

Packet on Mental Health and Addiction Equity Act (H.R. 1424)

- A Summary of the Bill, prepared by the Committees on Education & Labor, Energy & Commerce, and Ways & Means
- A Fact Sheet on the Bill, prepared by the Office of Speaker Pelosi
- “Ending Insurance Discrimination Is Not Just the Right Thing to Do, It’s the Smart Thing to Do,” prepared by the Office of Rep. Patrick Kennedy (D-RI)
- Information on the Bill’s Two Offsets:
 - Arguments in Favor of Increasing the Medicaid Rebate, prepared by the Committee on Energy and Commerce
 - Letter from Freshmen Democrats on Self-Referral to Physician-Owned Hospitals Provisions
- “Why H.R. 1424 Is A Strong Mental Health Parity Bill,” prepared by the Committee on Energy and Commerce
- Letter in support from the Parity Now Coalition, a coalition of more than 100 organizations
- Letter in support from Mental Health America
- Letter in support from American Psychiatric Association
- Letter in support from American Psychological Association

**PAUL WELLSTONE MENTAL HEALTH
AND ADDICTION EQUITY ACT OF 2007 (H.R. 1424)
Rep. Patrick Kennedy and Rep. Jim Ramstad**

Summary

This bill permanently reauthorizes and expands the Mental Health Parity Act of 1996 to provide for equity in the coverage of mental health and substance-related disorders compared to medical and surgical disorders. The legislation ensures that group health plans do not charge higher co-payments, coinsurance, deductibles, and impose maximum out-of-pocket limits and lower day and visit limits on mental health and addiction care than for medical and surgical benefits. The Department of Health and Human Services, the Department of Labor, and the Internal Revenue Service may penalize health plans for discriminatory practices under the bill and individuals may bring a private right of action to receive covered benefits.

Parity Requirements

The bill does not mandate group health plans provide any mental health coverage. However, if a plan does offer mental health coverage, then:

- Equity in financial requirements. The plan or coverage must ensure that any financial requirements applied to mental health and substance-related disorders are no more restrictive or costly than the financial requirements applied to the predominant requirement on comparable medical and surgical benefits that the plan covers. Financial requirements include deductibles, co-payments, coinsurance, and out-of-pocket expenses.
- Equity in treatment limits. The plan or coverage must also ensure that any treatment limitations applied to mental health and substance-related disorders are no more restrictive than the treatment limitations applied to the predominant limitation on comparable medical and surgical benefits that the plan covers. Treatment limitations include caps on the frequency or number of visits, limits on days of coverage, or other similar limits on the scope and duration of treatment.
- Prohibits discrimination by diagnosis. The plan or coverage must cover the mental illnesses and substance-related disorders included in the Diagnostic and Statistical Manual of Mental Disorders (DSM) – the mental health practitioner’s guide to mental illnesses. This is the same coverage that Members of Congress have.
- Equality in out-of-network coverage. If the plan or coverage offers out-of-network benefits for medical and surgical benefits under the plan, then it must also offer out-of-network coverage for mental health and substance-related disorders.

Scope of Coverage

- The mental health parity requirements apply to group health plans with 51 or more employees, but does not apply to health coverage in the individual insurance market.

Cost Exemption

- If the requirements in this bill result in increased actual total costs of coverage that exceed 2% during the first plan year or 1% in subsequent years, the plan may choose to be exempt from the equity requirements for the following plan year.

Effect on State Mental Health Parity Laws

- The bill would establish a federal floor but permits states to go further to protect their citizens. This bill would not supersede any state law that provides consumer protections, benefits, rights, or remedies stronger than those in this bill.

Transparency in Medical Management

- Plans will be required to make information about criteria used for medical necessity determinations and reasons for denials relating to mental health and addiction treatment available. The bill expressly clarifies that nothing in the Act prevents the use of medical management tools that are based on valid medical evidence and are relevant to the patient whose medical treatment is under review.

Enforcement

- The Internal Revenue Service may impose a tax of \$100 per day per beneficiary on employers or insurers who do not comply with the equity requirements of this bill. The Department of Health and Human Services and Department of Labor can also enforce the provisions of this bill. Aggrieved individuals may bring a civil action to obtain covered benefits.

Government Accountability Office Reports

The bill requires GAO to produce three reports:

- A study of the bill's impact on health care costs, access to coverage, quality of care, government spending on mental health and addiction treatment and other public services, and use of medical management by plans.
- A biannual assessment of obstacles beneficiaries face in obtaining appropriate care under their health plans.
- A study of the availability and use of uniform patient placement criteria that can help guide health plans' determinations of medical necessity.

Effective Date

- The bill is effective in the first health plan year that begins on or after January 1, 2009.



