

THE CAMPAIGN TO INSURE MENTAL HEALTH
AND ADDICTION EQUITY

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CONGRESSIONAL FIELD HEARING ON
THE MENTAL HEALTH EQUITY BILL

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TUESDAY
JANUARY 16, 2007

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PROVIDENCE, RHODE ISLAND

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The Field Hearing was held at the Rhode Island Station House, Room 313, 1 Smith Hill, Providence, Rhode Island, at 9:30 a.m., Congressman Patrick Kennedy (D-RI), presiding.

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P-R-O-C-E-E-D-I-N-G-S

(9:27 a.m.)

REP. KENNEDY: Good morning, everybody.

It's an honor to have you all here this morning to join us for our first of many hearings across this country on our whole Health America tour where we begin to highlight the need in this country for mental health coverage in our health insurance system. Now it may seem redundant to talk about mental health coverage as part of our whole health insurance system because how can you have full health insurance without mental health coverage?

Well that's just the point of this hearing, is to highlight the fact that, even in this day and age, we still do not have mental health coverage as part of our whole health insurance. It's pretty remarkable in this day and age that insurance in this country still carves out mental health as something separate and distinct from whole health coverage, that the brain is something of a separate organ, if you will, when it comes to health insurance, and when you require health insurance coverage for the brain and mental illnesses, you pay higher deductibles, higher copays and higher premiums, as if mental health insurance is not equal to other physical

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1 health insurance.

2 Now we are here today to explore why that
3 is, what are the bases for that discrimination? Why
4 is that stigma still with us today? And what are the
5 impacts of that remaining stigma on our current health
6 care system and what are the impacts of that stigma
7 today on our society? Today we have with us both
8 those from our government, those from the criminal
9 justice system, those from the health care system,
10 those who are consumers in our society and others to
11 testify to these answers.

12 And what we will be hearing, I believe,
13 are some pretty sobering answers as to the impact of
14 having not addressed up front the very basic premise
15 that the mind and the body are one and the same and
16 that if we are going to treat one's overall health,
17 that we need to treat the whole person. And that is
18 why we would like to have the first panel testify.

19 But before I introduce the first panel, I
20 want to say what an honor it is today to be joined by
21 my colleagues here. First I want to introduce and
22 welcome to the state my colleague who is a co-sponsor
23 of legislation on this issue that would ensure parity
24 of coverage, which means equal coverage, parity
25 meaning par, on par coverage and insurance in this

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1 country, Jim Ramstad from Minnesota.

2 (Applause)

3 REP. KENNEDY: Now Jim has had quite an
4 influence on me, and many of you know how close he is
5 to me and he has been a mentor to me, in many respects
6 a great influence on me. But just so that you know
7 what an influence I am on him, if any of you have
8 picked up this morning's paper, you see that after his
9 name, it is Jim Ramstad, D - Minnesota.

10 (Laughter)

11 REP. KENNEDY: So as to understand, this
12 goes both ways, I am having a profound influence on
13 him as well and we are slowly working our magic
14 through osmosis making him a democrat. But in the
15 meantime, I hope not to get him in too much trouble,
16 especially since the Republican National Convention is
17 in his state in '08 and I'm sure they are going to
18 make a lot of fun of the fact that in the headlines in
19 today's paper they refer to him as a democrat. But
20 that being said, he has been an outspoken champion for
21 the Paul Wellstone Mental Health Equitable Treatment
22 Act for a long time.

23 And I might add, he has been the one who
24 has introduced and advocated for the distinction
25 between the Senate version of the Paul Wellstone Act

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1 in the Senate and the House version which includes
2 drug and alcohol coverage, and that is really the
3 difference in the bill because in the House version we
4 have drug and alcohol coverage. And frankly, there is
5 going to be no bill in this Congress that we are going
6 to pass that does not include drug and alcohol
7 coverage as part of it.

8 (Applause)

9 REP. KENNEDY: So, at this time, I would
10 like to turn the microphone over to Jim Ramstad.

11 REP. RAMSTAD: Thank you very much,
12 Patrick.

13 Thank you all for that very warm welcome.

14 Senator, thank you for being here today, for your
15 leadership. I want to thank everyone who worked hard
16 to put this hearing together, particularly Mike
17 Zaymore, Patrick's staff and Andrew McKechnie from my
18 staff, you have worked tirelessly for these hearings
19 and we appreciate it very, very much.

20 I've read a lot through the years as a
21 student of politics about Rhode Island politics and I
22 was very, very interested in that headline of the
23 *Providence Journal*. Actually, the story was great and
24 I have been called a lot worse, so please--

25 (Laughter)

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1 REP. RAMSTAD: This is a great
2 opportunity, seriously, to discuss what I believe is
3 the most critical public health issue facing the
4 American people and that is equitable treatment for
5 people suffering the ravages of mental illness and
6 chemical addiction. 53 million Americans suffering
7 from mental illness, 26 million Americans suffering
8 from alcohol and drug addiction. With those numbing
9 statistics, each which represent a person who is
10 suffering, this is not just another public policy
11 issue, this is truly a matter of life or death for
12 millions of Americans.

13 It's time to finish what Patrick mentioned
14 was started by Senator Paul Wellstone in the mid `90s,
15 my friend and colleague, it's time to end the
16 discrimination against people with mental illness and
17 addiction, it's time for Congress to pass the Paul
18 Wellstone Mental Health and Addiction Equity Act.
19 It's a national disgrace that 270,000 people,
20 according to SAMHSA, Substance Abuse Mental Health
21 Associations, according to SAMHSA, 270,000 people at
22 least were denied access to treatment for addiction
23 last year, 270,000 people, that's how many we know
24 about.

25 Last year alone 150,000 of our fellow

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1 Americans died as the direct result of chemical
2 addiction, 30,000 Americans committed suicide as a
3 result of their depression and it's a national crisis
4 that addiction cost our economy \$400 billion last year
5 and untreated mental illness over \$150 billion. It's
6 a tremendous financial cost on our nation, on our
7 businesses. And think of the cost that can't be
8 measured in dollars and cents, the human suffering,
9 the broken families, the shattered dreams, ruined
10 careers, destroyed lives and so forth.

11 But there is hope, there is hope. It's
12 well documented that treatment works and recovery is
13 possible, even for this hard-headed Norwegian. I woke
14 up from my last alcoholic blackout in a jail cell in
15 Sioux Falls, South Dakota on July 31st of 1981. I was
16 under arrest for a host of offenses stemming from my
17 last alcoholic blackout and I'm alive and sober today,
18 25 years, 5 months and 16 days later, only because of
19 the grace of God. The access I had to treatment and
20 the fellowship of recovering friends, people like
21 Patrick who have the courage, who have the courage to
22 inspire so many of us.

23 I'm living proof that treatment works and
24 recovery is possible, but too many people in our
25 country don't have that same access to treatment,

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1 that's why Congress must pass this equity legislation.

2 We are alarmed by the dwindling access to treatment
3 for chemically dependent people, over half the
4 treatment beds are gone today that were here in this
5 country ten years ago, over 60 percent of the
6 adolescent treatment beds are gone today that were
7 here just a decade ago. It's time to reverse this
8 trend.

9 Expanding access to treatment is not only
10 the right thing to do, it's also the cost effective
11 thing to do. We've got all the empirical data in the
12 world, and we are going to hear much of it today, to
13 prove that equity for mental health and addiction
14 treatment will save literally billions of dollars
15 nationally, while not raising premiums more than one
16 half of one percent in the worst case scenario. It's
17 well documented that every dollar we spend on
18 treatment saves up to \$12 in health care, social
19 service, criminal justice costs, costs of lost
20 productivity, absenteeism and injuries in the work
21 place and other costs.

22 A source no less than the *Wall Street*
23 *Journal* has stated that untreated depression alone
24 cost American businesses \$70 billion last year, \$70
25 billion, that's billion with a B. So the studies all

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1 show that breaking down the barriers to treatment is
2 cost effective, whether it's the Rand Corporation
3 study or the Rutgers study, the California study, the
4 Minnesota study, Columbia University study, you name
5 it, we've got all the empirical data in the world to
6 show that treatment is cost effective, treatment for
7 mental illness and addiction.

8 Let me conclude and let's get to our first
9 panel, let me just say this as strongly as I possibly
10 can, it's time to end the discrimination against
11 people suffering from mental illness and addiction.
12 It's time to prohibit health insurers from placing
13 discriminatory restrictions on treatment. It's time
14 to provide greater access to treatment, the American
15 people simply can not afford to wait any longer for
16 Congress to act. So thanks again to all of you for
17 coming here today to share your expertise and your
18 experience. I certainly appreciate your work on this
19 issue and let the hearing begin.

20 REP. KENNEDY: Thank you very much, Jim.

21 And I'm honored this morning that we have
22 one our colleagues on the Senate side, our newest
23 member of the Senate, Senator Sheldon Whitehouse, join
24 us and I think that his perspective particularly as a
25 former Attorney General and United States Attorney

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1 lend itself very well to today's hearing because he
2 can speak very insightfully to the fact that so much
3 of our criminal justice system has become the mental
4 health system of last resort.

5 In this country, we have ended up
6 criminalizing our mental health diseases because we
7 have lacked a forward thinking health care system that
8 treats mental illness as the illness that it is. And
9 instead we have taken a punitive approach to mental
10 illness and instead incarcerated people, rather than
11 give them the treatment that they need. And as a
12 result, we are going to hear later from Chief Esserman
13 from the Providence Police, but I think it is very
14 appropriate that we do hear this morning from Senator
15 Whitehouse, former Attorney General and former U.S.
16 Attorney as well.

17 Sheldon?

18 SEN. WHITEHOUSE: Thank you, Patrick.

19 I am here this morning to commend our
20 Congressman for his courage, for his energy, for his
21 passion and for his initiative on this subject and to
22 welcome Congressman Ramstad from the great State of
23 Minnesota who joined us here. I want to let Jim know
24 that the last time Patrick had a member of Congress
25 here it was Newt Gingrich.

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1 (Laughter)

2 SEN. WHITEHOUSE: So we are getting
3 accustomed to his bipartisan appeal.

4 Two quick points. One is that I think
5 anybody who is familiar with the health care system
6 sees that it is just riddled with areas in which the
7 pursuit of the self-interested welfare of an
8 individual participant in the system creates costs for
9 the system at large. There is a disconnect between
10 what people do to advance their own interests in the
11 health care system and what that does in terms of
12 overall costs and you see it throughout the health
13 care system, I mean you see it in dozens of different
14 ways.

15 But it seems to me that the refusal that
16 as a society we engage in to treat mental health as
17 part of the overall health picture is just one of
18 those places and that if we grappled with it
19 effectively, we would find that in fact there are
20 lowered social costs rather than heightened social
21 costs, even though one individual player or another
22 might experience higher costs. And we have to, we
23 cannot in government just walk away from a system that
24 works as idiotically as our present health care system
25 and say, well, you know, too bad, market forces are at

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1 work here. We have a responsibility here to make them
2 be effective for the people of the country, and the
3 health care system is breaking us and this is one way
4 we can get into making it work better.

5 The second point that I want to mention is
6 the criminal justice perspective that Patrick
7 mentioned and that I'm sure Chief Esserman will speak
8 to in his time. But clearly over and over again the
9 engagement of people in the criminal justice system,
10 particularly at the lower levels of violence, is
11 related to addiction issues, depression issues, other
12 issues that are capable of treatment. Astonishingly
13 enough, when I became Attorney General, Rhode Island
14 had no drug court and indeed it was possible to get a
15 drug court started because prosecutors were opposed to
16 the idea, it seemed that it was soft on crime.

17 Well we started the drug court and it has
18 worked very effectively, even to the point where it's
19 now been taken out to schools through the truancy
20 court program, so there really is a better way to cope
21 with the social problems of the behaviors that lead to
22 criminal activity. So many people really want to lead
23 honorable lives but simply can't find their way
24 through their addiction and through their depression
25 and it's very expensive for all of us to pay for that

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1 with arrests, with jail cells. I think everybody in
2 this room knows that it costs about \$7,000 or \$8,000
3 to teach a child in our public schools, it costs
4 nearly \$100,000 to keep them at the juvenile training
5 school and much, much better to treat the cause at its
6 root and go on from there.

7 So, once again, I want Patrick to know
8 that he has got a friend in the Senate on this issue
9 and, again, welcome, Jim, to the great State of Rhode
10 Island. You will probably turn back into a republican
11 when you leave, it's part of the Rhode Island thing.
12 People become democrats when they get here.

13 (Laughter)

14 REP. KENNEDY: Thank you very much,
15 Sheldon.

16 Now I would like to invite our Senate
17 Majority leader, Senator Teresa Paiva-Weed, to begin
18 and thank her for offering us this opportunity in the
19 Senate to have this room today, and the opportunity to
20 have this hearing and have her begin the testimony
21 today.

22 Thank you, Senator.

23 PANEL ONE

24 THE IMPACT OF MENTAL HEALTH AND ADDICTION

25 SEN. PAIVA-WEED: Thank you, Congressman

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1 and thank you. Welcome to Rhode Island and to the
2 Rhode Island State Senate Hearing Room.

3 I'm honored to be asked by you to be a
4 participant in this panel, I want to commend you for
5 your work on this issue and your commitment to this
6 issue and certainly welcome the support of our new
7 U.S. Senator as well.

8 I had chosen today to speak to a different
9 aspect of the issue of mental illness. As we know,
10 mental illness is an illness in the same way that
11 asthma and diabetes are illnesses, yet both our public
12 as well as our private response is often, and support
13 systems differentiate between mental disorders and
14 other problems.

15 The response and differential treatment
16 has led to serious barriers to the most appropriate
17 care, treatment and preventative measures. It would
18 be unfair to simply single out the private insurers
19 today because we, as governmental insurers, often
20 treat it differently as well. I'm particularly
21 concerned with the plight of children with mental
22 health needs and their families. Almost one in five
23 children in our nation suffers from a mental illness
24 or serious emotional disturbance. Unmet, these needs
25 lead to school and home distress and higher, long-term

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1 societal costs.

