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I would like to thank Chairman Stark and Ranking Member Camp for holding this hearing on the important issue of mental health and substance abuse parity for both private insurance as well as Medicare.

As a psychiatrist for over 30 years, I have been an advocate for full parity for all mental health and substance use disorders for all payers both public and private. Most of my career has been in mental healthcare administration in both the public and private sector. I spent 10 years in the public health system in Maryland, three of those years as director of the State Mental Health Authority.

I have also been chief executive officer of two national managed behavioral healthcare organizations: Greenspring Health Services and Magellan Health Services. Both of these companies held responsibility for managing the mental health and substance abuse benefits for millions of Americans. These individuals were insured by commercial insurers, Medicaid, or Medicare. I was CEO of Magellan from 1998 to 2001, and chairman for almost two more years. During that time Magellan was the largest of the managed behavioral healthcare companies and had approximately 70 million members. Magellan managed the behavioral health benefits for approximately 40 percent of Fortune 500 companies. I had the privilege of serving on the President's New Freedom Commission on Mental Health in 2002 and 2003, and more recently co-chaired a work group for the National Business Group on Health that produced a document in December 2005 entitled "An Employer's Guide to Behavioral Health Services." Currently, I am providing health consulting services. My comments about the Chairman's Medicare Mental Health Modernization Act of 2007 are based on these professional experiences.

There have been at least four major publications over the last decade to summarize the progress that has occurred in the behavioral health field, as well as many of the remaining challenges. Key recommendations to address these challenges would advance the treatment success of individuals with mental health and substance use disorders.

The publications include:

1. The 1999 publication of the Surgeon General's Report on Mental Health;
2. The President's New Freedom Commission Report on Mental Health in 2003;
3. The Institute of Medicine's report on Improving the Quality of Healthcare for Mental and Substance Abuse Conditions from November 2005; and
4. The December 2005 National Business Group on Health's guide to behavioral health services mentioned above.

All of these documents recognize the critical importance of adequate financing of behavioral healthcare services in implementing the recommendations outlined in all of these national reports. Removing or reducing the financial barriers that exist today in private insurance, Medicare, and Medicaid are minimum requirements for the successful achievement of effective, evidence-based behavioral health services and the improvement of the lives of our citizens who are suffering from these illnesses. The most significant barrier to equal access is of course the 50 percent coinsurance requirement for outpatient psychotherapy services under Medicare, whether delivered by a psychiatrist, psychologist or other behavioral health specialist. If a Medicare patient has an office visit with any other medical specialist such as a cardiologist, endocrinologist,

or oncologist for a physical illness the coinsurance is 20 percent. The Medicare Mental Health Modernization Act would end this longstanding discrimination against the mentally ill.

Other witnesses can attest to the negligible increase in cost resulting from the implementation of parity in many insurance programs over the last two decades. Numerous studies have shown that the increased cost for full parity ranges from no increase in cost to an increase of around 0.9 percent in total medical premiums. At Magellan we managed a number of accounts that introduced parity benefits, and in our experience, the increase in cost was from a low of 0.2 percent to about 0.8 percent of the premium. Most of the increase was due to an expansion of outpatient services, paired with a decrease in out-of-pocket expenditures for the consumer and a corresponding increase in expenses by the payer. The concern that providing equal benefits for medical and behavioral health care would lead to runaway costs and increases in utilization has not materialized in study after study. All of these studies, however, were based on the ability to provide utilization management of the mental health benefit.

There have been a number of unintended and deleterious consequences that have resulted from the arbitrary limitation of access to specialty behavioral services. I will focus on two of these consequences in my testimony, as I am sure other witnesses and panel members will discuss other important negative consequences.

Increased reliance on the general medical setting for behavioral care and use of psychiatric medications as the sole form of mental health treatment.

Many patients want their mental health and substance abuse treatment to be given by primary care physicians and this type of utilization has increased significantly over the past decade. But due to benefit limitations and higher out-of-pocket expenses for mental health services, patients who both want and need access to specialty care often have little choice but to receive mental health treatment in primary care settings alone. Most primary care offices are not equipped to provide a full range of behavioral diagnostic and treatment services. The most common intervention by the primary care office for these disorders is the prescription of psychotropic medications, and increasingly these drugs are being used as the sole form of treatment.