H.R. 1424, Paul Wellstone Mental Health and Addiction Equity Act

Key Points:

- **This bipartisan bill, sponsored by Rep. Patrick Kennedy (D-MA) and Jim Ramstad (R-MN), is designed to end discrimination against patients seeking treatment for mental illnesses.**
- **Specifically, the bipartisan bill prohibits insurers and group health plans from imposing treatment or financial limitations when they offer mental health benefits that are more restrictive from those applied to medical and surgical services.**
- **The bill applies only to insurers and group health plans that provide mental health benefits. It also exempts businesses of 50 or fewer employees; and businesses that experience an overall premium increase of 2 percent or more in the first year and 1 percent in subsequent years.**
- **Over the last eight years, the Federal Employee Health Benefits Program (FEHBP) has made “parity” coverage for mental health care available to Members of Congress and 8.5 million other federal employees. Research has shown that there has been no significant cost increase attributable to this parity requirement in FEHBP.**
- **Furthermore, the nonpartisan Congressional Budget Office has estimated a miniscule impact on premiums for the mental health parity bill – just two-tenths of one percent.**
- **The two offsets in this bill were included in the CHAMP (Children’s Health and Medicare Protection) Act, which the House passed on August 1, 2007. One increases the rebate (or discount) that pharmaceutical companies are required to provide to State Medicaid programs for drugs provided to Medicaid beneficiaries. The second prohibits physicians from referring patients to hospitals in which they have an ownership interest (with a grandfather provision).**
- **This bipartisan bill is supported by a long list of groups, including the American Medical Association, American Hospital Association, American Nurses Association, American Academy of Pediatrics, National Hispanic Medical Association, American Counseling Association, National Association of Social Workers, Families USA, American Psychiatric Association, American Psychological Association, National Mental Health Awareness Campaign, and Mental Health America.**

It is anticipated that the House will consider H.R. 1424, Paul Wellstone Mental Health and Addiction Equity Act, during the week of March 3. This bipartisan bill is designed to end the discrimination against patients seeking treatment for mental illnesses. Enactment of this landmark bill would be one of the major achievements of the 110th Congress. **Members are urged to vote YES on this bipartisan bill.**

Following is an overview of some of the bipartisan bill's key provisions.

Requires equity in financial requirements. Under the bill, an insurer or group health plan must ensure that any financial requirements – such as deductibles, copayments, coinsurance, and out-of-pocket expenses – applied to mental health and addiction benefits are no more restrictive or costly than the financial requirements applied to comparable medical and surgical benefits that the plan covers.

Requires equity in treatment limits. Under the bill, a group health plan must ensure that the treatment limitations – such as frequency of treatment, number of visits, and days of coverage – applied to mental health and addiction benefits are no more restrictive than the treatment limitations applied to comparable medical and surgical benefits that the plan covers.

Does not mandate mental health benefits. The bill does not mandate insurers or group health plans to provide any mental health coverage. The bill's provisions only apply to plans that choose to offer mental health coverage.

Exempts certain businesses. The bill exempts small businesses with 50 or fewer employees. It also exempts those businesses that experience an overall premium increase of 2 percent or more in the first year and 1 percent in subsequent years.

Covers same mental illnesses and addiction disorders as FEHBP. The bill ensures that group health plans cover the same range of mental illnesses and addiction disorders covered by the Federal Employees Health Benefits Program – i.e., the mental illnesses and addiction disorders included in the mental health practitioner's guide, the Diagnostic and Statistical Manual of Mental Disorders (DSM).

Does not mandate out-of-network benefits. The bill simply states that if a plan already offers out-of-network benefits, it must offer out-of-network benefits on the same terms for mental health services as it does for medical and surgical services.

Does not pre-empt stronger state parity laws. The bill establishes a federal standard, a floor of protections that would apply to job-based health coverage, but allows states to be more protective of their residents with stronger parity laws.

Explicitly permits medical management of health benefits. The bill allows the use of medical management tools that are based on valid medical evidence and pertinent to the patient's medical condition so that specific coverage is not arbitrary in its application and more transparent to the patient.

Provides for enforcement. The bill provides remedies to protect beneficiaries' rights and permits enforcement of the bill's equity requirements by the Internal Revenue Service, the Department of Health and Human Services, and the Department of Labor.

ENDING INSURANCE DISCRIMINATION IS NOT JUST THE RIGHT THING TO DO, IT'S THE SMART THING TO DO

- “Overall, the evaluation showed that parity could be implemented with some increase in access to MH/SA [mental health and substance abuse] care but **little or no increase in total MH/SA spending.**”
(Dept. of HHS, *Evaluation of Parity in the Federal Employees Health Benefits (FEHB) Program: Final Report*, 12/31/04)
- “MH/SA [mental health and substance abuse] **spending fell by 8 to 18 percent after parity** was implemented, despite lower consumer cost sharing and higher limits on use of MH/SA care.”
(Dept. of HHS, *Effects of Vermont’s Mental Health and Substance Abuse Parity Law*, 2003)
- **Depressed workers lose 5.6 hrs per week of productive work time** vs. 1.5 hours per week for non-depressed workers. This costs employers and extra \$31 billion per year. These figures do not include disability claims.
(Stewart et al., *Cost of Lost Productive Work Time Among US Workers With Depression*, JAMA, 6/18/03)
- **Alcohol-related illness and premature death cost over \$129.5 billion** in lost productivity in 1998.
(NIAAA, *10th Special Report to the U.S. Congress on Alcohol and Health*. 2000)
- **Suicides in one year cost the U.S. \$13 billion** in lost earnings.
(Knox, K.L. et al. *American Journal of Public Health*, 2005)
- Healthcare use and **healthcare costs are up to twice as high among diabetes and heart disease patients with co-morbid depression**, compared to those without depression, even when accounting for other factors such as age, gender, and other illnesses.
(National Center on Quality Assurance. *State of Healthcare 2004: Industry Trends and Analysis*. Washington, DC: NCQA; 2004; Lustman PJ. Clouse RE. *Depression in diabetic patients: The relationship between mood and glycemic control. Journal of Diabetes and Its Complications*, 2005; 19: 113-122.)
- Patients with mental illness and substance abuse disorders are often less responsive to treatment. For example, **depressed patients are three times as likely as non-depressed patients to be non-compliant** with their medical treatment regimen.
(Ziegelstein RC. *Depression in patients recovering from a myocardial infarction. JAMA*, 2001; 286(13): 1621-1627.)
- **Limiting employer-sponsored specialty behavioral health services increased the direct medical costs** of beneficiaries who used behavioral healthcare services by as much as 37%. Further, the specialty behavioral health service limitation substantially increased the number of sick days taken by employees with behavioral health problems. The study concluded that savings attributed to limiting behavioral health benefits were fully offset by increased use of other medical services and lost workdays.
(Rosenheck RA. Druss B. Stolar M. Leslie D. Sledge W. *Effect of declining mental health service use on employees of a large corporation: General health costs and sick days went up when mental health spending was cut back at one large self-insured company. Health Affairs*, 1999; September/October: 193-203.)