2 It is very troubling to me that only about
3 25 percent of children in need of treatment actually
4 receive the services that they need and most often
5 they receive services only after a preventable
6 condition has manifested itself, a mind condition has
7 escalated. Most recent Rhode Island statistics reveal
8 that among care givers of children with mental health
9 needs on Medicaid, 52 percent are unable to get
10 support from family or friends, 54 percent are unable
11 to work due to the fact that they are care taking and
12 83 percent feel overwhelmed due to their children's
13 needs.

14 In the East Bay area, I've come in contact
15 with any number of families over the years with
16 children with mental health needs. Most recently, one
17 constituent in one family that I spoke to summed it up
18 well when she said if my child was in a wheelchair,
19 the neighborhood, the community would be supportive
20 but because my child suffers from mental illness,
21 there is no one that understands. Stories such as
22 these are told too often, our over-burdened child
23 welfare and juvenile justice programs are overflowing
24 with families who have experienced similar devastating
25 conditions. For these families and to stem the tide

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1 of children into these programs, we must act.

2 Once again, while much is said about
3 private insurance, we cannot overlook the relationship
4 between mental health services and Medicaid. Medicaid
5 is the only payment source for care for more than half
6 of the children who suffer from serious mental
7 illness, the future of Medicaid then is inseparable
8 from the issue of access to services for children with
9 mental health needs. Efforts to contain Medicaid
10 costs most often include eligibility restrictions,
11 reducing benefits, increasing copayments or reducing
12 provider payments.

13 During this year's state budget
14 discussions, as I'm sure you'll hear from Chairman
15 Costantino, Medicaid becomes a point of attention,
16 certainly at the U.S. Congress it is as well. This
17 might be the most opportune time to make dramatic
18 changes in a system that disappoints more than it
19 delivers. The time of close budgetary scrutiny may
20 offer the perfect opportunity for restructuring our
21 children's mental health system, developing a less
22 fragmented and more responsive community of care.
23 Let's make this the year we realize equality for
24 children and their families.

25 Thank you.

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1 REP. KENNEDY: Thank you.

2 (Applause)

3 REP. COSTANTINO: Thank you, Congressmen.

4 This is a wonderful thing you are doing, particularly
5 with the human face you both put onto this issue. I
6 am Steven Costantino, I'm Chairman of the House
7 Finance Committee. Previous to that, I kind of had a
8 reversal of fortune, I was the Executive Director of
9 the Drug and Alcohol Treatment Association, so I was a
10 lobbyist who became an elected official which seems to
11 be rare in these days.

12 But I have been touched by this issue
13 pretty much very intensely, I had a brother who
14 committed suicide due to his addiction and so it is an
15 issue that not only touches us directly but touches us
16 indirectly often.

17 You had mentioned stigma and I really
18 believe that still is the issue that really presents
19 the barrier to moving this issue forward. I believe,
20 in terms of Medicaid and state services, I believe we
21 are still subsidizing the insurance industry on this
22 issue and I will continue to have that feeling until
23 we do get parity. And the issue about parity, in the
24 State of Rhode Island, I believe it was in 2001 we
25 passed the Parity Bill, and I stand to be corrected if

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1 that's not the year, and we have had it for a long
2 time. But I think Rhode Island is a case where just
3 because you have something in state law doesn't
4 necessarily mean you are actually getting parity in
5 the State of Rhode Island.

6 Yes, we have it on our books but the key
7 to this issue is not so much that we have parity but
8 who enforces that parity is actually happening. Which
9 department of state government, which federal
10 department will be involved in the enforcement of
11 addiction and mental illness being on the same par as
12 all other medical illnesses? And yes, we have heard
13 the diabetes example and one of the issues that's
14 constantly thrown out is, well, how successful is
15 treatment? And we know that that is a fallacy.

16 In fact, I would suggest if someone goes
17 off their diabetes medication, do we stop providing
18 them treatment? If someone decides to even start
19 smoking, do we refuse to have, when they find out they
20 have cancer, do we refuse them treatment? The answer
21 to that is no and really it is the stigma that's
22 involved with this issue that is the undercurrent of
23 why we have not moved on this issue.

24 Also, I believe the field has to be in
25 line with each other. Let's face it, why is a

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1 physician, when he is hit with an addiction, called
2 impaired and some low income person, when they are
3 hit, an addict? So, as a field, we need to really
4 standardize what we are talking about, we can no
5 longer run a campaign against addiction, a campaign
6 for mental illness on slogans, we need to be real in
7 our policy.

8 We talk about social progress and social
9 progress is tremendously lacking in this field in
10 terms of where we have moved, not so much as the
11 field. The field has moved to be credentialed, yet
12 the industry will tell you that they cannot hire
13 professionals to do this and a lot of that has to do
14 with the lack of reimbursement mostly from the
15 insurance industry. They have put this aside and yet
16 they will admit that are there cost off-sets? Yes.
17 Do they effect all the other medical expenditures?
18 Yes, yet they no longer move on the issue.

19 There are no longer, in this state we had
20 Edgehill, High Point, they are no longer here, they
21 are gone, they are but a memory and that was due to
22 the strangling of that modality to a point where they
23 could no longer be here. Does everybody need 30 days
24 treatment? No, but does everybody need two days
25 treatment? And that's where we are at this point.

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1 This is a great, great opportunity and I
2 thank you for the opportunity to speak today.

3 (Applause)

4 REP. KENNEDY: Well said.

5 There is a monitor set up in the gallery
6 right behind us, as I understand, if people are
7 interested. I know there are many people standing up
8 so that they can catch it on the interconnect, if they
9 want to sit down and watch the hearing and then be
10 able to, for those who want to testify as public
11 members, know when to come back in and speak. So
12 someone, Chris, can show them. Raise your hand,
13 Chris. If they want to follow Chris out, if they want
14 a place to sit and watch the hearing, please do that.

15 As we move on, I would like to have
16 Colonel Esserman take us from the approach of the
17 police. As chief of police from our largest city, you
18 could shed some light on the impact of the displaced
19 cost to our society of not having a health insurance
20 system that treats mental illness, and so you end up
21 picking up the broken pieces, Colonel, do you not, of
22 a lack of a mental health system when you end up
23 having to send your police officers out and really
24 pick up the broken pieces of a system that does not
25 treat addiction and alcoholism and does not treat

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1 mental illness. And you end up becoming the first
2 responders because of a lack of a primary care system
3 that treats mental health in our health care system?
4 And could you explain that in our own words?

5 CHIEF ESSERMAN: I come here today with
6 few statistics but many stories, the story of a young
7 man, the last death in this city, who committed
8 suicide this weekend in a car with a gun. That story
9 didn't start this weekend, that story started a long
10 time ago. I come here as a police chief in a nation
11 where homicides are now back up in our nation for the
12 second year in a row. We lose more than 16,000 of us
13 every year across this country to murder, the murder
14 rate is going up. The suicide rate in this nation is
15 double the murder rate, but I feel no moral outrage in
16 our community about it.

17 If you ask an American police chief the
18 best way to fight crime, I hope if they are worth
19 their salt they will tell you to invest and not
20 arrest, that arrest cannot be the only solution. The
21 prison population is one that is now the largest
22 mental health wards in the nation, we make little
23 distinction on who we put in and little distinction on
24 who we let out. And I love my country, I'm a patriot,
25 I'm a father with three children and I love my

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1 country, but I truly do not worry that Iraq will have
2 boots on the ground in Providence, Rhode Island, I do
3 not think they will invade us.

4 I worry that we are killing ourselves and
5 that the war is within, that with the number of people
6 we are losing to murder, the number of people we are
7 losing to suicide, the number of people that we choose
8 to punish in our country, the number of people we
9 incarcerate, has never engaged the national spirit to
10 have a serious conversation about the issue. But I
11 think I would speak for many American police chiefs in
12 this country when I say it's time for that
13 conversation, that we are not the only answer, that we
14 take no pride in the number of people we are arresting
15 in this country and we take no pride in the number of
16 people we are incarcerating.

17 And it is extraordinary how many young
18 people we are arresting and incarcerating in this
19 country and the danger is within. That I am sworn to
20 maintain the safety and protect the public, I can't do
21 that without an honest conversation about where the
22 threat comes, so I am grateful to be here today, I'm
23 grateful for the invitation. I would like to turn the
24 world over to my children a better one than I
25 inherited, I hope you can help us do that.

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1 Thank you.

2 (Applause)

3 REP. KENNEDY: Thank you very much.

4 Gary, I'll quickly say in addressing the
5 displaced costs of not having a strong mental health
6 system, you've highlighted that you pay for it in a
7 number of ways, most particularly through our justice
8 system. You made very good reference to the fact that
9 our prison system is really our largest mental health
10 system. Chief Baca from the Los Angeles County Jail
11 said that he runs the largest mental health system in
12 the country and that's the Los Angeles County Jail.
13 The fact is our prisons are the largest mental health
14 system in the country.

15 Yesterday, in the *New York Times* there was
16 an op/ed, mentally ill behind bars and it talks about,
17 according to the Justice Department, this last
18 September, 54 percent of jail inmates in state prisons
19 and 64 percent of inmates across the country reported
20 mental health problems within the past year, according
21 to the Department of Justice. In other words, this is
22 not something that's a surprise to anybody and yet
23 it's going unattended but, in addition to the cost
24 borne by our justice system, we are also paying
25 enormous costs in our health care system.

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1 And next, I would like to hear from a
2 hospital executive of our second largest hospital
3 emergency room in the state in Landmark Hospital in
4 Woonsocket, hear from President Gary Gaube about the
5 impact of untreated mental illness on the costs
6 incurred at a hospital from untreated mental illness
7 and the displaced costs on the rest of medical care
8 when you do not treat up front the costs of mental
9 illness. How does that reflect itself in the ripple
10 effect of overall costs on the rest of the system in
11 the hospital? And it's an honor to have you, Gary,
12 thank you for coming up.

13 MR. GAUBE: Thank you very much for
14 inviting us here, Congressman Kennedy, Senator
15 Whitehouse, Congressman Ramstad.

16 We represent, I represent a community
17 hospital in Northern Rhode Island, we have 214 beds.
18 We have a very busy emergency department, we see about
19 47,000 emergency visits a year and of that 47,000,
20 about 3,000 are mental or addiction patients, it's a
21 very tough environment for us. We also have an 18-bed
22 psychiatric unit that's almost 100 percent occupied,
23 so the outlets that we have are very slim in order to
24 treat our addiction and mental health patients.

25 The market we treat is very difficult, the

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1 market we treat is really, there are really two parts
2 to it, young and poor, and a large elderly population.
3 And both those sections of the population really have
4 no recourse but to get their care locally and that
5 puts a huge burden on us in our emergency department.

6 In a few minutes, I'm going to ask
7 Dr. Victor Pincus, who runs our emergency department,
8 Dr. Victor Pincus is a Harvard Medical doctor in
9 charge of our emergency department and he can give you
10 some real life examples of what happens to patients in
11 our emergency room and you'll be surprised, maybe not
12 surprised but sad to hear about what these people go
13 through.

14 In our market, being a market of indigent
15 people, people without any resources, it's very
16 difficult for those people to seek mental treatment
17 other than the hospital emergency room. That becomes
18 their focal point, that becomes their treatment room,
19 if you will, so we have people coming into our
20 emergency department that frankly now overwhelm our
21 emergency department. We can't give them true primary
22 care which should occur outside of the ED, not in our
23 emergency department, that's not possible here. We
24 can't give them the chronic care, we also can't treat
25 the long-term effects of their disease properly, but

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1 we are put in the position of where we have to and
2 that's just not possible.

3 Many of the people that come into our ED
4 have comorbid conditions and they come in frequently,
5 whether it's heart disease, diabetes or things like
6 that. We can treat that comorbid condition but what
7 we can't treat is the mental illness or the addiction,
8 we don't do a good job, we are not equipped for that
9 and that's where the problem is. The people that are
10 indigent have no outlet, no one will accept them, the
11 care givers will not accept them. Those that are
12 fortunate enough to have insurance have the situation
13 happening where the insurance will run out before
14 their treatment runs out and therefore they go without
15 treatment and that's just not a good thing. What
16 happens here? The patient and the family are hurt.

17 With the situation in our emergency
18 department where our emergency department has grown by
19 14 percent each year since the beginning of this
20 decade. You can imagine the chaos in that emergency
21 department, it has to get better. When people that
22 have mental illness or addiction come into our
23 emergency department they number about five to ten
24 percent of the total visits, and with that, we cannot
25 treat the acute care people because those five or ten

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1 percent actually consume 20 or 30 percent of the
2 resources in that department and that can't go on much
3 longer.

4 What I'm telling you is this, that the
5 system is broken. Unless there are better payment
6 mechanisms to get these people better outlets, nothing
7 will change. In fact, it's masked, people think that
8 everything is okay but if you look inside an ED, it's
9 not okay. And if you could just share a minute or two
10 with me, I turn it over to Dr. Pincus and he can give
11 you some real life examples.

12 REP. KENNEDY: If I could, Dr. Pincus, I
13 would really like to know what the true numbers are
14 though. I mean you said 20-30 percent, but are you
15 taking into account car accidents, stabbings, domestic
16 violence, slip and falls? Are those being recorded
17 for underlying issues of drug and alcohol
18 intoxication? Are we, because do we have codes for
19 that? Are you coding when someone comes in for
20 intoxication or not? Are you coding for mental
21 illness or are you coding just for lacerations or
22 contusions? And if you are not coding for mental
23 illnesses because they are not covered by insurance,
24 how can you honestly say that it's only 20 percent or
25 30 percent of your case load in any given emergency

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1 room?

2 MR. PINCUS: Oh, no, it's much more than
3 that. Before I worked at Landmark, I worked at Rhode
4 Island Hospital, the only level one trauma center in
5 this state. Eighty percent of all the trauma
6 admissions had drug and alcohol related incidents,
7 eighty percent.

