverage limits is helping to fuel our country’s ongoing overdose and suicide crises, which are killing well over 100,000 Americans each year. During the greatest public health crisis of our generation, we should be tearing down the barriers to coverage for individuals seeking treatment for mental health and substance use disorder care. Instead, when individuals finally summon the courage to seek help, the mental health and addiction coverage their health plans have promised is too often denied.

Your committees can also help draw the connection between inadequate mental health and addiction provider networks and plans’ grossly unequal reimbursement. If enforced, the Federal Parity Act can be a powerful lever to address this issue. Health plans are required to set reimbursement for mental health and addiction providers in the same way as they do for other types of medical providers. Yet, data from a new report by the actuarial firm Milliman demonstrates that mental health and addiction providers are reimbursed 19 percent less than primary care providers and 16 percent less than other medical specialists nationally for office visit services. Not surprisingly, plans have difficulty attracting mental health and addiction providers. The same report shows that disparities in behavioral health out-of-network utilization, compared to medical/surgical out-of-network utilization, continued to increase for all service types in 2016 and 2017. For outpatient facility care, the disparity in out-of-network behavioral health utilization disparities nearly doubled between 2013 and 2017 – from 3.0 times to 5.7 times out-of-network utilization for medical/surgical outpatient facility care. If health plans raise rates to attract providers in other areas of medicine (as is often the case), health plans should be doing the same for mental health and addiction.

We believe it is also important to show how health plans inequitable coverage of mental health and addiction has profound economic costs that are eventually paid by taxpayers. Mental health conditions are the leading cause of disability in the United States. Depression alone costs our economy \$210 billion a year. Furthermore, when individuals cannot get needed coverage for mental health and addiction care, they frequently lose their jobs, and families often deplete savings and mortgage homes in a desperate attempt to pay for treatment out of pocket, with the end result that individuals end up on Medicaid. Inadequate mental health and addiction coverage is also tied to our nation's crisis of homelessness: at least one-quarter of the more than 550,000 people experiencing homelessness on any given night in the United States suffer from a serious mental illness.

Notably, the U.S. District Court in the Northern District of California recently ruled that United Behavioral Health (UBH), the nation's largest managed behavioral healthcare company, had created its own flawed medical necessity guidelines to wrongly deny mental health and addiction care. In *Wit v. UBH*, the class-action case with more than 50,000 individuals denied coverage, the court found the record "replete" with evidence that financial considerations had infected the development of the guidelines and that UBH used this as a strategy to "mitigate" the impact of the Federal Parity Law. Parity hearings within your committees should explore the prevalence of plans using restrictive manage care practices to avoid paying for needed mental health and addiction care.

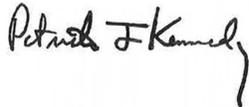
The hearings also can help bring everyone up-to-date with the U.S. Department of Labor (DOL), state insurance departments and other government agencies current parity enforcement efforts. The hearings could be used to promote best regulatory reporting and enforcement practices, including the need to: 1) require more insurer reporting of processes, strategies, evidentiary standards and other factors used in complying with the Federal Parity Law (and applicable state laws); 2) identify additional resources for regulators to carry out more parity audits; 3) standardize the fidelity of parity audits; 4) implement more effective risk management strategies that insurers can use (such as online parity compliance tools and accreditation standards); 5) recommend ways to increase civil (and perhaps criminal) penalties for non-compliance; and 6) understand how consumers can better leverage the Federal Parity Law to prevent unlawful denials of care.

Hearings on federal parity would also be an opportunity to draw attention to current bills that have been introduced and referred to your Committees to promote compliance, enforcement and transparency. This includes the Behavioral Health Coverage Transparency Act (HR 2874) introduced by your colleague Rep. Joseph Kennedy of Massachusetts. HR 2874 would require group health plans to disclose to federal regulators how they are making parity decisions, and the rate and reasons for denials of mental health claims and establish a Consumer Parity Unit that gives consumers a single place to get information about their rights and to submit complaints with assurance of timely responses. Another important bill is the Mental Health Parity Enforcement Act (HR 2848), introduced by your colleague Donald Norcross of New Jersey. HR 2848 expands the Department of Labor's civil monetary penalty authority to issue fines for parity violations, which was a key recommendation of the President's Commission on Combating Drug Addiction and the Opioid Crisis.

Finally, we urge your committees to delve into the devastating consequences of repealing (or overturning) of the Affordable Care Act. As you know, the Federal Parity law only requires that mental health and addiction coverage be at parity with other types of medical coverage *if* a plan offers mental health and addiction coverage. But, the ACA's essential health benefits required most types of health plans to cover mental health and addiction care, thereby triggering the Federal Parity Act's protections. If the ACA were to go away, the Federal Parity Act would be much less powerful. Additionally, the loss of critical protections like those for preexisting conditions and taking away insurance from millions of people would further undermine our country's response to the overdose and suicide crises.

We stand ready to assist you in any way we can. Thank you for your continued commitment to getting all Americans the mental health and addiction care they need.

Sincerely,



Patrick J. Kennedy
Former U.S. Representative (D-RI)
Founder, The Kennedy Forum



James Ramstad
Former U.S. Representative (R-MN)
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