SUPPORT THE PAUL WELLSTONE MENTAL HEALTH AND ADDICTION EQUITY ACT (H.R. 1424)

Arguments in Favor of Increasing the Medicaid Rebate

1. No one is arguing that Medicaid rebates should be increased to pay for the mental health parity bill because drug companies would benefit from increased use of drugs under an improved mental health parity law. That argument is a red herring.
2. *Spending on drugs has increased faster than inflation in recent years.* The Congressional Budget Office's *Budget Options* volume from 2007 lists increasing the rebate paid by pharmaceutical manufacturers as a potential cost-saving policy for the federal government. Specifically, CBO notes that spending by Medicaid for prescription drugs increased at a rate of 13 percent annually between 2000 and 2005.
3. *Drug manufacturers received significant relief from the rebate in the 2006 Medicare drug law.* With the introduction of the Medicare drug benefit in 2006, Medicaid spending for prescription drugs fell substantially, to only \$10.2 billion. When drug spending from the low income Medicare beneficiaries was transferred from Medicaid to Medicare with the new Part D benefit, manufacturers were no longer paying the Medicaid rebate on that entire portion of drug spending.
4. *Medicaid currently gets, on average, less than a 20% discount on prescription drugs.* Currently for brand-name drugs, the basic rebate is equal to the maximum of a fixed percentage of the Average Manufacturer Price (AMP), currently 15.1%, and the difference between the AMP and "best price" (the lowest price offered to private purchasers). There is an additional rebate if AMP grows faster than inflation. Overall, Medicaid receives an average rebate from manufacturers of slightly more than 20 percent under the current pricing system (not including the additional rebate tied to price inflation). Boosting the rebate from the flat 15.1 percent to 20.1 percent would increase the average Medicaid rebate (relative to AMP) to about 24 percent. This savings is shared with the States as well as the federal government.
5. *Increasing the rebate may enable private purchasers to buy certain drugs at lower prices.* Although manufacturers offer large discounts to private purchasers, according to CBO the best-price provision discourages them from offering discounts between the flat 15.1% rebate because any such discount automatically triggers a Medicaid rebate. A flat higher rebate percentage would allow manufacturers to offer slightly greater discounts without triggering the best-price provision.

Congress of the United States
Washington, DC 20515

February 28, 2008

The Honorable Nancy Pelosi
Speaker
U.S. House of Representatives
H-232 U.S. Capitol
Washington, DC 20515

Dear Speaker Pelosi:

We write today to ask for your consideration and support for inclusion of a provision passed in the Children's Health and Medicare Protection Act (H.R. 3162) in this year's Medicare bill. Section 651 would have prohibited Medicare and Medicaid funds from supporting self-referral to physician-owned hospitals. We are united in the belief that this fiscally responsible provision is critical to the continued viability of full service community hospitals and the quality of health care provided to patients.

Self-referral to physician-owned hospitals encourages the selection of healthier, less complex, and insured patients for higher reimbursement. Consequently, this shifts patient care away from full service community hospitals and harms the safety net for more vulnerable populations. The end result threatens patient safety, limits access to care, promotes overutilization, and further erodes the Medicare Trust Fund. CBO recognized how self-referral affects patient care and Medicare reimbursement in its estimate last year. Enactment of Section 651 would lead to significant cost savings of \$700 million over five years and nearly \$3 billion over 10 years.

We believe that providers should be encouraged and incentivized to continually innovate and discover new ways to improve the quality and delivery of health care. Self-referral, however, is a false short cut. Numerous independent and government studies show that physician ownership and self-referral does not lead to improved outcomes. For example, the Department of Health and Human Service's Office of Inspector General's recent report found that specialty hospitals are ill-equipped to handle emergencies, often relying on local EMS to transport their own patients to nearby emergency departments. These ongoing problems can lead to unsafe, life-threatening care in physician-owned specialty hospitals.

We commend your leadership and the work of Chairman Rangel, Chairman Stark, Chairman Dingell, and Chairman Pallone in advancing this critical provision in the CHAMP Act last year. Section 651 will take effective and long overdue action to address the clear and present dangers of self-referral to physician-owned hospitals. We stand ready to work with you to help enact this provision into law. Thank you for your attention to and consideration of this request.