8 REP. KENNEDY: Eighty percent?

9 MR. PINCUS: Eighty percent.

10 REP. KENNEDY: Eighty percent of the--

11 MR. PINCUS: Eight percent of the admitted
12 patients that were injured for trauma were related to
13 drug and alcohol. I would say that, you know, 80
14 percent of my motor vehicle accidents and injuries are
15 related to some form of alcohol and drug.

16 REP. KENNEDY: And how would you reimburse
17 for that? Would that insurance companies have any
18 kind of follow up for those people after they were
19 released from the hospital? Would you say that they
20 followed up saying this person has maybe, needs an
21 intervention, needs some drug and alcohol counselling,
22 we should follow up with this person?

23 MR. PINCUS: Something we do as emergency
24 physicians, but it's not something that's supported by
25 insurance companies, it's called the teachable moment.

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1 You know, you have moment and sometimes you can teach
2 or intervene, an intervention, and it only takes a few
3 minutes. It's been pioneered at Yale, in emergency
4 medicine residency, and also at Rhode Island Hospital
5 where if you can intervene and explain to that person
6 that not everybody who drinks alcohol or uses
7 substances ends up in the emergency department, that
8 this is the first time that they are injured, you have
9 a teachable moment.

10 But there are not a lot of resources for
11 follow up, it's mostly related to their acute injury.

12 We see the--

13 REP. KENNEDY: The problem with insurance,
14 particularly with those insurance companies that carve
15 out mental health and behavior health, is that they
16 don't consider it as part of physical health and
17 therefore reimburse it separate and, therefore, they
18 don't treat it as part of the emergency room
19 reimbursement system. And so what happens is--

20 MR. PINCUS: Right.

21 REP. KENNEDY: --someone has to get
22 preauthorization for that kind of teachable moment
23 after that moment has passed.

24 MR. PINCUS: You can't get reimbursed for
25 that.

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1 REP. KENNEDY: You can't get reimbursed
2 for it.

3 MR. PINCUS: No. I mean, in general,
4 mental health, I mean we are the second to last stop.

5 We are the last stop for a lot of addicted patients
6 because they don't have resources, uninsured or
7 insured, and I can tell you that, you know, the pure,
8 when Gary Gaube mentions 20 to 30 percent, that's the
9 pure addicted patient that comes into our emergency
10 department who is intoxicated, who is either looking
11 for a detox or not looking for a detox and the
12 resources that those patients, they have triple the
13 length of stay of any other emergency department
14 visit, they require a 24-hour or one-on-one sitting.

15 Sometimes they are violent, they require
16 chemical sedation and physical restraint and
17 sometimes, in a small community emergency department
18 like ours, those, the adults are mixed in with kids.
19 We don't have the resources to put kids in a separate
20 area to watch them with separate security guards
21 because we can only afford one or two security guards
22 and we have to put them in the same area, so we have
23 adults mixed with children, males mixed with females
24 and it can be a horrible situation.

25 We can have children in our emergency

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1 department for five and seven days, in our emergency
2 department, a windowless room without access to
3 therapy, counseling and potentially coming and going.

4 I mean I've never spent seven days straight in an
5 emergency department, to my, my impression is it's
6 equivalent to torture.

7 REP. KENNEDY: I couldn't imagine, I've
8 spent shifts but it is amazing to me.

9 MR. GAUBE: This is only the tip of the
10 iceberg. Really, this is all hidden, people don't
11 know about this. When you have a child that spends 14
12 days in an emergency room, something is very wrong
13 someplace.

14 REP. KENNEDY: I will tell you I have been
15 shocked by it. When I go in and talk to every
16 hospital I go into, when I tour my district and I ask
17 my emergency room physicians what are your biggest
18 problems, case loads, and they tell me it's psych
19 problems, it shocked me because most people don't
20 think of mental health problems when they think of
21 emergency rooms and that's the message we want to get
22 out today in the hearing and we need more people to
23 understand in this country that this is what's
24 creating the crisis. And what would you consider we
25 think of, this is the most costly care, emergency

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1 rooms is the most costly care and you would consider a
2 lot of this is we are paying for this, enormous cost.

3 MR. PINCUS: You can't measure the cost
4 because it goes into, I mean it goes into the
5 resources we have that take away from treating other
6 acutely ill patients. We have our, if we don't have
7 sitters or security, our emergency department
8 technicians who are there initially to draw blood and
9 to help with the care of other patients have to sit
10 with those patients, walk them around. I mean, you
11 know, I've had a child in the emergency department for
12 five days who I had, I would take him outside. We
13 brought games in for the patient, we played cards with
14 the patient but, and it's just, you know, he had no
15 safe place to go.

16 And I want to say one thing though, that I
17 think it's going to get better in this state because
18 of something that Representative Costantino brought to
19 legislation and that's the Kids Link, and I have
20 already seen it improve in my emergency department and
21 it's that there is one phone call access to point of
22 entry, and that's something that we don't have for
23 adults but it's something that we do have for kids now
24 and I think that's going to improve the care for these
25 families.

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1 I have a list of seven, six or seven
2 examples of things that are horror stories, but we're
3 the canary, the proverbial canary, we can tell you
4 when something is broken and thankfully, in this
5 state, they have listened with regards to the children
6 but in the country we need to listen with regards to
7 all of them, all of the adults and the children. The
8 CDC has just released a report that emergency
9 departments are overcrowding and we are burdened with
10 preparing for pandemic flues and terrorism. We are
11 your first line of defense in terrorism and there is a
12 lot of pressure to push mental health to the back of
13 the ED but we can't allow it to happen.

14 REP. KENNEDY: Thank you.

15 I would like to, now it's the health
16 policy, Elizabeth, Representative Dennigan. Maybe you
17 could give us some perspective now.

18 REP. DENNIGAN: Thank you very much. My
19 name is Representative Elizabeth Dennigan, I'm a,
20 welcome, Congressmen, I'm glad to see you here today.

21 I'm going to turn into an emergency nurse,
22 and have represented many clients in my law practice
23 who, because of problems with substance abuse, have
24 run into some trouble with the law. If I could make
25 any point clear today, I think it's the importance of

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1 having physicians and having science be at the
2 forefront.

3 I was listening to a segment on NPR a
4 couple of days ago and they asked the scientist if we
5 had to look back in 25 years at the year 2007, what
6 would we say about science? And they would say
7 actually there is a lack of science in government,
8 that we are looking at a lot of other issues but we
9 are dismissing the science. So I'm glad you are going
10 to be traveling around the country, perhaps you could
11 even have MRI scans looking at, you know, there has
12 been researched that shows that there is enlarged
13 ventricles, that there is increased white matter in
14 certain types of psychiatric conditions. And that
15 makes it really clear for people who may not realize
16 the connection between someone who has a medical
17 condition and a psychiatric condition.

18 So, although you'll be traveling around
19 the country, maybe you have already realized that
20 Rhode Island, look at the turnout here today, we have
21 great policy makers who have been working for years on
22 mental health and medical conditions. We have the
23 Zania Law, we have a mental health advocate in Rhode
24 Island, I'm not sure if other states do, who if
25 someone with a mental health issue has a legal

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1 problem, they step right in and we also have a mental
2 health association who they are here at every hearing.

3 When Chairman Costantino called a hearing
4 last week on the prison population and looking at
5 substance abuse, we could count on all these
6 stakeholders to be at that hearing, so we have a lot
7 of good things happening in Rhode Island.

8 As an emergency nurse and an attorney, I'm
9 always looking at laws, like the emergency medical
10 treatment, the MTALA law and while I don't think
11 that's a problem in Rhode Island, I think someone can
12 get into our EDs without being asked about insurance,
13 we'll see if the doctor agrees with me here, once you
14 start treating them.

15 The number one thing I know, I can tell
16 you I work Saturday and Sunday in the ED this week and
17 I knew what everyone's insurer was because that one
18 had Mass Health, so these options were not available
19 and this one didn't have insurance so they were going
20 to be staying in the ER for many days. And when the
21 doctor said that he considered it torture, I have to
22 say I said the exact same thing this weekend. If you
23 visit our EDs, and I work in an ED that's recently
24 been renovated, and areas for supervision was
25 enlarged. And that still wasn't enough, there were

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1 people, we call them bumped, putting three people in a
2 very small room, the corridor is all full, because
3 many of these individuals need increased supervision.

4 And there is a 13 year old next to a 50
5 year old and then there were a couple of individuals,
6 dementia from a nursing home, there were abusive
7 people, people with four point restraints, screaming
8 and yelling. And it's particularly heart wrenching
9 when you see a young child that is in a bed, and is
10 witnessing all that and waiting for treatment. And if
11 a parent or people want to visit, they are often, they
12 have to be escorted out because of escalating violence
13 with a certain individual. So I'm glad to be able to
14 talk about a little bit of what I see in the ED.

15 But Representative Costantino, something I
16 learned last week, someone asked the question, well,
17 there aren't enough beds, are there? And I said to
18 myself, well, of course, there is a 100 percent
19 capacity in all these psych beds and they said, oh,
20 no, it's not because we don't fund the beds. So we
21 will have vacant beds in facilities throughout the
22 state that are not funded, so people will, again, stay
23 in the ED.

24 Thank you very much for having this
25 opportunity.

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1 REP. KENNEDY: Thank you all very, very
2 much and I really appreciate all your testimony.

3 (Applause)

4 REP. KENNEDY: The second panel could come
5 up.

6 (Pause)

7 PANEL TWO

8 THE CASE FOR EQUAL TREATMENT

9 REP. KENNEDY: The second panel please
10 take their seats.

11 I would like to start off, Jim, Jim
12 McNulty, my good friend and great leader. Jim, we had
13 a terrific first panel, wonderful testimony from, I
14 think outlined really in a very comprehensive way the
15 enormous challenges we have before us on a policy
16 level. What I would like to have you do is kind of
17 take us into a kind of, from the perspective of a
18 consumer, as someone who has been in the system, how,
19 you know, it makes a difference to have available,
20 accessible treatment, what a difference that can make
21 in helping people live independent lives.

22 And how if we weren't so reliant on the
23 kind of acute care treatment that we've just heard
24 about we wouldn't have to worry about the beds, we
25 could have community-based support systems where

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1 people could live independently and productively and
2 very happy lives. And so I thank you for your
3 leadership, your courage in the face of great stigma
4 and stereotype, and thank you for your friendship as
5 well and thank you for being here.

6 MR. MCNULTY: The first panel actually, I
7 did hear quite a bit of the testimony and they
8 certainly set up an interesting problem for all of us
9 to try and grapple with. As someone who lives with
10 mental illness, actually being here today is sort of a
11 deja vu all over again experience. I just saw my good
12 friend Bill Emmett in the room and recall that ten
13 years ago this year we were down in Washington with
14 Senator Domenici and Senator Wellstone trying to get
15 parity kicked into high gear there and you've been, I
16 give you a lot of credit, you've been pushing it ever
17 since you've been down there.

18 I can't believe we are still here talking
19 about the same issues and, if anything, the problem
20 has gotten substantially worse. I said at the time at
21 the press conference that we had for the kick off of
22 the parity part two on the federal level treatment
23 works, if you can get it. That's still true, the
24 problem is I think we are actually farther away from
25 being able to access the treatments that people need.

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1 I had a rather remarkable experience a little over a
2 year and a half ago, I went to a hospital emergency
3 room because I was feeling some chest pain.

4 I have to tell you a middle aged man
5 walking into a hospital emergency room complaining of
6 chest pain you get immediate attention. I was on a
7 stretcher, I had an IV with nitroglycerin, I had
8 aspirin and I was hooked up to an EKG monitor within
9 ten minutes of my setting foot in the hospital
10 emergency room. Now I can tell you I've gone to visit
11 many of my friends while they have been waiting for
12 psychiatric reasons in hospital emergency rooms and it
13 took 8 to 12 hours to be seen by a psychiatric
14 specialist.

15 Substance abuse illnesses are still second
16 class and it permeates the way we look at them, it
17 permeates the way we think about them, it permeates
18 the way we pay for them. Quite frankly, when I worked
19 for the State of Rhode Island, the Division of
20 Behavioral Health Care, I was amazed at how it was
21 always so easy for the behavioral health care budget
22 to slide to the bottom of the pile. There is always a
23 reason that we can find to cut spending on mental
24 health and substance abuse. There have been very few
25 reasons in my experience, in the last 12 to 15 years,

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1 that we have found a reason to increase spending and
2 you have heard today the results of that.

3 You have heard hospital administrators,
4 you have heard a police chief, you have heard any
5 number of individuals, representatives from the public
6 who are telling you that the failure to treat mental
7 illnesses and substance abuse disorders on an even
8 hand with all other illnesses is in fact costing us
9 more money. We are not, we don't see it in the
10 medical cost ledger though because Chief Esserman's
11 money doesn't come out of the health care dollar, the
12 L.A. County Jail isn't paid for out of the health care
13 dollar, that's a completely different budget.

14 And I think until we start realizing that
15 we are not allocating the money efficiently and
16 effectively, that until we really get serious about
17 treating mental illness and substance abuse on a par
18 with all other illnesses we are going to keep coming
19 back here again, and again and again. And I'll tell
20 you what, the next time I show up in this room to talk
21 to you, I really want to be talking about something
22 completely different, like how well this has gone, so
23 thank you.

24 REP. KENNEDY: In your own experience,
25 Jim, how have you found treatment in your own life?

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1 In your own experience, how have you found the system
2 and over the years, beginning when you started?

3 MR. MCNULTY: It's deteriorated, access to
4 care is a lot harder. I know a lot of psychiatrists
5 and I have a hard time finding psychiatrists. What
6 happens is my doctors drop out of practicing
7 psychiatry. I have had in the last probably eight
8 years, I have probably had four psychiatrists and it's
9 a real challenge to find new ones because many of them
10 are not open and taking new patients in their
11 practice. Certainly not, the insurance companies say
12 that they have panels but, you know, I've called some
13 panels, some doctors who were ostensibly on some of
14 these panels and found a very difficult time getting
15 in and seeing somebody.

