Patrick J. Kennedy

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U.S. Department of Labor
Advisory Council on Employee Welfare and Pension Benefit Plans (ERISA Advisory Council)
200 Constitution Ave. NW
Washington, DC 20210

Dear Members of the ERISA Advisory Council,

I appreciate the opportunity to submit testimony on the important moral and economic issue of mental health and substance use disorder (MH/SUD) parity in insurance coverage. Historically, individuals with MH/SUDs have experienced deep-seated discrimination, including in disability and health insurance coverage. Congress first sought to address rampant discrimination in health insurance by passing the Mental Health Parity Act of 1996 (MHPA), which prohibited large group health plans that offered mental health benefits from having higher lifetime and annual dollar limits for mental health services than for physical health benefits.

While a step forward, MHPA did not address other critical issues, including other discriminatory financial requirements and treatment limitations. Furthermore, MHPA did not include substance use disorders. In order to broadly combat discrimination in health insurance coverage, I coauthored the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Federal Parity Act) with my dear friend, the late Congressman Jim Ramstad (R-MN). This landmark law has a simple premise – individuals seeking MH/SUD treatment deserve the same coverage as those seeking physical health treatment. After all, the brain is part of the body.

When we were fighting to pass the Federal Parity Act, many health insurers claimed the sky would fall if we prohibited discrimination against MH/SUD services. One of the primary arguments was premiums would rise if insurers were required to cover MH/SUD at parity with physical health services.

Yet, thankfully, we had evidence from the Federal Employee Health Benefit Program (FEHBP). After President Clinton mandated parity in FEHBP plans, research demonstrated that there was no increase in premiums. And after the Federal Parity Act was enacted, parity improved access to services without increasing premiums. There is even a built-in mechanism in the Federal Parity Act for plans to be exempted from parity requirements if a plan can show an increase of premiums of more than one percent in any plan year due to compliance. Tellingly, no plan has ever applied for this exemption.

When we look at the nature of these conditions, we see why parity has not increased costs. Untreated (or undertreated) MH/SUDs drive large increases in physical health care costs. Research by both Milliman and Moody's has shown that individuals not receiving needed MH/SUD treatment have 2 to 3.5 times higher physical health care costs and individuals without MH/SUDs. Smart insurers are recognizing that treating MH/SUDs is key to controlling overall costs. According to Moody's, "[Insurance] companies that can better treat mental and behavioral issues will have an advantage over those that fail to improve in this area, leading to greater long-term growth."

Employers are also finally seeing the enormous impacts that MH/SUDs have on their bottom line. In addition to driving physical health care costs higher, failing to meet their employees' mental health and substance use needs results in decreased productivity ("presenteeism"), absenteeism, and turnover. Dr. Tom Insel, former director of the National Institute of Mental Health, noted that "the economic costs of mental illness will be more than cancer, diabetes, and respiratory ailments put together."

Of course, the costs of untreated MH/SUDs are also borne by public programs and taxpayers. An all-too-frequent trajectory of individuals with even "high quality" commercial health insurance is having care denied, losing employment and income, and eventually transitioning to Medicaid and other public benefits. Too many individuals become disabled and even homeless. Discrimination against these conditions also contributes to early mortality, with 300,000 individuals dying each year from deaths of despair – drug overdoses, suicide, and alcohol use.

There is now broad bipartisan recognition of the importance of parity in health insurance. However, rampant discrimination in disability insurance coverage has largely escaped scrutiny. Indeed, most disability insurance policies limit benefits for disabilities caused by MH/SUDs to only 24 months, while disabilities caused by physical illnesses face no such limitations.

Such discrimination is indefensible. Rampant discrimination in disability insurance benefits reinforced the pervasive message that MH/SUDs are shameful and unworthy of financial protections. Implicit (and often explicit) in such discrimination is that the individual suffering is at fault. When individuals are denied disability benefits because of their mental health or substance use disorder, they are directly impacted – and costs shift to taxpayers when public programs must fund services for individuals who lose critical financial protections.

When advocates push to eliminate this discrimination, we once again hear spurious claims that ensuring parity in disability insurance will cause premiums to rise. Yet, when Vermont prohibited discrimination in disability insurance against individuals whose disabilities were due to their MH/SUD, insurers easily complied and costs didn't increase.

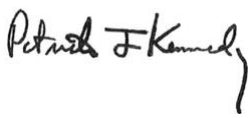
Much like parity in FEHBP, Vermont's experience is illuminating. When the Vermont Department of Financial Regulation was considering outlawing discrimination against MH/SUDs in disability insurance, insurers claimed that costs would increase as much as 25 percent and they would be forced to exclude or limit coverage. Yet Phil Keller, who worked for the Department for 30 years, testified before you this summer that after Vermont went ahead and prohibited discrimination in 2008, "not once…was I made aware of complaints from either consumers or agents that the cost of disability insurance had risen because of the required coverage of mental health conditions," in

stark contrast to frequent affordability complaints about health care, long-term care, and automobile insurance. Vermont's experience has shown that prohibiting disability insurance discrimination against mental health conditions had little to no impact on premiums.

Addressing our ongoing mental health and addiction crisis is a defining issue of our time. We can no longer allow individuals with these conditions to be subject to legalized discrimination. I urge members of the ERISA Advisory Council to support the cause of bringing parity to disability insurance coverage. There can simply be no justification for discriminating against an individual because their disability is caused by an MH/SUD rather than a physical health condition.

Thank you for your time and attention to this important issue.

Sincerely,



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