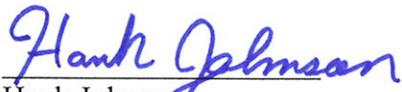
Sincerely,



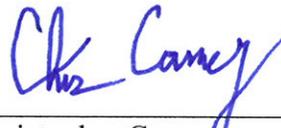
Jason Altmire
Member of Congress



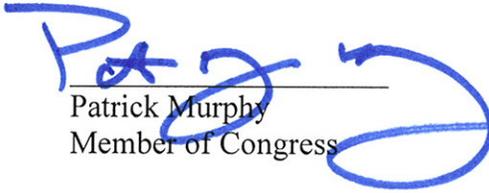
Ron Klein
Member of Congress



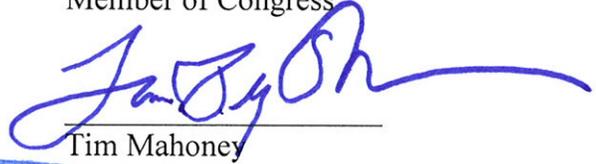
Hank Johnson
Member of Congress



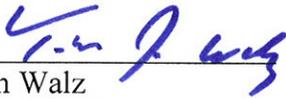
Christopher Carney
Member of Congress



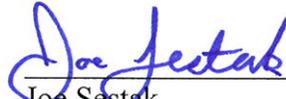
Patrick Murphy
Member of Congress



Tim Mahoney
Member of Congress



Tim Walz
Member of Congress



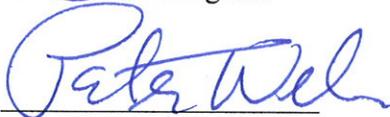
Joe Sestak
Member of Congress



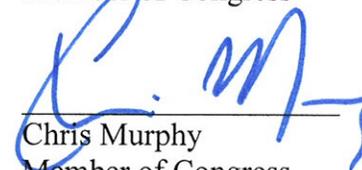
Jerry McNerney
Member of Congress



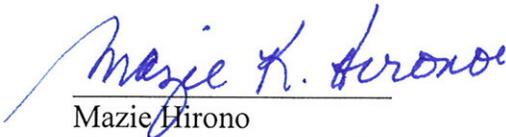
Joe Donnelly
Member of Congress



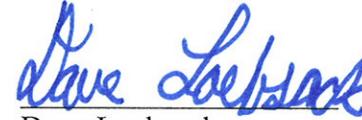
Peter Welch
Member of Congress



Chris Murphy
Member of Congress



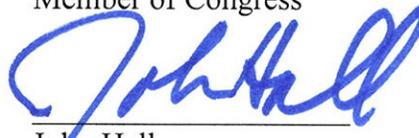
Mazie Hirono
Member of Congress



Dave Loebsack
Member of Congress



Joe Courtney
Member of Congress



John Hall
Member of Congress



Kathy Castor
Member of Congress



Paul Hodes
Member of Congress



Phil Hare
Member of Congress



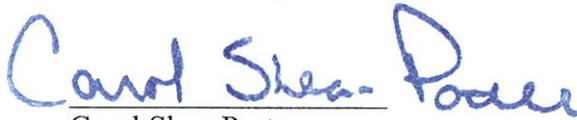
Bruce Braley
Member of Congress



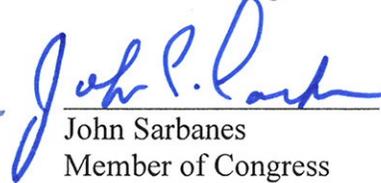
Michael Arcuri
Member of Congress



Betty Sutton
Member of Congress



Carol Shea-Porter
Member of Congress



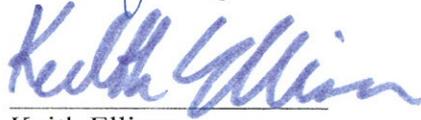
John Sarbanes
Member of Congress



Nancy Boyda
Member of Congress



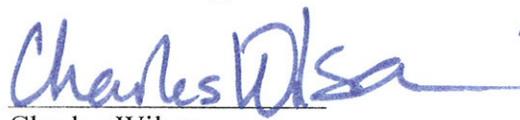
John Yarmuth
Member of Congress



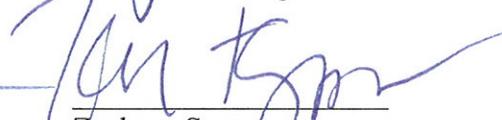
Keith Ellison
Member of Congress



Gabrielle Giffords
Member of Congress



Charles Wilson
Member of Congress



Zachary Space
Member of Congress



Brad Ellsworth
Member of Congress



Yvette Clarke
Member of Congress



Steve Cohen
Member of Congress

- cc:
- The Honorable Steny Hoyer, Majority Leader
 - The Honorable James Clyburn, Majority Whip
 - The Honorable Rahm Emanuel, Democratic Caucus
 - The Honorable Charles Rangel, Chairman, Ways and Means
 - The Honorable Pete Stark, Chairman, Health Subcommittee
 - The Honorable John Dingell, Chairman, Energy and Commerce
 - The Honorable Frank Pallone, Chairman, Health Subcommittee

**WHY H.R. 1424 IS
A STRONG MENTAL HEALTH PARITY BILL**

- 1. If an insurer provides mental health and substance abuse benefits, the House bill requires out-of-network care for these benefits if the insurer has out-of-network care for medical/surgical benefits.**
 - The bill requires out-of-network care for mental health and substance abuse if the insurer has out-of-network care for medical and surgical benefits.
 - There is no mental health parity without this requirement, because insurers currently restrict services for mental illnesses by not having enough qualified physicians in their networks.