16 So I have to say, overall, I think the
17 system has gotten much, much tighter on the outpatient
18 side and I think you made a point at the start of this
19 panel, depending on inpatient beds is the most
20 expensive single way to pay for and I mean it's not
21 fun, let's face it. So what have I seen? My friends
22 and I, the people I work with, we have seen the system
23 get a lot less user friendly, if you will.

24 REP. RAMSTAD: Jim, I just want to thank
25 you for not only your courage, you have been a great

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1 inspiration to so many people across the country and
2 you have also been not only a leader in Rhode Island
3 mental health issues, the call for parity, but a
4 leader nationally, certainly as President of NAMI and
5 one of the real leaders of that organization. I just
6 want to thank you, it's been a privilege to work with
7 you and we are going to get this done. You mentioned
8 the two pioneers who originated this legislation, Paul
9 Wellstone and Pete Domenici.

10 Paul Wellstone, I loved him like a
11 brother. We had some differences politically but
12 there is no better champion on this issue, no better
13 champion for the underdog anywhere than Paul
14 Wellstone. Paul used to say, when I would get
15 discouraged because I was having problems with our
16 leadership or not getting enough cosponsors, he would
17 say, Jim, just never forget it took us 40 years in
18 this country to pass the Civil Rights Act, it took 40
19 years. He said we are going to get this done, but
20 just have patience. Well my patience is wearing thin
21 too, like yours, Jim, and now is a window of
22 opportunity. So, thanks to leaders like you and
23 others at the grassroots level across this land, we
24 are going to get there, but we couldn't do it without
25 you. I just wanted to thank you.

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1 MR. MCNULTY: Well thank you for your kind
2 words and let me assure you that anything I can do and
3 the folks I work with, that we can do to help push
4 this forward, we really, I think the time is now.

5 REP. KENNEDY: And Jim, let me just say
6 the greatest blow we can make to this stigma is having
7 consumers like yourself come out and self-disclose
8 that. As consumers, we refuse to remain silent and
9 say that we are afraid of the stigma ourselves and
10 that we are going to be succumb to the silence and the
11 stress and the stereotype that those outside would
12 place on us by this illness and thereby be confined by
13 it and imprisoned by it.

14 And NAMI, the National Association for the
15 Mentally Ill, is a fantastic consumer-driven
16 organization and Faces and Voices of Recovery, which
17 is a group of recovering addicts and alcoholics, is
18 also a great organization because frankly this is the
19 biggest set of illnesses in the country, bigger than
20 cancer, bigger than cardiovascular disease and so
21 forth. But you wouldn't know that by the amount of
22 attention and dollars that go into medical research or
23 services in this country.

24 And the reason why it is not reflected
25 through the government by the people is because the

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1 people in this country do not advocate for themselves
2 because they are afraid to self-disclose and petition
3 their government for representation. And until the
4 people in this country say, as they wouldn't have said
5 30 years ago about cancer because it used to be a
6 shame and a stigma to say that someone would have
7 cancer 30 years ago and now that's totally changed.
8 Until people are prepared to say that they have had a
9 diagnosable mental illness and are prepared to say
10 that they have been unashamed about getting mental
11 health treatment, we are never going to break the
12 stigma down.

13 And so I appreciate your being one of the
14 many ripples of hope that are helping to break down
15 the walls of oppression and stigma that are out there
16 that are keeping this illness hidden and people in the
17 shadows, so thank you very much. And now I would like
18 to have Dr. Paul Lieberman talk a little bit about
19 your experience in the state.

20 Paul, thank you.

21 MR. LIEBERMAN: Thank you, Congressman.

22 I just would add to the point that you and
23 Jim were making that in addition to consumers having
24 been shy and silenced by the threat of stigma, I think
25 health care professionals have also been too quiet for

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1 a long time. Physicians and maybe even particularly
2 psychiatric health care professionals have been quiet
3 in advocating for our patients and our profession.
4 And so I'm extremely glad to be able to participate
5 and I really appreciate your work in setting up this
6 process. It's obvious from the number of people here
7 that a lot of people have a lot to say about this and
8 I think it's overdue, so I really appreciate that.

9 I'm the President at the moment of the
10 Rhode Island Psychiatric Society and so I'm
11 representing the society. I'm also on the faculty at
12 Brown and I am on the medical staff at Butler
13 Hospital. What I'm going to say is very brief and I
14 think familiar, some of it has already been said, but
15 I think it's important to restate certain fundamental
16 facts from a psychiatrist's perspective that I think
17 need to orient any discussion of parity for mental
18 health services, facts about psychiatric disorders and
19 their treatments and I'll be brief.

20 There are four facts. The first fact is
21 these disorders are common, they afflict people from
22 all walks of life and they inflict very significant
23 harm, personal distress and suffering, impairments in
24 functioning, reductions in quality of life, physical
25 illness and even death. Death from suicide is an

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1 extremely common occurrence in all the major mental
2 illnesses, substance abuse, depression, schizophrenia,
3 so that's fact one. Fact two, they have biological
4 causes. Three, they are treatable and they improve
5 significantly with appropriate care. And four,
6 appropriate treatment, however, while sometimes brief
7 and simple, can be protracted and complex as well.

8 In all these respects, psychiatric
9 disorders are not different from any other medical
10 conditions and so should be treated alike in terms of
11 access to care and adequacy of reimbursement. This is
12 what psychiatrists believe. Psychiatric disorders are
13 common and I'll give you some examples, estimates of
14 the lifetime prevalence of major depression, major
15 depression vary from 10 percent to 25 percent in women
16 and from 5 percent to 12 percent in men. That means
17 that a woman has roughly one chance in four of
18 developing a major depression at some point throughout
19 her lifetime and that's just major depression,
20 comparable rates for anxiety disorders and substance
21 abuse disorders are even higher.

22 People are affected at any age but for
23 most of the most severe psychiatric conditions, the
24 onset is in early adulthood or even earlier and so may
25 have lifelong or at least long lasting effects. I

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1 think an important recent WHO study documented that of
2 all medical conditions it is depression which is
3 responsible for the greatest disability worldwide,
4 depression. Depression is also the second leading
5 contributor to global burden of disease, according to
6 the WHO, among people 15 to 44 years old. It seems to
7 me arbitrary and foolish to limit access to treatment
8 for such a condition.

9 Psychiatric disorders have biological
10 causes, there is no single explanation for an
11 individual's developing a psychiatric disorder such as
12 depression, anxiety or schizophrenia, but the
13 importance of biological causes is established beyond
14 any doubt. Inherited biological characteristics, for
15 example, have been found to influence an individual's
16 vulnerability to stressful life events and to
17 depression. Although psychosocial aspects of
18 psychiatric disorders cannot be ignored, all the major
19 mental illnesses have significant biological bases.

20 Psychiatric treatment works and the
21 effectiveness of psychiatric treatment compares very
22 favorably with those in other branches of medicine
23 and, finally, although brief treatments can be
24 remarkably helpful and cost effective, longer, more
25 complex and sometimes more expensive treatment

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1 programs and regimens may be required. I had an
2 example with a patient a few months ago, a single dose
3 of one of the major anti-psychotic medications costs
4 \$900 for a one-month supply and that was a low dose,
5 \$900, I couldn't believe it.

6 Of course this range of costs from the
7 brief and inexpensive to the very expensive is also
8 true for treatments in most other medical conditions,
9 it's not just true in psychiatry, it's true in
10 oncology and cardiology, surgical specialties. The
11 case for parity in mental health is based upon these
12 facts which demonstrate the similarities of
13 psychiatric conditions to other medical diagnoses.

14 Thank you.

15 REP. KENNEDY: Thank you very much.

16 Dr. Rasmussen, would you please present?
17 It's an honor to have you here, the Chief Medical
18 Office of Butler Hospital.

19 MR. RASMUSSEN: Thank you very much.

20 I'm going to show some of those slides
21 that were referred to earlier by Representative
22 Dennigan which I think hopefully some of these
23 pictures will illustrate why it is that there should
24 not be stigma about mental health and substance abuse
25 illnesses. There is no question that anyone in this

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1 room has about the fact that when you have chest pain,
2 it's paid for. You go to the hospital, you get
3 evaluated by the latest in technology and you receive
4 quick and adequate treatment.

5 Following that, you are admitted to the
6 ICU and the latest in technology comes to bear. You
7 are given electrocardiograms, stress tests, scans of
8 your heart and they are able to diagnose exactly where
9 the problem is and how to fix it. Unfortunately, this
10 is not the case, as you heard already from Jim McNulty
11 and others, about our leading mental illnesses,
12 including depression and substance abuse. It is
13 actually the case that we now are able to look at
14 abnormalities in neuronal circuits in these major
15 psychiatric disorders, including depression,
16 schizophrenia and chemical dependency.

17 And just like we can look at an image of a
18 heart that is diseased, we can find out that there are
19 abnormalities in the way that particular tissues
20 function. Here you can see, in a heart diseased
21 patient, reduced activity in a spot where there was a
22 myocardial infarction. We are now being able to see
23 that there are abnormalities in tissue function in
24 these major psychiatric disorders. Neurologic
25 diseases are illnesses of the brain so, for example,

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1 if you have a stroke, it involves your motor cortex or
2 your basal ganglia or you have a problem with your
3 vision, it may involve your visual cortex.

4 Psychiatric illnesses are also diseases of
5 the brain, the difference being instead of involving
6 the structures that influence motor function or
7 sensation, they involve structures that control
8 emotion and structures that control cognition. Why is
9 it that there is full payment for a lesion in the
10 motor cortex but if there is a psychiatric problem in
11 the frontal cortex, we don't pay for it? Treatment,
12 for chest pain, the latest is available, pacemakers,
13 open heart surgery, stents and, again, all of these
14 procedures, very expensive, are covered.

15 We know that sometimes just abstinence in
16 chemical dependency can make all the difference in the
17 world and here you see illustrated, as an example, a
18 normal patient's basal ganglia, their dopamine
19 receptors which are known to be abnormal in patients
20 with chemical dependency. Someone who has been
21 abusing methamphetamine loses those dopaminergic
22 receptors and, following 24 months of abstinence, a
23 return to normal.\

24 In addition to that, it's not only
25 abstinence but in other major psychiatric illnesses,

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1 like obsessive compulsive disorder, we can find that
2 drug treatments change abnormalities that are known to
3 exist in the disease in the basal ganglia and that not
4 only are drugs effective but psychotherapies, such as
5 cognitive behavior therapy, do the exact, identical
6 thing as drug treatments, so we have effective
7 treatments for these illnesses.

8 And as we move into the future, we have
9 the advantage of now beginning to be able to influence
10 these circuits directly. Over the course of the next
11 ten years, in the scientific aspect of the treatment
12 of mental illnesses, this is going to be a very
13 exciting time where we are going to be able to use the
14 advances in the basic science of genetics and
15 molecular biology to understand the causes of mental
16 illness and to develop new, effective and even more
17 effective treatments. Let's not be behind in terms of
18 how mental illnesses are paid for, we need to advance
19 the science and we need to erase the stigma, and I
20 appreciate the efforts of both representatives to
21 advance this agenda for the American people.

22 REP. KENNEDY: Thank you very much,
23 Doctor, thank you for a very compelling presentation.

24 I really appreciate you putting it in the visual.
25 Really we are a very visual society, we learn a great

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1 deal through the visual. And I always, when I speak
2 on the floor, bring those pictures of the PET scans to
3 the floor when I speak on this issue because they are
4 so compelling. And thanks to modern x-rays and these
5 new images, brain imaging technology, we really can
6 see the physical nature of the brain and it really
7 doesn't make any sense, once you now can see this, it
8 takes the mystery that most of the stigma preys upon
9 and debunks it. So thank you very much.

10 Now I would like to turn to Marianne Monte
11 and have you say a few words. Thank you, Marianne,
12 for being here.

13 MS. MONTE: Thank you so much, Congressman
14 Ramstad and Congressman Kennedy, thank you so much for
15 the invitation to talk with you today about the
16 importance of mental health parity and its effects on
17 our businesses.

18 I would like to focus my remarks today on
19 two areas of importance, the first is the business
20 case for offering mental health benefits to employees
21 and what employers can do to try to achieve this for
22 their employees. Both of these topics ultimately help
23 run our businesses more positively, giving our
24 employees and ultimately our customers the best
25 possible service they can get.

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1 Employers spend billions of dollars each
2 year on medical and dental benefits for their
3 employees and I think most business executives would
4 agree with me when I say that a healthy employee tends
5 to be a happy employee. As an HR Director at Bank
6 Rhode Island, it's hard not to see that mental health
7 problems resulting in employee relations issues to
8 unplanned disability leaves of absences are on the
9 rise. Sadly, many employers feel it's not their place
10 to proactively get involved on those issues. I would
11 suggest that employers who create cultures that
12 support mental health treatments, helping employees
13 obtain the assistance they need is indeed in an
14 employer's best interest.

15 In fact, there is an incentive to reducing
16 the prevalence of mental health issues on an
17 employer's bottom line. Consider the following
18 statistics from the Society for Human Resource
19 Management. Depression alone cost U.S. employers
20 almost \$44 billion and is associated with more annual
21 sick days and higher rates of short-term disability
22 than any other chronic condition. Total medical
23 expenditures were four to five times higher for
24 employees with mental disorders compared to medical
25 expenditures for employees with no mental illness.

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1 The costs of physical medical care are higher for
2 individuals with mental disorders. In addition to
3 incurring costs for mental health, people with mental
4 disorders spend more on general medical care than
5 those without such conditions.

6 Now obviously the indirect costs of mental
7 health impairment outweigh the direct cost, the cost
8 of combined, the combined cost for absenteeism and
9 lost productivity related to depression are much
10 higher than the direct cost associated with treatment.

11 Finally, pharmaceuticals related to mental
12 health are responsible for a growing percentage of
13 prescription drugs costs as new classes of drugs to
14 treat depression, anxiety and other mental impairments
15 are increasingly prescribed.