The 2003 New Freedom Commission Report has described the general medical system as the “de-facto mental health system.” The Surgeon General’s Report of 1999 documented that primary care physicians prescribe over 60 percent of psychotropic drugs. Some studies have shown that over 50 percent of patients with depression who receive any treatment are managed exclusively in primary care settings. This percentage is even higher among older adults covered under Medicare. Primary care physicians are an essential part of the health care system for behavioral disorders, but when this becomes the only option, we are depriving many patients of the most effective and medically appropriate treatment. Many primary care physicians have expressed the need for greater support and collaboration from behavioral health specialists, and enactment of the Medicare Mental Health Modernization Act would make this possible.

Several studies have documented the delivery of suboptimal psychiatric care when located solely in primary care settings. The National Comorbidity Survey Replication Study (NCS-R) found that only 12.7 percent of mental health patients treated in the general medical setting received minimally adequate care compared to 43.8 percent treated in the specialty mental health sector (Wang et al, *Arch of General Psych*, 2005).

Most studies have shown that the majority of mental health and substance use disorders have better outcomes when appropriate drug treatments are combined with psychosocial interventions. Most, but not all, private payers and the Medicare program have benefit structures that make it less expensive for the consumer to access care in the general medical setting with psychotropic drug treatment than to get optimal access to specialty care where a more effective combination of

psychosocial and pharmaceutical interventions can be delivered. Many health care leaders as well as legislators and citizens have expressed concerns that psychiatric drugs are being overused in some populations. Concerns have been raised about the frequent use of stimulant drugs such as Ritalin for children with Attention Deficit Disorders, anti-depressant usage for depression in children and teenagers, and anti-psychotics being used extensively in the elderly. As long as we continue to have a benefit design that restricts access to the most appropriate care, we should not be surprised by these trends.

Limited ability to appropriately address high-risk, high-cost chronic conditions such as diabetes and congestive heart failure.

Lack of access to effective behavioral health care for common mental disorders such as depression also contributes to the inadequate intervention by health care professionals for high-risk and high-cost chronic medical (physical) conditions. Many studies have shown that a small percentage of patients with chronic medical conditions insured by Medicare, as well as other payers, account for a majority of the spending. We now know that a significant number of these patients also have behavioral disorders, particularly depression. The estimates range from as high as 30 to 50 percent of patients with diabetes and heart conditions. The medical costs for patients presenting chronic medical conditions along with mental health conditions such as depression are often double those of patients without a comorbid behavioral condition (see New Freedom Commission Report and the National Business Group on Health Report listed above).

Many physicians, managed care companies, disease management companies and payers, including Medicare, are exploring specialized interventions for this high-cost subgroup to address the chronic medical conditions and behavioral health concerns of these patients. Without effective treatment for depression and other common behavioral conditions presenting in 30 to 50 percent of these patients, however, the success of these intervention programs will be severely limited.

Evidence-Based Practices and Collaborative Care

In my final comments, I would like to focus on another key aspect of the Medicare Mental Health Modernization Act of 2007. The legislation recognizes the importance of evidence-based practices and requires the Medicare program not only to equalize benefits between medical and behavioral health care services, but also to cover a range of evidence-based practices for care.

Just as health care payers have been slow to modernize their payments for behavioral health services, they likewise have not allowed for payment of clinical programs that have been scientifically proven to be more effective than the traditional inpatient programs and office-based outpatient programs. As I said at the beginning of my testimony, parity is a minimum requirement – but not a sufficient one – to bring Medicare payment policies in line with 21st Century treatment for mental health and substance use disorders.

There are several community-based treatment programs listed in the Medicare Mental Health Modernization Act that are both more effective and less expensive than the traditional inpatient care currently funded by Medicare. Oftentimes, these community-based programs do not require the addition of new services under Medicare, but only flexibility in payment so that these more efficient programs can be substituted for the more costly services.