- 2. If an insurer provides mental health and substance abuse benefits, the House bill ensures that there is adequate coverage for the treatment of all mental illnesses.**
 - This provision clarifies that an insurer who offers mental health and substance abuse benefits should cover all mental illnesses and substance abuse disorders. This is to address prejudice against those with specific mental illnesses such as autism or eating disorders.
 - To be clear though, health plans can still determine if a specific benefit is medically necessary for a person. For example, although every plan that has mental health benefits would have to offer coverage for depression, the plan would not have to provide treatment if the physician determines that it is not medically necessary.

3. The House bill permits appropriate medical management of mental health benefits.

- The bill expressly permits the use of medical management tools that are based in valid medical evidence and pertinent to the patient's medical condition so that specific coverage is not arbitrary in its application and more transparent to the patient.

4. The House bill includes strong enforcement mechanisms.

- The House bill provides remedies to protect beneficiaries' rights by maintaining state consumer protection laws for injured individuals.
- The Department of Health and Human Services, the Department of Labor, and the Internal Revenue Service may penalize health plans for discriminatory practices under the bill.

5. The House requires transparency in denials of care.

- Consumers with addiction and mental illnesses often cannot get information about their plans' definition of "medically necessary" care.
- The House bill would codify requirements for plans to disclose information about "medical necessity" determinations to consumers.

Parity Now Coalition

February 28, 2008

The Honorable Patrick Kennedy
407 Cannon House Office Building
United States House of Representatives
Washington, DC 20515

The Honorable Jim Ramstad
103 Cannon House Office Building
United States House of Representatives
Washington, DC 20515

Dear Representative Kennedy and Representative Ramstad:

The undersigned organizations applaud you for your commitment to mental health and addiction parity legislation. We wish to thank you and your staffs for the countless hours you have dedicated to this bill thus far and look forward to working with you towards enacting the *Paul Wellstone Mental Health and Addiction Equity Act of 2007* into law.

We hereby lend our formal support to this invaluable piece of legislation.

NATIONAL ORGANIZATIONS

AIDs Action Council
Alliance for Children and Families
American Academy of Child and Adolescent Psychiatry
American Academy of HIV Medicine
American Academy of Neurology
American Academy of Pediatrics
American Association for Geriatric Psychiatry
American Association for Marriage and Family Therapy
American Association for Psychological Rehabilitation
American Association for the Treatment of Opioid Dependence
American Association of Children's Residential Centers
American Association of Pastoral Counselors
American Association of Suicidology
American College of Occupational and Environmental Medicine
American Counseling Association
American Federation of Teachers
American Foundation for Suicide Prevention
American Group Psychotherapy Association
American Hospital Association
American Medical Association
American Mental Health Counselors Association
American Music Therapy Association
American Nurses Association
American Occupational Therapy Association
American Psychiatric Nurses Association
American Psychoanalytic Association
American Psychotherapy Association
American Probation and Parole Association
American Public Health Association
American School Health Association
American Society of Addiction Medicine
Anna Westin Foundation
Anxiety Disorders Association of America
Association for the Advancement of Psychology
Association for Ambulatory Behavioral Healthcare
Association for Psychological Science
Association of American Medical Colleges
Association of Jewish Family & Children's Agencies
Association of Recovery Schools
Association of University Centers on Disabilities
Bazon Center for Mental Health Law
Betty Ford Center
Bradford Health Services
Caron Treatment Centers
Center for Clinical Social Work
Center for Science in the Public Interest
Children and Adults with Attention-Deficit/Hyperactivity Disorder
Child Welfare League of America
Clinical Social Work Association
Clinical Social Work Guild 49, OPEIU
Community Anti-Drug Coalitions of America (CADCA)
Cumberland Heights
Depression and Bipolar Support Alliance
Disability Rights Education & Defense Fund
Easter Seals
Eating Disorders Coalition for Research, Policy and Action
Eating Disorder Referral and Information Center/EDReferral.com
Entertainment Industries Council
Faces and Voices of Recovery
Families for Depression Awareness
Families USA
Family Voices
Federation of Families for Children's Mental Health
First Focus
Hazelden Foundation
HIV Medicine Association
Housing Works, Inc

organizations supporting strong federal mental health and addiction parity legislation
c/o Carol McDaid, Capitol Decisions - 202-638-0326 - cmcdaid@capitoldecisions.com
Scott Barstow, American Counseling Association - 703-823-9800 - sbarstow@counseling.org