16 Given these few statistics, clearly mental
17 health matters to businesses. The impact of mental
18 health problems in the work place has serious
19 consequences not only for the individuals but for
20 their coworkers, managers and family members.
21 Educating employees and managers about mental health
22 problems and intervening early can make an enormous
23 difference. Promotion of good mental health practices
24 can be part of a human resources philosophy.
25 Partnering with hands-on insurers and EAP providers

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1 can make all the difference to those employees
2 suffering from mental illness.

3 So what can employers do? Simply make it
4 clear to employees that there is no stigma associated
5 with mental health impairments. Many employees with
6 mental health issues are embarrassed to seek care. By
7 regularly communicating with employees about your
8 mental health benefits, you can reinforce the message
9 that seeking help is acceptable. Educate employees on
10 mental health. Our EAP provider helps our employees
11 and managers on how to recognize warning signs for
12 mental health, each of our employees receives an EAP,
13 personalized EAP card so they don't have to ask
14 someone for the EAP phone number. Our Internet has a
15 direct link to their Web site and we constantly
16 reinforce that this is a confidential service we
17 provide to all of our employees and their household
18 members.

19 Finally, spend some time on your benefits
20 design. During our 2007 benefits renewal, we made a
21 conscious choice to stay with our current health care
22 provider because we felt their mental health benefits
23 were superior to those of their competitors.
24 Ultimately, we felt the increased cost of staying with
25 our existing provider would outweigh the impact of

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1 switching on our employees. Employers who make a
2 choice to implement a culture that supports good
3 mental health will help their employees tremendously,
4 not to mention potentially helping their bottom line.

5 Thank you.

6 REP. KENNEDY: Terrific. Thank you very,
7 very much.

8 (Applause)

9 REP. KENNEDY: Thank you all very much, I
10 appreciate all of your testimony.

11 Jim, you had a question?

12 REP. RAMSTAD: Just a quick question. I
13 realize we want to stay on schedule, but first of all,
14 thank you all, those were wonderful presentations.
15 All of you I know are leaders in your respective
16 fields and I appreciate your being here today and the
17 progressive approach that you all take to dealing with
18 this problem. I just want to ask you, well any of the
19 witnesses who feels qualified to speak on this, our
20 critics sometimes question the efficacy of treatment,
21 especially for chemical addiction. Are you familiar
22 with the studies comparing the recidivism rates with
23 respect to substance abuse vis-à-vis those of more
24 physically identified illnesses, heart disease, kidney
25 disease, liver disease, diabetes and so forth?

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1 MR. MCNULTY: I'm not familiar with the
2 statistics, but let me just try and do an analogy. I
3 shared with you the fact that I went in for chest
4 pains and what happens is they found out that I have
5 this incredibly high cholesterol, high triglyceride
6 situation and the only way to rationally control it is
7 through lifestyle change. How easy do you think that
8 is to do and just how well do you think I'm doing
9 lowering my cholesterol and triglycerides? Let me
10 just say that I could probably be doing a lot better,
11 although I have gotten it down into the high normal
12 range.

13 The point is that none of this stuff is
14 easy. We have done the easy stuff, we have taken the
15 low hanging fruit. We have to recognize that
16 individuals who are living with addictive disorders
17 are not doing it really through choice, they need
18 help.

19 The other thing that frustrates me, I sat
20 on the NIMH Advisory Counsel for four years, we have
21 developed and we have seen some really good treatment
22 practices that we could use to work with people,
23 nobody will pay for them and that is a problem,
24 including the U.S. Government. I have to tell you,
25 I'm going to hold the Medicare accountable for that as

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1 well, they just won't do it.

2 Steve mentioned cognitive behavioral
3 therapy, there are analogues to that in addiction
4 therapy. We are not paying for it, we are not doing
5 it.

6 MR. LIEBERMAN: I don't know the specific
7 answer comparing the recidivism rates for psychiatric
8 disorders to other medical conditions. In
9 psychiatric--

10 REP. KENNEDY: Chronic illnesses. Maybe
11 you make the analogy to diabetes, people have to keep
12 going back for diabetic care, heart disease, asthma
13 care, people have to keep going back. No one holds it
14 against an asthmatic, no one holds it against a
15 diabetic. I mean can we just be up front about this?

16 I mean the expectations are totally different, I mean
17 you take a heart, you go in for, you get your heart
18 medication, you're fine. You don't get your heart
19 medication, you get into trouble, okay? So, if I
20 don't get my medication, which is treatment, I'm going
21 to be in trouble, okay? But people hold that against
22 me, but no one would hold it against someone who has
23 got heart disease if they don't get their heart
24 medication.

25 But it's a different, it's analogous but

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1 people have totally different expectations because
2 they put a totally different standard on it, but it's
3 exactly the same thing.

4 MR. MCNULTY: Exactly, get over it.

5 REP. KENNEDY: And now where would you be,
6 Jim, without treatment? Where would you be without
7 treatment?

8 MR. MCNULTY: Dead.

9 REP. KENNEDY: Dead.

10 MR. MCNULTY: Or in prison.

11 REP. KENNEDY: Okay.

12 MR. LIEBERMAN: Excuse me. If I could
13 just make a couple sort of random points about this.
14 I think, going on something that Jim said, that it's a
15 range of situations so that it's known, for example,
16 that very short interventions in a primary care
17 physicians office can cut the incidents of cigarette
18 smoking. Just talk to people about cigarette smoking
19 and a very high percentage of people respond to that.
20 It's very low cost, it's a big bang for your buck.

21 On the other extreme, severe and
22 persistent mental illness does not respond to that
23 kind of very brief, time limited intervention, it just
24 doesn't, nor does cancer, nor does congestive heart
25 failure, nor does rheumatoid arthritis or a number of

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1 medical conditions that people unfortunately have to
2 deal with for many, many years through many complex
3 treatments, and they work and then they stop working.

4 It's not fundamentally different than many of the
5 psychiatric conditions that we treat.

6 And I think that one of the advantages in
7 fact that psychiatric treatment has is that
8 psychiatrists and psychiatric health care
9 professionals have some understanding of the
10 chronicity of these disorders and how to think about
11 it and how to think about how difficult it is to
12 withstand this and stay in treatment for such a long
13 time, which other medical practitioners may not
14 understand as well.

15 REP. RAMSTAD: And I certainly appreciate
16 the responses, we've got to get to the next panel.
17 But just let me wrap this up by saying the studies
18 I've seen show that, as much as this can be
19 quantified, the efficacy of treatment, as much as it
20 can be reaffirmed in terms of numbers, that the
21 recidivism rate is no greater for the treatment of
22 mental illness, mental diseases, including chemical
23 addiction, than it is for the treatment of diabetes,
24 asthma and hypertension. The figures, again, show
25 about the same success rates, so thank you again to

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1 all four of you.

2 (Applause)

3 REP. KENNEDY: Would panel three please
4 come up? While the panelists are taking their seats,
5 I would like to thank the Rhode Island Medical Society
6 and the Rhode Island Council of Community Mental
7 Health Services, Mental Health America and, again,
8 NAMI, the National Alliance for the Mentally Ill, for
9 all their assistance in helping to put today's hearing
10 together and for all their assistance in this national
11 tour that we are commencing starting with today's
12 hearing.

13 PANEL THREE

14 THE RHODE ISLAND EXPERIENCE

15 WITH MENTAL HEALTH AND ADDICTION COVERAGE

16 REP. KENNEDY: Now that the third panel
17 is seated, I would like to begin, Michael Noonan.

18 Michael, would you begin this panel?

19 MR. NOONAN: My name is Michael Noonan
20 and I want to thank the members of the panel,
21 Congressman Kennedy, Congressman Ramstad for taking
22 the time to come and talk about my 17 year old
23 daughter, Erin, and her experience with alcoholism,
24 and what has happened over the last three years and
25 how it's affected her and our lives.

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1 I brought a few pictures today just to
2 show you who Erin is because many times you can talk
3 about the issues, you can talk about, you know,
4 what's happening, about monies and all this kind of
5 thing but it's not reality.

6 This is a picture of my daughter Erin
7 when she went to Proute and she won the 2005 state
8 championship on the soccer team, and this is myself
9 and her when we were in Thailand. This is in a
10 refugee camp and she was helping out some of the
11 refugees on the Thai-Burmese border. That was in
12 2005 and this was in February of 2006 and I would
13 like you to just remember those days and the dates as
14 I go through the chronology of what happened with her
15 from there.

16 So, in June of 2004, Erin was
17 hospitalized with alcohol abuse, she had a blood
18 level of .32, and she was kept overnight and it began
19 a change for us and our family. Again in June, 2004,
20 she began individual counseling on a weekly basis, as
21 well as with an adolescent group bimonthly and this
22 continued for two years until June of 2006. In April
23 of 2005, the following year, she went to Myrtle Beach
24 with another family. We explained to them about her
25 drinking problems that she has had in the past, she

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1 was doing well and she in turn had problems, came
2 back and we took her to Meadows Edge in North
3 Kingston for an evaluation.

4 They recommended a six week intensive
5 outpatient program, they call it an IOP. She went to
6 that three times per week, my wife and I also went
7 two times a week. From there, after completing that,
8 she began weekly counseling with a substance abuse
9 counsellor, as well as her other counseling that she
10 was going to. In July of 2005, she had been going to
11 three AA meetings a week and also had a sponsor in
12 the program and, from July of 2005 through March of
13 2006, I think she was managing pretty well, only to
14 find out later that she had only been sober for two
15 months straight during that period of time.

16 In March through May of 2006 there was a
17 decrease in her attendance to the AA meetings, she
18 had more aggressive behavior, she was tardy at school
19 and her academics, where she was a B student, began
20 to decline. On 6/6/2006, after going to an AA
21 meeting, she came home intoxicated and she was
22 belligerent and about 11:00 that night, she took off
23 in the pouring rain, and ran to the beach about a
24 mile away and said I'm just going to swim and never
25 come back. At that point in time, I feared for her

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1 life, and I ran after her and stayed with her for a
2 couple of hours until we were able to get her to come
3 home.

4 We took her to the Kent House for an
5 interview and it was determined that appropriate
6 treatment, a placement, what was right for her
7 because we didn't know. The counselor in her
8 discharge summary said that "the client's symptoms of
9 loss of control, blackouts, high tolerance, mood
10 swings, personal changes indicates a need for
11 residential care. The client's uncontrollable use
12 puts her safety at risk and the risk of other's
13 safety".

14 We reviewed all the female adolescent
15 inpatient options in Rhode Island. Guess what?
16 There really aren't, and actually in the country
17 there is a lacking, very much a need for under 18
18 female residential programs.

19 After much consultation, etcetera, we
20 decided to admit her to Hazelton in Minnesota. I
21 contacted United Behavioral Health to confirm her
22 inpatient rehab for chemical dependency. They stated
23 that there was a \$200 deductible and 30 day coverage.

24 I asked if there was anything I needed to do prior
25 to her admittance and they said there was nothing

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1 else I needed to do. On 6/26/06 Erin was admitted to
2 Hazelton Center for Youth and Families. We had to
3 take out a home equity loan of \$23,000 to be able to
4 pay for this.

5 On 6/27/06 a letter from UBH was
6 authorizing a stay from 6/25 to 6/29. When I wrote
7 my second appeal for the denial, which was on 11/2, I
8 still had not received payment for that five day
9 stay, although the contract says I should be paid
10 within 30 days. On 7/21/06, and pardon all the
11 dates, but on 7/21/06 she was discharged from
12 Hazelton to Rosekrantz Griffin Wilson Campus in
13 Rockford, Illinois where she still stays and,
14 although it's good that her counseling is being paid
15 for, we are paying \$4,000 a month for her to be at
16 that program.

17 On 8/3/2006 the first level of appeal was
18 reviewed at United Behavioral Health for the adverse
19 determination on 6/30/2006. On 8/25 a letter from
20 UBH was received stating that they requested more
21 information from Hazelton, although later I found out
22 that they had already denied the claim on 8/9, but
23 yet I received a letter on 8/25 stating that they
24 requested more information and it was still in
25 process. On 9/6, I spoke to a claims representative

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1 at UBH, he stated the first level appeal had been
2 denied on 8/9/2006 and both Hazelton and myself were
3 never notified.

4 I requested a copy of the denial and also
5 asked for payment of the first five days of her
6 treatment, which I still had not received. He stated
7 he would make a request. A week later, he called me
8 back again stating that he had followed up with the
9 appeals office on Philadelphia to obtain a copy of
10 the denial. On 9/18 I received a certified letter
11 from UBH dated 9/11 stating denial of the first level
12 appeal review which was received on 8/3, this is 15
13 days past the contracted rule of 30 days. On
14 11/2 I sent in a second appeal. On 11/6 I received a
15 fax from an appeals coordinator stating "UHB has
16 received a request from you for an appeal of adverse
17 determination on 6/30/2006 for services provided by
18 Hazelton Foundation. As of 9/11, you have exhausted
19 your internal appeals options", so I could not file a
20 second appeal, although it took me a while to put all
21 that information together. I called, and on 11/7,
22 the next day at 8:15, I received a call back saying
23 that the first level appeal was performed on 7/21 as
24 an urgent appeal and then on 8/9 a second level
25 appeal was filed.

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1 I stated I received the letter on 9/11
2 stating that the first level appeal was denied and I
3 should have received the letter by 8/30. My letter I
4 sent in on 11/2 was received on 11/6 by UBH, this was
5 within the 60 days of receipt of the denial of first
6 appeal. So it's around, and around and around,
7 frustration and then later that day the
8 representative called me back stating that I was
9 correct, and that they would process it and I would
10 hear from them within 15 business days or 30 days.

11 I received a check on 12/22/2006, six
12 months after initiation of her treatment. It was
13 only that I received that monies from being
14 persistent and from having help from Congressman
15 Kennedy and his office. I have a masters degree in
16 business, I have worked in the health care field for
17 27 years, yet I found it extremely difficult trying
18 to obtain reimbursement for medically necessary
19 service. In October, 2005, the *Providence Business*
20 *News* reported "United Health profits soar 21 percent
21 on cost control". I felt that I was part of that
22 cost control, that's what I just experienced.