Unfortunately, the current draft of the Chairman's bill fails to recognize one critical evidence-based practice that has already shown great effectiveness, especially for elderly depressed patients: collaborative care. While parity and the access to evidence-based specialty mental health treatments are essential to reducing the barriers to effective treatment for the millions of older adults with common mental disorders, many older adults will continue to visit primary care

providers rather than mental health specialists for treatment of common mental disorders such as depression. “Collaborative care programs” facilitate effective collaboration between primary care physicians and mental health specialists, and over 35 studies spanning 20 years of research in the United States and Europe have demonstrated that collaborative care programs are more effective than the care available if collaboration is restricted. Collaborative care has been shown to more than double the effectiveness of traditional care for depression, and at a lower cost than traditional care alone.

In short, collaborative programs improve access to evidence-based mental health treatments and improve coordination of primary care and mental health care for patients with a combination of mental and chronic medical disorders. I will reference the National Business Group on Health’s Report to describe the collaborative care model:

“Collaborative Care: A Cost-Effective Primary Care Treatment Modality”

Successful interventions to improve care for depression have a number of common features, commonly referred to as “collaborative care.” The collaborative care model focuses on treatment in general medical settings (vs. specialty behavioral healthcare settings) for most patients. Collaborative care includes and combines several quality improvement strategies, such as screening, case identification, and proactive tracking of clinical (e.g., depression) outcomes, clinical practice guidelines and provider training, support of primary care providers treating depression by a depression care manager (e.g., a nurse, clinical social worker, or other trained staff), and collaboration with a behavioral health specialist (e.g., a psychologist or a psychiatrist).

While the details vary, collaborative care interventions have two key elements. The first is case management by a nurse, social worker, or other trained staff, to facilitate screening, coordinate an initial treatment plan and patient education, arrange follow up care, monitor progress, and modify treatment if necessary. Case management can be provided in the clinic and/or by telephone. The second is consultation between the case manager, the primary care provider, and a consulting psychiatrist, in which the psychiatrist advises the primary care treatment team about their caseload of depressed patients. This consultation is intended to maximize the cost-effectiveness of collaborative care, by facilitating a process described as “stepped care,” where the treatment algorithm starts with relatively low-intensity interventions such as antidepressant medication prescribed by the primary care provider and telephone case management, with patients who fail to respond being shifted to progressively more intensive approaches including specialty behavioral healthcare.

More than ten large trials, in a wide range of settings, have demonstrated the feasibility of improving depression treatment and outcomes, relative to usual care. The documented benefits of collaborative depression care include:

- Higher rates of evidence-based depression treatment (i.e., antidepressant medication and/or psychotherapy)
- Better medication adherence/compliance
- Reduction in depression symptoms, and earlier recovery from depression
- Improved quality of life
- Higher satisfaction with care
- Improved physical functioning
- Increased labor supply

Collaborative care has typically been found to increase direct healthcare costs slightly, relative to usual care, mainly by increasing the use of evidence-based depression treatment. However, this investment yields substantial improvements in patients’ health status and functioning, so that collaborative care is more cost-effective than usual care for depression and has very favorable

cost-effectiveness compared with other accepted medical interventions. For example, the largest trial of collaborative care for depression to date found that the program participants were depression-free for an additional 107 days over two years, relative to usual care, without adding significant increases to healthcare costs.

Many of the elements of collaborative care would be adequately financed if the parity section of this bill is approved. However, to fully implement an evidence-based collaborative care program two additional services would need to be included for reimbursement, as the current Medicare payment structure would not allow for payment. These two elements are: 1) the care management/disease management function, and 2) the psychiatric consultation to care managers and primary care providers. Over 30 studies suggest that these elements are required to make collaborative care effective and to achieve maximum value from the mental health benefits covered under the parity section of this bill. I would hope that the committee would consider adding these service categories. The addition of these categories would allow older adults to receive more effective treatment for common mental disorders in primary care settings, where many of them prefer to receive care, while also providing access to consultation from experienced mental health specialists and effective mental health specialty services if needed.

This concludes my testimony, and I would like to thank the Subcommittee for inviting me to present these views and suggestions. I would welcome any questions from the Chairman or members of the Subcommittee.