Human Rights Campaign
 Institute for the Advancement of Social Work Research
 Johnson Institute
 Kids Project
 Legal Action Center
 Mental Health America
 NAADAC – The Association for Addiction Professionals
 National Advocacy Center of the Sisters of the Good Shepherd
 National Advocates for Pregnant Women
 National Alliance of Methadone Advocates
 National Alliance to End Homelessness
 National Association for Children of Alcoholics
 National Association of Addiction Treatment Providers
 National Association of Anorexia Nervosa and Associated Disorders – ANAD
 National Association of County and City Health Officials
 National Association of County Behavioral Health and Developmental Disability Directors
 National Association of Mental Health Planning & Advisory Councils
 National Association of Pediatric Nurse Practitioners
 National Association of School Psychologists
 National Association of Social Workers
 National Association of State Directors of Special Education
 National Association on Alcohol, Drugs and Disability, Inc.
 National Committee to Preserve Social Security and Medicare
 National Council for Community Behavioral Healthcare
 National Council on Alcoholism and Drug Dependence (NCADD)
 National Council on Independent Living
 National Development and Research Institutes, Inc. (NDRI)
 National Eating Disorders Association
 National Eating Disorders Coalition

National Educational Alliance for Borderline Personality Disorder
 National Education Association
 National Hispanic Medical Association
 National Mental Health Awareness Campaign
 National Recreation and Park Association
 National Research Center for Women & Families
 National Rural Health Association
 Northamerican Association of Masters in Psychology
 Obsessive Compulsive Foundation
 PACER Center
 Partnership for a Drug-Free America
 Presbyterian Church (USA) Washington Office
 Recovery Network Foundation
 School Social Work Association of America
 Society for Research on Child Development
 Society of Professors of Child and Adolescent Psychiatry
 Students for Sensible Drug Policy
 Suicide Prevention Action Network USA
 State Associations of Addiction Services (SAAS)
 Therapeutic Communities of America
 TII CANN – Title II Community AIDS National Network
 Tourette Syndrome Association, Inc.
 Union for Reform Judaism
 United Jewish Community
 United Methodist Church - General Board of Church and Society
 United Neighborhood Centers of America
 U.S. Psychiatric Rehabilitation Association
 Wellstone Action

LOCAL AND STATE ORGANIZATIONS

622 Communities Partnership, Inc., Minnesota Affiliate of the National Council on Alcoholism and Drug Dependence, Inc
 AA Safe Haven
 Abilities in Motion
 Addiction Recovery Institute
 Addiction Resource Council
 Addiction Treatment Providers of New Jersey
 Advocates for Recovery
 Alabama Voices for Recovery & Drug Education Council
 Alcohol and Addictions Resource Center
 Alcohol and Drug Abuse Council of Delaware County, Inc.
 Alcohol and Drug Council of North Carolina
 Alcoholism and Substance Abuse Providers of New York State
 Alcoholism Council of New York
 Alcoholism Council of the Cincinnati Area, NCADD
 Alliance for Eating Disorders Awareness
 Alliance for Recovery
 Alliance for Substance Abuse Prevention, Inc.
 Alpha Project for the Homeless

A New PATH (Parents for Addiction Treatment & Healing)
 Anacostia Young Peoples Club
 Arizona Association of Alcohol and Drug Abuse Counselors
 Arizona Council of Human Service Providers
 Arkansas Association of Substance Abuse Treatment Programs
 Association of Persons Affected by Addiction
 Association of Substance Abuse Programs of Texas
 Aspire of Western New York, Inc.
 Barbara Schneider Foundation
 Behavioral Health Services Association of South Carolina
 BRiDGEs, Madison County Council on Alcoholism and Substance Abuse, Inc.
 Bucks County Council on Alcoholism and Drug Dependence

organizations supporting strong federal mental health and addiction parity legislation
 c/o Carol McDaid, Capitol Decisions – 202-638-0326 – cmcdaid@capitoldecisions.com
 Scott Barstow, American Counseling Association – 703-823-9800 – sbarstow@counseling.org