23 It is difficult. I cannot explain to you
24 how difficult it is to have a daughter go through
25 what she has been going through and have to deal with

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1 this stuff on top of it, it is very, very difficult.

2 It went to state that United Health Care's quarterly
3 earnings were up to \$842 million, that's \$842 million
4 in three months. The *Milwaukee Journal* in April,
5 2006 had an article of the then CEO, Mr. McGuire, at
6 \$1.6 billion in stock options, yet they wouldn't pay
7 for my daughter's health, and actually it was her
8 life, I believe.

9 She can get what she gets because of my
10 persistency and because of help with people like
11 yourselves that care about people that have substance
12 abuse and mental illness. What about those who can't
13 speak for themselves? That's what I would say.
14 Thank you very much for you time.

15 (Applause)

16 REP. KENNEDY: Going on down, maybe I
17 could have, Mark, you take it next.

18 MR. REYNOLDS: Thank you Congressman
19 Kennedy and Congressman Ramstad for inviting me
20 today. My name is Mark Reynolds and I serve as the
21 Chief Executive Officer of Neighborhood Health Plan
22 of Rhode Island. We are an unusual health plan
23 because of our mission and our customers, we partner
24 with community health centers and other primary care
25 providers to really focus on increasing access to

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1 care and improving the quality of health care,
2 particularly for uniquely vulnerable populations.

3 We have been nationally recognized by the
4 National Committee of Quality, excuse me, the
5 National Committee for Quality Assurance in *U.S. News*
6 *and World Report* for our work on quality access and
7 customer service. I'm here to support the Paul
8 Wellstone Mental Health Equitable Treatment Act
9 because it is our experience that an integrated
10 approach to health care, one that treats both
11 physical and mental health issues simultaneously is
12 the most effective method for delivering high
13 quality, cost effective care.

14 Physical and mental health are
15 inextricably linked, our health care system and our
16 insurance systems need to recognize this. People
17 with chronic behavioral health treatments frankly die
18 younger than others, people with depression have a
19 reduced ability to follow medication regimens, thus
20 hindering the treatment of their medical conditions.

21 People who are clinically depressed are actually
22 three to four more times likely to die within the six
23 months following a heart attack. Depression is,
24 however, quite common, about 25 percent of the people
25 with chronic illnesses experience sever depression at

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1 any point in time.

2 Our direct experience as an insurer
3 reinforces these findings. One of our members is an
4 adolescent female who has struggled for the past two
5 years with managing diabetes. Dealing with daily
6 injections, the mood swings accompanied by high and
7 low sugar levels has made this complicated. Add onto
8 that adolescent hormones, extra parental monitoring
9 and a drastically reduced sense of independence and
10 it's become a recipe for problems. During this time,
11 she has become depressed and her depressed mood has
12 effected all aspects of her life, including trying to
13 manage her diabetes.

14 Over the course of several months, this
15 young woman had multiple diabetes related hospital
16 inpatient admissions. Our case management team
17 identified depression as a major factor in the lack
18 of her appropriate diabetes management. We helped
19 this young woman access closely supervised medical
20 and psychiatric outpatient treatment and set up
21 home-based individual and family treatment programs,
22 including in-home education and monitoring. In the
23 six months since the start of the intervention, she
24 has not been readmitted to the hospital for her
25 diabetes and she continues to work with her therapist

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1 on her depression issues.

2 Neighborhood reinforces this medical
3 behavioral health connection through the way we
4 interact with our providers. We have configured our
5 reimbursement code system to allow for primary care
6 physicians to submit claims for addressing both
7 behavioral health assessment and medical management.

8 After all, nearly 74 percent of Americans who seek
9 help for depression go to their primary care
10 clinician first. We actively also work with our
11 medical providers to promote the collocation of
12 behavioral health and medical health services in a
13 given site, this one-stop shop approach really
14 provides a much more appealing atmosphere for people
15 that are facing behavior health issues.

16 Treating behavioral health needs is a
17 critical part of overall behavioral, excuse me,
18 overall health care and it's really the only way to
19 provide comprehensive and fully appropriate care.
20 Mental health and substance abuse cannot be
21 considered separate from medical care, they interact
22 in ways that effect people's medical well being.
23 Thank you again for letting me speak to your panel.
24 Neighborhood fully supports mental health parity and
25 the Paul Wellstone Act.

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1 Thank you.

2 REP. KENNEDY: Thank you.

3 (Applause)

4 REP. KENNEDY: Jim Purcell, CEO of Blue
5 Cross/Blue Shield of Rhode Island. Thank you, Jim,
6 for being here with us today and being able to
7 present on behalf of Blue Cross/Blue Shield. I
8 appreciate your being here to testify and offering
9 your perspective on this.

10 MR. PURCELL: My pleasure. Thank you,
11 Congressmen Kennedy and Ramstad, it's a pleasure to
12 be here. As CEO of the state's largest health
13 insurer, sometimes being at hearings like this is a
14 little bit like being the skunk at the lawn party, it
15 can be difficult, but here I don't feel that way
16 because we actually do have some good things to say.

17 The subject of our discussion is what are the
18 lessons learned in Rhode Island as a result of what
19 we've done? We have a mental health parity act and I
20 should say behavioral health parity act, not mental
21 health, behavioral health because it combines
22 substance abuse and mental illness.

23 That's huge, that's something I
24 understand that your bill is designed to do, but we
25 have done it. The bottom line is it didn't break the

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1 bank, it's not full parity, it didn't break the bank
2 for the insurers. What we don't have in Rhode Island
3 yet is full parity with regard to office visits,
4 outpatient visits. There is a mandate only to
5 necessitate 30 per year. I believe that's bad
6 medicine, it's bad law and it's bad insurance.

7 Who are the people that are most likely
8 going to need those extra visits? The people who are
9 really in tough shape, they are in harm's way, and
10 when do they run out of the 30? Oh, right around the
11 holiday season. And where do they end up? In the
12 emergency room and we heard about that. The cost of
13 covering additional office visits is minuscule. Blue
14 Cross had about 2,000 requests last year for office
15 visits in excess of 30, we do now cover, except for
16 the self-insured and for municipalities, we do cover
17 in excess of 30. We do it on an exception basis but
18 we do not do preauthorization, the physician sends in
19 a form.

20 If there were 2,000 office visits, that
21 probably would have cost us an additional between
22 \$200,000 and \$300,000, that's a drop in the bucket
23 and what it could prevent is pretty obvious. Blue
24 Cross fully supports complete parity between
25 behavioral health and physical health. As Mark

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1 testified, the combination of behavioral health and
2 physical health is key. I know, Congressman Kennedy,
3 you were at an event in Newport in which we discussed
4 this and collocated, integrated behavioral and
5 physical health is so obviously necessary that it's
6 almost negligent not to have it. We have to find
7 ways, as insurers, to reimburse for that.

8 Parity does not just mean coverage,
9 parity also means fee parity because, as everybody
10 likes to remind me, what insurers pay for impacts the
11 system, what we cover impacts the system, so what we
12 pay providers has a huge impact on what we get
13 delivered. For example, do we pay psychologists the
14 equivalent for an office visit as we would on the
15 physical side for an MD? For Blue Cross, the answer
16 is yes. We use the full Medicare RV/RVS system so
17 that an office visit for an MD and a psychologist is
18 reimbursed the same, and we are proud of that and we
19 think it's cost effective.

20 I'm very proud of what Blue Cross has
21 done with regard to its coverage. As we said, the
22 Rhode Island statute has nearly parity, but I want to
23 tell you a few things that we have done so that our
24 coverage just about achieves parity. In 2001, prior
25 authorization for standard outpatient treatment was

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1 eliminated, in 2002 all annual limits for higher
2 levels of care were removed and made equal to medical
3 benefits per contract and we learned, the lesson
4 learned, it didn't break the bank. Now there are
5 some things that you have to watch out for, this is
6 not one of them.

7 In 2004 full parity in reimbursement to
8 providers was implemented, full parity. In 2004
9 unlimited annual coverage of the health and
10 behavioral assessment codes were implemented,
11 enabling health providers to evaluate and treat the
12 emotional components of physical health, something
13 that Mark was talking about. In 2005 prior
14 authorization at admission for higher levels of care,
15 including inpatient, eliminated for part providers.
16 In 2006 standard outpatient psychotherapy benefits
17 increased from 30 to 50 for nearly all fully insured
18 commercial members.

19 I will say, on another front, I know you
20 guys can only take on so much, but Medicare's
21 treatment is shameless. For those of you who don't
22 know, Medicare reimburses, on the physician side, 80
23 percent with a 20 percent copay for the patient. For
24 behavioral health, it's 50 percent, so I know money
25 is tough and it is a money issue, and I suppose we've

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1 got to do this one step at a time but the bottom line
2 here is that we have a system, it's not perfect. On
3 behalf of Blue Cross, we have tried to remove every
4 barrier we possibly can to getting treatment and we
5 are proud of the treatment that we deliver. I thank
6 you for holding this hearing, I think it's incredibly
7 important.

8 REP. KENNEDY: Thank you very, very much
9 for your testimony.

10 REP. RAMSTAD: Before we proceed, I've
11 got to interrupt. I know time is of the essence here
12 but I want to thank you, Mr. Purcell, your testimony
13 is a huge breakthrough for the effort to pass parity
14 nationwide. For you, as the CEO of Blue Cross, to
15 come in here, Blue Cross of Rhode Island, to come in
16 here and talk about the Rhode Island experience and
17 then to go a step further and say you fully support,
18 on behalf of Blue Cross, complete parity is
19 monumental. And I want to thank you for telling it
20 like it is, for being progressive as a CEO. Can you
21 help us with Blue Cross and other insurance companies
22 across the land?

23 And I say that seriously. If you can
24 share the Rhode Island experience and your views on
25 complete parity with your fellow chief executive

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1 officers of insurance companies across the land, that
2 will be an enormous help in pushing this effort
3 forward.

4 MR. PURCELL: I'll try the best I can.

5 REP. RAMSTAD: Thank you, thank you very
6 much. And by the way, Pete Stark, who is Chairman of
7 the Ways and Means Subcommittee on Health, where I
8 sit, is introducing and determined to pass Medicare
9 parity as well.

10 (Applause)

11 REP. KENNEDY: Rich? Good to have you.

12 MR. LECLERC: Good morning, Congressman
13 Kennedy, Congressman Ramstad. It's my pleasure to
14 speak with you this morning about the Rhode Island
15 experience, at least from my perspective, with mental
16 health and addictions coverage as it pertains to the
17 issue of parity which we, as an organization, fully
18 support and endorse.

19 My comments are not intended to blame any
20 one particular aspect of our complex and intricate
21 health care financing, administrative and delivery
22 system, many aspects work well, many don't. I do
23 want to share with you some of the areas that, in my
24 opinion, are the key touch points in making mental
25 health and addictions parity work successfully from

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1 the Rhode Island experience and an improvement. In
2 designing effective parity, we need to look at both
3 the supply and demand side of the equation. On the
4 demand side, we need to address the design of certain
5 basic benefits that should be included in the service
6 package for mental health and addictions treatment.

7 I assume that we could all agree, at
8 least all of us in this room could all agree that
9 covered benefits should include inpatient, emergency
10 services, crisis intervention, psychiatric and
11 psychological evaluation, medication management,
12 counseling, psychotherapy, to name a few, but
13 consideration should also be given to include day
14 treatment, intensive outpatient program, partial
15 hospitalization, outreach, home visiting and
16 specialized services for individuals with co-
17 occurring disorders and social case management.

18 I realize that the area of benefit design
19 may go beyond the scope of what may be considered a
20 pure parity bill which in essence would require
21 health plans to treat physical health and behavioral
22 health benefits, payments and administration
23 equitably. An inadequate benefit plan for physical
24 health, however, would result in an equally
25 inadequate benefit plan for mental health and

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1 addictions disorder. So, in the long run and
2 ideally, benefit design requirements should be
3 considered as part of any national legislation and
4 regulation.

5 On the supply side of the parity
6 legislation, payment and administrative practices
7 need to be examined. Examples still prevalent in
8 Rhode Island are low reimbursement rates and
9 inadequate payment structure, high service copays and
10 deductibles, limitation on number of visits and
11 services, significant payment delays, capricious and
12 arbitrary denials usually blamed on the computer or
13 on human error and continual requests for claims
14 resubmission. We have frequent examples of needing
15 to make multiple phone calls followed by waiting 45
16 to 50 minutes to obtain authorization for treatment
17 and then waiting six or eight months for payment.

18 After payment is obtained, we are
19 notified that we are an out of state network
20 provider, which is incorrect, payment is recouped by
21 the health care plan and the chase is on again to
22 receive payment. There exists, in some cases,
23 selective micro management through frequent
24 requirements for service authorizations and
25 reauthorizations. For some outpatient services,

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1 especially our child and family intensive treatment
2 services, we are frequently told that authorization
3 is not needed and, after several months of services,
4 payment is denied due to lack of authorization.

5 No one can be held accountable it seems
6 for these errors which, again, frequently repeat
7 themselves and reoccur. Some health plans have
8 cumbersome and delayed-ridden credentialling of
9 licensed independent practitioners and clinicians,
10 requests for credentialling of clinicians to be added
11 to a provider's panel frequently takes, in some
12 cases, more than a year. We are told that human
13 error is to blame. This is not occasional but
14 frequent occurrence, this is not experienced by a few
15 providers, it is system-wide. It is pervasive, it's
16 unacceptable and it's discriminatory.

17 These practices hamper the access to care
18 for individuals and families, that's where it counts.

19 The impact is also felt on providers through
20 increased costs and frustration. Fewer and fewer
21 providers and practitioners are willing to remain on
22 a health plan's provider panel, resulting in further
23 problems with access to care for individuals with
24 mental health addictions problems. Without the
25 necessary and basic mental health addictions

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1 treatment parity, benefit, parity becomes a hollow
2 promise. Without sufficient qualified providers,
3 there is limited or no access. Without access,
4 parity is a sham.