Burke Council on Alcoholism & Chemical Dependency, Inc.
 California Association of Addiction Recovery Resources
 California Association of Alcohol and Drug Program Executives
 California Association of Alcoholism and Drug Abuse Counselors
 Chautauqua Alcoholism & Substance Abuse Council (CASAC)
 Children's Health Initiative
 Chemical Dependency Center of Charlotte-Mecklenburg, Inc.
 Coalition of Louisiana Addiction Prevention and Service Providers
 Coastal Horizons Center, Inc.
 Colorado Association of Alcohol & Drug Service Providers
 Community and Family Resources
 Compassionate Women of the World
 Connecticut Association of Addiction Professionals
 Connecticut Association of Non-Profits
 Council on Addictions of New York State (CANYS)
 Council on Alcohol and Drug Abuse for Greater New Orleans
 Council on Alcoholism and Drug Abuse of Sullivan County
 Council on Substance Abuse – NCADD
 The Council on Substance Abuse & Mental Health
 County Alcohol and Drug Program Administrators Association of California
 Dads and Daughters
 Delaware Association of Rehabilitation Facilities
 DePaul's National Council on Alcoholism and Drug Dependence – Rochester Area
 Depression and Bipolar Support Alliance
 Detroit Recovery Project
 Division for Learning Disabilities of the Council for Exceptional Children
 Dora Weiner Foundation
 Drug and Alcohol Service Providers Organization of Pennsylvania
 Drug and Alcohol Treatment Association of Rhode Island
 The Elisa Project
 Employee & Family Resources, Inc.
 Erie County Council for the Prevention of Alcohol and Substance Abuse, Inc.
 Exponents
 Faces and Voices of Recover – Greenville, SC
 Faces and Voices of Recovery - Pee Dee
 Faces and Voices of Recovery – South Carolina
 Faces and Voices of Recovery – Westchester
 Feeling Blue Suicide Prevention Center
 Florida Alcohol and Drug Abuse Association
 Focus on Community
 Friends of Delaware and Otsego Counties, Inc.
 Friends of Recovery – Monroe County
 Friends of Recovery – Vermont
 Gail R. Schoenbach/FREED Foundation
 Gateway Foundation
 Georgia Council on Substance Abuse
 GLAD House, Inc.
 Greater Flint Project Vox
 Greater Macomb Project Vox
 Gurze Books
 Hanley Center
 Harbor Hall, Inc.
 Hope4you
 Illinois Alcoholism and Drug Dependence Association
 Indiana Association of Substance Abuse Providers
 Iowa Substance Abuse Program Directors' Association
 Jawonio, Inc.
 Kansas Association of Addiction Professionals
 Kingdom Recovery Center
 Kristin Brooks Hope Center
 Long Island Council on Alcoholism and Drug Dependence
 Maine Alliance for Addiction Recovery (MAAR)
 Maine Association of Substance Abuse Programs
 Maine Substance Abuse Foundation
 Maryland Addictions Director's Council
 Maryland Chapter of the National Council on Alcoholism and Drug Dependence
 Maryland NAMA
 Massachusetts Association of Alcohol and Drug Abuse Counselors
 Massachusetts Association of Alcoholism and Drug Abuse
 Counselors McHenry County Mental Health Board (IL)
 McShin Foundation
 Mental Health and Substance Abuse Corporations of Massachusetts
 Methadone Support Org.
 Michigan Association of License Substance Abuse Organizations
 Mississippi Association of Addiction Services
 Missouri Addiction Counselor Association
 Missouri Association of Alcohol & Drug Abuse Programs
 Missouri Recovery Network
 Missouri Recovery Network – Jefferson City Chapter
 Montana Addiction Service Providers
 Montana Association of Alcohol and Drug Abuse Counselors
 M-Power, Inc.
 Mountain Council on Alcohol and Drug Dependence

organizations supporting strong federal mental health and addiction parity legislation
 c/o Carol McDaid, Capitol Decisions – 202-638-0326 – cmcdaid@capitoldecisions.com
 Scott Barstow, American Counseling Association – 703-823-9800 – sbarstow@counseling.org

Nantucket Alliance for Substance Abuse Prevention, Inc.
Nantucket Behavioral Health
National Alliance on Mental Illness, Minnesota
National Alliance on Mental Illness, Rhode Island
NCADD, Greater Kansas City
NCADD, Michigan
NCADD, South Bay
NCADD, Greater Detroit Area
NCADD, Long Beach
NCADD, Middlesex County, Inc.
NCADD, New Jersey
NCADD, Northwest Florida
NCADD, Orange County
NCADD, Phoenix
NCADD, Sacramento Region Affiliate
NCADD, San Fernando Valley
NCADD, Silicon Valley
NCADD, St. Louis Area
NCADD, Tulare County, Inc.
National Council on Alcoholism/Lansing Regional Area, Inc
Nebraska Association of Behavioral Health Organizations
Nevada Alliance for Addictive Disorders Advocacy,
Prevention & Treatment Services
New England National Alliance of Methadone Advocates
New Hampshire Alcohol & Other Drug Service Providers
Association
New York AIDS Coalition
NJ Advocates – NJ Chapter of NAMA
Nick's Place
North Carolina Association of Alcoholic Residential
Facilities
North Carolina Substance Abuse Providers Association
North Dakota Addiction Treatment Providers Coalition
Northern California Chapter of the National Alliance of
Methadone Advocates
Northern Michigan Project Vox
Northpointe Council, Inc.
Ohio Citizen Advocates for Chemical Dependency
Prevention & Treatment
Ohio Council of Behavioral Healthcare Providers
Oklahoma Faces and Voices of Recovery
Oklahoma Substance Abuse Services Alliance
Ophelia's Place
Oregon Prevention, Recovery, and Education Association
PAR – People Advocating Recovery
Parent-To-Parent, Inc.
Pennsylvania Recovery Organization – Achieving
Community Together (PRO-ACT)
Puente de Vida

The RASE Project/Buprenorphine Coordinator
Program
Recovery Center
Recovery Consultants of Atlanta, Inc.
Recovery Resource Center
Volunteers of America Alaska
Royal Oak (Michigan) Save Our Youth Task
Force
Recovery Resources
Rockland Council on Alcoholism and Other Drug
Dependence
Samaritan Village
Seaway Valley Prevention Council
The Second Road, Inc.
Society of Addiction Counselors of Colorado
South Carolina Association of Alcohol and Drug
Abuse Counselors
South Dakota Association for Addiction
Professionals
South Dakota Council of Substance Abuse
Providers
Spirit Works Foundation Center for the Soul
Substance Abuse and Addiction Recovery
Alliance (SAARA) of Virginia
Substance Abuse Directors Association of
Alaska
Substance Abuse Recovery Alliance of Utah
Suicide Awareness Voice of Education
Tennessee Association of Alcohol, Drug, &
Addiction Services
Townsend Recovery, LLC
Transformation Center
Turning Point Recovery Center
Upstate Cerebral Palsy (NY)
Utah Behavioral Healthcare Network
Vericare Management
Vermont Association of Drug & Alcohol
Programs
Virginia Association of Alcohol and Drug
Counselors
Virginia Association of Drug and Alcohol
Programs
Washington Association of Alcoholism &
Addiction Programs
Western Massachusetts School Substance
Abuse Counselors Association
West Virginia Association of Alcohol and Drug
Abuse Counselors, Inc.



February 27, 2008

Dear Representative:

On behalf of Mental Health America and our 320 affiliates across the country, I am writing to express our strong support for House passage of the Paul Wellstone Mental Health and Addiction Equity Act of 2007, H.R. 1424, at the earliest possible date. House passage of this historic legislation is a critical step toward enactment this year of a strong mental health parity law.

Mental health conditions are the leading cause of disability in the U.S. for individuals ages 15-44, and a leading cause of premature death, implicated in 90% of the more than 30,000 suicides annually in this country. While scientific advances have led to the development of a range of effective treatments, millions of Americans who need mental health care are routinely denied access to those treatments, with often tragic results.

Despite a compelling body of science documenting that such practices are anachronistic and costly to employee health and to the "bottom line," employer-sponsored health plans routinely continue to set strict, arbitrary treatment limits and financial requirements on mental health coverage, while imposing no such limitations, or far less onerous limitations, on coverage for other illnesses. It is shocking, more than 40 years after the passage of civil rights laws and 15 years after passage of the Americans with Disabilities Act, that federal law still permits insurance discrimination on the basis of mental illness. Our polling has consistently shown that Americans abhor such discrimination and support the enactment of a strong mental health parity law. Congress can and must pass such legislation this year.

Please support improved access to needed mental health treatment. Please support H.R. 1424.

Sincerely,

A handwritten signature in black ink, appearing to read "David L. Shern". The signature is fluid and cursive, with a long horizontal stroke at the end.

David L. Shern, Ph.D.
President and CEO

American Psychiatric Association

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February 28, 2008

Dear Representative:

I am writing on behalf of the American Psychiatric Association, the national medical specialty representing more than 38,000 psychiatric physicians nationwide, to strongly urge you to vote to approve comprehensive legislation requiring an end to insurance discrimination against patients requiring treatment for mental illnesses (including substance related disorders), embodied as H.R. 1424 in the House.

Mental illnesses can and do have a devastating impact on millions of Americans every day. These illnesses reach across all ethnic, cultural, social, gender, and economic boundaries, impacting not only our patients but their families as well. Over 35 million experience disabling symptoms of mental disorders each year. The good news is that treatment works. Unfortunately, most American health insurance coverage does not cover the care our patients need at a level comparable to coverage for other health conditions.

It is long overdue for Congress to act to end this discrimination. Over the last eight years, the Federal Employees Health Benefit program has made "parity" coverage for mental health care available to Members of Congress and 8.5 million other federal employees. Implemented through 350 health plans throughout all regions of the country, research has shown that there has been no significant cost increase attributable to this enlightened parity requirement. It is time the rest of the country followed suit.

We urge you to vote for passage of H.R. 1424 and to reject any weakening amendments. This is a critical step in the process that will enable the House and Senate to send a final law to the President this year. On behalf of our members – and most importantly on behalf of their patients – we urge you in the strongest possible terms to pass this bill, and ultimately for the Congress as a whole to approve the strongest possible parity law.

Thank you for your support.

Sincerely,



Carolyn B. Robinowitz, M.D.
President





AMERICAN
PSYCHOLOGICAL
ASSOCIATION
PRACTICE ORGANIZATION

February 28, 2008

Honorable Patrick J. Kennedy
U.S. House of Representatives
Washington, DC 20515

Honorable Jim Ramstad
U.S. House of Representatives
Washington, DC 20515

Dear Representatives Kennedy and Ramstad:

I am writing on behalf of the American Psychological Association to express our strong support for House passage of H.R. 1424, the Paul Wellstone Mental Health and Addiction Equity Act. While the Mental Health Parity Act of 1996 was an important milestone for patients and consumers, the APA has urged Congress for more than a decade to close loopholes in the law so that benefits discrimination is finally and completely ended in the private healthcare system.

Much progress has been made toward enactment of parity this year. The Senate passed a strong bill that we support, S. 558, last September, and through your tireless leadership H.R. 1424 has progressed through committee consideration and is ready for floor action. We hope that passage of H.R. 1424 will lead to continued negotiation toward a parity bill that is acceptable to both the Senate and the House of Representatives. With the intense work that has been accomplished in both chambers, Congress has an historic opportunity to enact mental health parity into law this year.

Both the Senate and House mental health parity bills are strong. Both eliminate discrimination against mental health and substance use benefits. Both preserve strong parity and consumer protection laws, and both will extend parity protection to 82 million more people who cannot be protected under state laws. We urge House passage and negotiations now to work out differences with the Senate so that mental health parity will become a reality for the millions of Americans who need this equitable coverage.

Sincerely,

Marilyn Richmond
Assistant Executive Director
Government Relations

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