5 I would make, in closing, four or five
6 recommendations for consideration on any legislation.

7 I would establish a minimum benefits level for
8 treatment of mental health and addictions disorders.

9 I would consider phasing in some level of enhanced
10 benefits, such as social case management. I would
11 ask that it require health care plans to establish
12 referral information linkages and collocation between
13 behavioral health and primary care services. I would
14 eliminate discriminatory payment and administrative
15 practices and impose financial and other penalties
16 for noncompliance and I would ask that it require
17 that the Secretary of Health and Human Services
18 produce an annual report to Congress evaluating the
19 implementation of, compliance with an enforcement of
20 this parity legislation and make recommendations for
21 improvement.

22 Thank you for listening and thank you for
23 your leadership, both your leadership in this parity
24 effort. Thank you.

25 REP. KENNEDY: Excellent testimony.

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1 Thanks, Rich.

2 (Applause)

3 REP. KENNEDY: Thank you very much, Rich.

4 Dr. Rhonda Robinson-Beale, please? Thank
5 you very much for coming.

6 MS. ROBINSON-BEALE: Thank you very much,
7 Congressmen Kennedy and Ramstad, I really appreciate
8 the opportunity to be here. And I want to
9 particularly thank Michael Noonan for his testimony
10 because I think it's true; this type of information
11 that we learn and we learn how to benefit from the
12 kinds of issues like this that are very gripping and
13 very person on how to improve the system.

14 Mr. Noonan, I'm sorry that that was the
15 experience that you had, but we will make a
16 commitment to work on that and make that kind of
17 situation not occur for patients in the future.

18 (Applause)

19 MS. ROBINSON-BEALE: I'm the Chief
20 Medical Officer for United Behavioral Health and I
21 appreciate the opportunity to be here today. We are
22 quite aware of the situation as it relates to
23 behavioral health. Being involved in various
24 national committees, and efforts and initiatives
25 around the issues of behavioral health, we know from

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1 the President's Commission, from the IOM, from the
2 National Equality Forum and from various
3 organizations that the mental health and substance
4 use disorder industry and area is a fragmented
5 system. We know that there's multiple issues that
6 need to be resolved, I applaud our Congressmen and
7 all our legislators for at least taking on this one,
8 huge challenge as a way of trying to address that.

9 We have many issues that we have to deal
10 with and, as we heard today, so many of those impact
11 and come together to cause many, many problems from
12 shortages of providers, bed shortages, lack of
13 coordination of care or poor coordination of care,
14 variability in care, variability in practice and
15 translation of what we know in terms of
16 evidence-based practice into practicality. As we
17 know, it takes 17.3 years for scientific evidence to
18 be actually translated into general practice, so we
19 know that our system needs a lot of help and there's
20 multiple pieces that would need to be addressed.

21 We recognize that this is something that
22 no one area can do alone, it's something that's going
23 to require all of us to work together as health
24 insurers, as providers, as consumers, as legislation
25 and as states and federal government. This is a huge

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1 issue but it's an important issue. At United, we
2 feel it's exceptionally important to the point where
3 we feel it's very, very important, as we heard
4 earlier, that there is evidence to show that
5 behavioral health illnesses have a neurological base,
6 that's absolutely true, and this also makes it
7 something that is very acceptable and more adaptable
8 in terms of people recognizing the complexity of it
9 but, most importantly, it is something that can be
10 addressed, and can be rectified and can be improved.

11 We also recognize, and United has done a
12 lot of work with an actuarial firm, Mellman &
13 Robertson, to find out exactly for our employers and
14 for others and to quantify the fact that hidden
15 behavioral health conditions in the medical side
16 cause a medical illness to increase in cost by six
17 times. That's for diabetes, stroke, cancer, all of
18 them. It is very, very important for people to
19 understand that hidden fact. When we look at the
20 antidepressant prescription incidents, we find it
21 anywhere between 9 and 16 percent of the medical
22 population. That is larger than any other medical
23 illness that exists, so it's there. The problem is
24 that it's not always recognized and certainly not
25 always treated.

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1 We are in support of the efforts to
2 overcome this one challenge, this one challenge of
3 parity. We are completely committed to the effort to
4 bring behavioral health benefits consistent with
5 medical coverage. We do so with the idea of
6 including quality and management as a process of
7 bringing in evidence-based practice and clinical
8 opinion into the process. I appreciate the
9 opportunity to be here and we appreciate the
10 opportunity to work with you both in terms of
11 furthering this bill ahead.

12 Thank you.

13 (Applause)

14 REP. KENNEDY: Thank you very much. If I
15 could, doctor, I would like to raise this issue
16 because you are committed to addressing Mr. Noonan's
17 issues that he raised, and one area that would be
18 very easy to address right away is one that was
19 raised by Mr. Purcell and that is fee parity. If we
20 are going to have parity, one way for you not to be
21 put at any competitive disadvantage of your
22 competitor here in Rhode Island, Blue Cross, would be
23 simply just to be paying the same as Blue Cross would
24 be paying the providers in the state, no more, no
25 less, just the same. Would you be prepared to do

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1 that?

2 MS. ROBINSON-BEALE: I love your direct
3 questions, Congressman Kennedy.

4 (Laughter)

5 MS. ROBINSON-BEALE: Let me say this,
6 that United Behavioral Health has just raised its
7 fees last year and certainly, as we do on an ongoing
8 basis, we will continue to examine those fees and
9 work with the providers in the area to try and bring
10 fees as, I would say as equitable as possible. Keep
11 in mind that we have employers who we have to also
12 answer to in terms of fees and the total cost of
13 care, but I will say that we will continue to examine
14 those fees.

15 REP. KENNEDY: When you raised the issue
16 that this is a complex problem, which is really the
17 nub of your testimony, and then you raised the issue
18 of evidence-based and the disparity, the reason why
19 we don't get the evidence-based into practice is that
20 no one is going into the treatment because they are
21 not being paid, so which comes first, the chicken or
22 the egg? You are not going to get people to go into
23 the field if they are not going to get paid and you
24 are not going to get quality people if you don't pay
25 them, and so you are right back to where you started

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1 from.

2 And in terms of the issue that you also
3 raised in terms of hidden medical costs, they will
4 remain hidden if you separate your behavioral health,
5 as you do in United, from United Health. You have
6 United Behavioral Health as a separate arm of your
7 insurance from United Health, no wonder it's hidden
8 to you because behavioral health is hidden from
9 medical, the rest of your medical insurance system.
10 It should be incorporated into United Health, that
11 way your diabetic who is costing you a lot of money
12 because they are also depressed can be treated in a
13 holistic fashion. And you don't have to worry about
14 spending a lot of money trying to get your diabetic
15 doctors to talk to the psychiatrists so that they can
16 talk and coordinate on a strategic plan, so they
17 don't end up costing you a lot more money when, if
18 they had just been under the same insurance plan with
19 the same deductible, and copay, and premium and
20 management plan, most of all, then you would save
21 money for both the patient, treatment and, as you
22 just said, for the employer that they are both
23 working for.

24 MS. ROBINSON-BEALE: You are absolutely
25 right with that, Congressman Kennedy. Let me

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1 clarify--

2 REP. KENNEDY: Thank you. I love it when
3 you say that.

4 (Laughter)

5 MS. ROBINSON-BEALE: Let me clarify the
6 situation. Certainly when we talk about behavioral
7 and medical integration it doesn't necessarily imply
8 that both behavioral and medical need to be
9 necessarily the same insurance but that there is
10 integration of data, information and coordination
11 between the care management, as well as a sharing of
12 information. At United Behavioral Health and United,
13 we work very diligently in terms of looking at our
14 claims systems to pre-identify those individuals who
15 are demonstrating claims through their patterns of
16 use that they are, a) have depression, substance
17 abuse disorders, anxiety, as well as having other
18 mental illnesses that are on the medical side.

19 We have case managers who work very
20 closely with the medical case managements and also,
21 in identifying those cases, work with the primary
22 care physicians to wrap around those primary care
23 physicians to offer case management services and
24 access to behavioral health providers. So the
25 integration and the identification of that hidden

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1 behavioral comorbidity is something that we actively
2 look for and actively coordinate in terms of case
3 management services.

4 REP. KENNEDY: My last point is that Rich
5 LeClerc obviously pointed out the other side of the
6 problem that Mr. Noonan said. As a provider, there
7 is this constant road block for anybody, either as a
8 consumer or as a provider, all these hoops people
9 have to go through in the mental health field that
10 they don't have to go through if they are getting the
11 otherwise physical health care that our system
12 provides, if they are properly insured. And the
13 notion is that it's made so much more difficult by
14 the cumbersome part of our health insurance system
15 that makes preauthorization and so forth so much more
16 difficult for them to get access to that care.

17 And the point being that if you allow
18 them to get the care without all of those hoops, you
19 would basically be making sure that you would be
20 treating them on par, as you would if they had any
21 other physical illness. And frankly, I think that
22 you are giving people a lot of credit if you think
23 that they are voluntarily just wanting to go in and
24 be mental health patients. Frankly, I don't know a
25 lot of people who voluntarily want to go get mental

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1 health treatment to begin with, let alone have to put
2 themselves through all the heartache of having to go
3 get reimbursement for mental health treatment.

4 You should consider that before you put
5 them through all the obstacles of having to fight for
6 reimbursement. I mean we already have the studies
7 that show that people who have good coverage for
8 mental health treatment don't get treatment because
9 of the stigma that's out there, so the notion that
10 you have to erect barriers in order to save money to
11 keep people from getting treatment is just a canard.

12 I mean you should, stigma is keeping people from
13 accessing treatment as it is, so I don't know why, we
14 should be encouraging people to get treatment, if you
15 want to reduce those costs that you just pointed out
16 are leading to chronic illness increases as a result
17 of the comorbidity costs that you identified.

18 MS. ROBINSON-BEALE: Well, again,
19 Congressman Kennedy, you are absolutely correct and
20 let me address it in two ways. First of all, in
21 terms of looking at, as I mentioned before, we look
22 actively in the medical sector for patients who show
23 signs and symptoms of behavioral comorbidity. Our
24 case managers talk to those individuals and find many
25 times that they are very uncomfortable about

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1 accepting a behavioral health referral. Whether it's
2 stigma or whether it's their own feelings about it,
3 what we do is we then work with them and their
4 primary care physicians around making sure that we,
5 a) help their primary care physician in their care of
6 that patient, but also continue to work with them
7 around helping them to better accept a referral to
8 behavioral health providers.

9 Let me also address the other issue that
10 you raised around barriers to care. United
11 Behavioral Health dropped its preauthorization
12 requirement for outpatient care in 2005 and that's no
13 longer a requirement as it relates to outpatient care
14 for behavioral health.

15 REP. RAMSTAD: Before we get to the
16 public testimony, I just want to mention a couple
17 things. First of all, Mr. Noonan, thank you for
18 putting a public face on the disease of addiction and
19 for demonstrating how addiction is truly a family
20 disease. One of our mentors, our chief advisors, is
21 Navy Captain Doctor Ronald Smith of the Bethesda
22 Naval Medical Center, both a Ph.D. psychologist and a
23 psychiatrist, former Chairman of the Department of
24 Psychiatry at Bethesda and also head of the chemical
25 dependency treatment program for the Navy.

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1 And Doctor Smith has taught us and showed
2 us through his studies that every time one person is
3 treated in a family, you are really treating at least
4 five others. You are treating, on the average, two
5 children, two other children, a spouse or significant
6 other, parent and a sibling, on the average. So,
7 when you treat one person, you are really treating
8 five people, given the family disease nature of what
9 we are talking about, so thank you for your courage
10 in coming forward and sharing your story.

11 And I want to thank you,
12 Dr. Robinson-Beale, for two things, first of all,
13 thank you for your, on a personal level, for your
14 commitment to Mr. Noonan and his family, your
15 assurance that this type of horror story won't happen
16 again. I have had a great working relationship with
17 United Health which happens to be headquartered in my
18 district and I appreciate your efforts to help us on
19 parity, your commitment here today. We will work
20 together and we will work on those quality issues.

21 Just let me ask you, on a policy level, I
22 heard you say that United Health is committed to
23 parity, that means committed to enacting the Paul
24 Wellstone parity bill?

25 MS. ROBINSON-BEALE: United is committed

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1 to the equalization of behavioral health benefits
2 with medical, yes. We do so with the idea that we
3 love the inclusion of quality and management as part
4 of that but, yes, we do support that.

5 REP. RAMSTAD: Well that's very
6 encouraging also, very, very important to us and
7 thank you for that commitment. We will work together
8 on those quality issues and in crafting this
9 legislation. Thank you very, very much.

10 MS. ROBINSON-BEALE: Thank you.

11 REP. KENNEDY: We would welcome from both
12 you, Jim and so forth how enforcement mechanisms,
13 what proper enforcement mechanisms you think would be
14 best put in place from the national perspective to
15 ensure an equal playing field when this bill gets put
16 in place, that would be very helpful. We are going
17 to apply this to ERISA and it's going to be put
18 across the board, so it would be very helpful to get
19 your perspective on enforcement.

20 MS. ROBINSON-BEALE: We certainly welcome
21 the opportunity and thank you so much.

22 REP. KENNEDY: And you know, on the
23 evidence-based, frankly that applies to everywhere.
24 I mean lets be honest here, there is no evidence-
25 based practicing for heart disease, heart attacks,

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1 asthma, diabetes. We are all over the board in this
2 country, it's not just in mental health. That's
3 another double standard here we have that we are
4 facing for those of us in mental health, they hold us
5 to a whole different standard. We want the evidence-
6 based when it comes to mental health because we have
7 to bend over backwards to prove that we are the ones
8 who have to raise to the standard to show that we are
9 doing it right.

10 Well, frankly, what about everyone else?

11 And they are not doing it evidence-based either and
12 you look at the statistics, basically half of the
13 evidence-based out there Jim can tell you, maybe you
14 can comment on it out there in terms of evidence-
15 based but in terms of practice of medicine out there,
16 it's, maybe you could tell us, I would probably get
17 it better if it came from you.

18 MR. PURCELL: Well when we look at
19 quality of care on the physical side, there is
20 tremendous unevenness in terms of its delivery, I
21 think primarily because we have in adequate
22 technology in the doctor's office at this point and
23 we know, we have talked about the whole technology,
24 emergency, excuse me, electronic medical records and
25 health information exchange. But just in terms of

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1 the basic medicine to be given to somebody with CHF,
2 40 percent don't get advised to do it, so you are
3 absolutely correct, I think it's pervasive in the
4 system and something has to be addressed.

5 MR. REYNOLDS: Congressman Kennedy, I
6 believe you are also referring to a Rand study that
7 was recently published which really took a very
8 substantial sample size, looking nationwide, to see
9 whether or not individuals were receiving appropriate
10 evidence-based medicine for the treatment of a
11 specific list of medical conditions and the Rand
12 study identified that only 54 percent of the people
13 nationwide were actually receiving evidence-based
14 medical care.

15 REP. KENNEDY: That's right and some of
16 those conditions were, they tried to cover general
17 medical conditions.

18 MR. REYNOLDS: General medical conditions
19 was the primary focus of this, that's right. I don't
20 believe any of the--

21 REP. KENNEDY: So diabetes, cancer,
22 asthma, whether you go beta blockers after a heart
23 attack, you know, general stuff. We are not talking
24 behavioral health here, we are talking things that
25 people accept, that are well known, that we should

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1 know better and we are not practicing evidence-based
2 medicine, so this doesn't just apply to behavioral.
3 So we should be applying this overall, so we should
4 just be holding a different standard on mental
5 health, but we do, I just want to point that out.

6 Anyway, I thank all of you for your
7 testimony, now we go to public testimony.

8 (Applause)

9 PUBLIC TESTIMONY

10 REP. KENNEDY: I would like Melinda
11 Lemos-Jackson, Neil Corkery, Joanne Pezzullo, Rick
12 Harris and Rich Goldberg to start out.

13 Melinda, I know you have to leave
14 shortly, so I would like to start with you and, while
15 everyone else is taking their seats, maybe, Melinda,
16 you can go ahead and start us off.

17 MS. LEMOS-JACKSON: Thank you. Thank
18 you, Congressmen, for this opportunity, good morning.

19 REP. KENNEDY: Good morning.

20 MS. LEMOS-JACKSON: My name is Melinda
21 Lemos-Jackson and I am here today to share a brief
22 glimpse into the life of a family living with a child
23 with mental behavioral health needs.

24 Our son Daniel was diagnosed with PDDNOS,
25 a type of autism, when he was three years old. After

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1 9/11, he was diagnosed with a generalized anxiety
2 disorder. When he was first diagnosed in 1998, we
3 were advised to not spend time wondering why our son
4 had autism but to get him the services he needs. We
5 came to realize that health insurance was really for
6 medical health and our son's needs are predominantly
7 mental behavioral health.

8 Over the years, we learned getting him
9 the services we need costs a fortune. Our health
10 insurance, United Health Care, then a private
11 commercial payer, back to United Health Care, dances
12 around his needs with various barriers. There is the
13 issue of covered services and out of network coverage
14 and the caveat regarding therapy for chronic
15 conditions. There is the network of therapists and
16 clinicians which frequently list closed practices
17 and/or therapists and clinicians with little if any
18 true expertise in my son's disability, I may add a
19 disability that now effects 1 in 166 children born
20 today in America.

21 Would you go to an internist for a heart
22 condition or would you go to a cardiologist? I have
23 placed the calls to the clinicians who, upon
24 interview, don't meet my son's needs, I have tried
25 some of the in-network clinicians who clearly are not

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1 suitable. I've sometimes spoken to the highly
2 regarded folks who are actually on the list, only to
3 find out that their practices are closed or they
4 can't take a son, a child like my son at this time,
5 so we get the services our son needs and we learn to
6 bring our checkbook and our Visa. Our health
7 insurance is not accepted.

8 In the past year, we have incurred debt
9 and expenses of over \$10,000 for our son, that's cash
10 out of pocket, that does not include what we have
11 paid for our premiums, that does not include the care
12 we have to provide to our other two children. These
13 services have been provided by certified,
14 credentialed professionals, speech therapists,
15 occupational therapists, psychologists and
16 psychiatrists. All of these therapies and
17 evaluations he has received are well regarded,
18 established, they are benchmarked, there is research
19 to support the services my son is receiving.

20 Biofeedback, which costs more than
21 \$1,000, has been the only intervention to date that
22 has reduced Daniel's phobia about loud sounds,
23 thunder, fireworks, any loud sound. This is a phobia
24 that prevents him from living a full life and will
25 certainly impede him from living an adult,

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1 independent life. This past December we were
2 surprised by a small fireworks display over Wickfrey
3 Village while Christmas shopping. When I realized I
4 heard fireworks, I panicked. I had Daniel's custom
5 ear molds in my purse and my husband had the three
6 kids. I ran through the dark towards my son yelling
7 stop, mommy is coming, I'm going to take care of you.

8 When I crossed the street and reached
9 him, I realized he and my daughter were excited and
10 happy. My son looked at me and said, mommy, it's a
11 miracle, I saw beautiful fireworks and I wasn't
12 afraid. It was amazing. I might even be ready for
13 the 4th of July. So there is the reason why we need
14 mental behavioral health parity in our health
15 coverage because miracles can happen, yet we continue
16 to allow so many children and their families to
17 suffer. For every child facing a mental illness or
18 presenting with behavioral health needs, there is a
19 family who suffers too, siblings bear the burden,
20 marriages crack under the stress, some data indicate
21 four to five marriages of children with special
22 health care needs ends in divorce.

23 Parity for mental behavioral health in
24 commercial health insurance plans will open the flood
25 gates, not the flood gates of uncontrolled costs but

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1 the flood gates for miracles, for hope and for
2 possibility.

3 Thank you, Congressmen.

4 REP. KENNEDY: Beautiful, beautiful.

5 (Applause)

6 REP. KENNEDY: Beautiful, Melinda. I
7 mean I would love to see, at some point, we need to
8 have, like I said, this enforcement procedure so that
9 if you buy the insurance, you get what you have had
10 insured because it doesn't make any sense not to get
11 the insurance that you paid for and, in this case,
12 it's just outrageous what's happened to you, but it's
13 happened to too many people and you should have some
14 right of redress for your situation.

15 Also, for those who are watching on the
16 interconnect, for my sake as a representative for you
17 in Washington, these stories have a very powerful
18 effect and I often take my time reading these stories
19 on the House floor and speaking about them in
20 committee. So, to the extent that people are
21 comfortable sharing their personal stories, it makes
22 a big difference because nothing is as powerful as
23 telling of someone's own experience to illustrate the
24 point of why we need to make these policy changes, so
25 thank you very much.

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1 MS. LEMOS-JACKSON: Thank you,
2 Congressman.

3 REP. KENNEDY: Joanne?

4 MS. PEZZULLO: My husband works in the
5 trucking industry and often those companies are
6 self-insured and they are exempt from parity. Our
7 mental health benefits have a \$100 deductible and a
8 50 percent copay. We have to attain preauthorization
9 a day before inpatient services and that's still 50
10 percent copay. Outpatient, we have a 50 percent
11 copay after the \$100 deductible and we are limited to
12 ten visits per calendar year and 60 visits per
13 lifetime, and that's combined with inpatient and
14 substance abuse. We have very little coverage and
15 it's certainly not affordable. I would hope that
16 parity would include self-insured companies. Thank
17 you.

18 REP. KENNEDY: Thank you, that's a
19 perfect point.

20 (Applause)

21 REP. KENNEDY: As you know, the majority
22 of people in the state are not covered because of the
23 self-insured, the ERISA exempt plans and that is why
24 the federal legislation is so vital and that is why
25 we are so excited about passing the federal

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1 legislation. So thank you for your testimony, it
2 points specifically as to the reason why we need to
3 pass federal legislation that will effect the
4 previously preempted ERISA self-insured plans.

5 Thank you.

6 Neil Corkery? Thank you, Neil, for
7 coming.

8 MR. CORKERY: Thank you, Congressman
9 Kennedy and also other members of the committee and
10 welcome to the state, Representative Ramstad.
11 Congressman Kennedy and I are good friends but also
12 former colleagues in the Rhode Island General
13 Assembly. And I was going to point out all of the
14 wonderful accomplishments we had in the general
15 assembly from utilization review legislation,
16 mandated benefits for substance abuse, both alcohol
17 and other drug disorders, the Zania legislation named
18 after your staff person who has done a great job,
19 Right Care and parity with former Lieutenant Governor
20 Fogarty.

21 But after listening to the testimony of a
22 lot of the consumers, even we are lacking in success
23 here when you look at the outcomes and so I think
24 less sanguine than some of the other speakers but
25 also sound a little bit like the skunk at the lawn

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1 party that Mr. Purcell talked about, especially when
2 I heard terms about breaking the bank. I don't know
3 if we would use that terminology with any other types
4 of insurance or human service initiatives, so it's a
5 little concerning for me, and I also, by the way, I'm
6 the Executive Director of the Drug and Alcohol
7 Treatment Association of Rhode Island, and unlike
8 Representative Costantino, I don't have to worry
9 about some of the constituencies you do.

10 You have to listen to the insurers, the
11 consumers, the payers and all that. I understand
12 that, I know it's exasperating to get legislation
13 passed, especially legislation of this magnitude, so
14 I give you great credit for holding this hearing
15 today, also proposing the legislation with
16 Representative Ramstad and also the series of
17 hearings you have across the country, and I'm also
18 glad to see that it now includes addiction equity, I
19 was a little concerned. That was one of my concerns
20 when I talked to you earlier and I understand it's
21 under the umbrella of mental health.

22 But I think, if I go back to my own, I'm
23 also a consumer, so I guess I can talk to that issue
24 as well. A little over 32 years ago, it seems like
25 an eternity but it's not, because I was a public

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1 employee, because I had classic Blue Cross, I was
2 able to go to a psychiatrist at the suggestion of my
3 wife, who thought that would be a good idea.

4 (Laughter)

5 MR. CORKERY: And it's probably the best
6 thing I ever did. He was a gentle, kind guy who just
7 listened to me and I was able to break through what a
8 lot of the people here are going to have to deal
9 with, the veil of denial and I guess the stigma and
10 the shame that goes with this illness, and it's still
11 prevalent, and I got help. There was no talk about
12 preauthorization, medical necessity. Why would you
13 go to a psychiatrist, anybody seek out a psychiatrist
14 to talk about his sham if there wasn't a need? I
15 mean I just don't understand that. And then there
16 was no talk of after care problems or length of stay.

17 So, at any rate, I'm looking back now on
18 those days and I'm wondering whether we have made any
19 progress at all. When I hear the stories from
20 Mr. Noonan, I mean it's bad enough for his daughter,
21 but he is an adult who is going through a crisis, but
22 he was able to do it. Can you imagine the person in
23 addiction, and some of you can, who has to deal with
24 this and you are going to appeal to some entity?
25 There has got to be some issue dealing with

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1 utilization review in this legislation, I really
2 think you need to look hard at this issue.

3 I know you are going to have to deal with
4 insurers and, despite some of the promises made here
5 today, I think that this is a big impediment to
6 people receiving treatment, especially given the type
7 of shame associated with it. The only thing I can
8 say in defense of going into treatment now is that
9 this will save someone's life. It saved my life, it
10 turned my whole future around, it brought me back my
11 family, it really rescued them and it's made me a
12 productive citizen, I hope. That should be everyone
13 in this room's opportunity, it shouldn't be based on
14 what kind of insurance they have, what their economic
15 status is.

16 It's almost like they should have your
17 Congressional insurance, that would be wonderful, it
18 we could have it.

19 (Laughter)

20 MR. CORKERY: But I really think that
21 everyone, every American is entitled to this, every
22 American has the right and I think we have the
23 obligation to provide the incentives through the
24 legislation that you are proposing, and hopefully you
25 will look at some of the suggestions from our

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1 national organization, SAAS, the State Association of
2 Addiction Services, and Howard Shapiro and others,
3 and certainly I want to thank you.

4 I want to thank Elizabeth Earles from the
5 Rhode Island Council on Behavioral Health
6 Organizations for sponsoring this, we well as Steve
7 DeTroy from the Medical Society. I think we all owe
8 you a debt of gratitude and I'm very happy to be
9 here.

10 Thank you.

11 REP. KENNEDY: Well, Neil, I just want to
12 thank you.

13 (Applause)

14 REP. RAMSTAD: You've been in the
15 trenches with us from day one and thank you for all
16 of your work and your leadership, we appreciate it
17 very much.

18 REP. KENNEDY: And, Neil, the legislation
19 is codifying the FEHBP, which is the Federal
20 Employees Health Benefit Plan, which has a very
21 generous parity benefit, it was defined under the
22 regulations, under President Clinton, and we are
23 going to keep it as defined, as per those regulations
24 back then, and it includes drug and alcohol coverage.
25 And we have already gotten some very positive

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1 acceptance by the major insurers in the talks that we
2 have had so far because, as you have heard from the
3 insurers so far today, they have done the numbers and
4 they've recognized, on the bigger picture, that in
5 paying for chronic illness in this country, they
6 can't afford not to pay for it because it's so
7 intertwined with all the other health care costs that
8 they are paying for that to not pay for it, as Jim
9 Purcell said so eloquently, would be negligent on
10 their part and financially ruinous to them because it
11 ends up coming out in different ways.

12 MR. CORKERY: Can I say one last thing?
13 I think it's incumbent upon us, we have not done a
14 good job of selling this, of education the public and
15 policy makers. So, you know, I'm not whining here,
16 I'm saying this is the things that I think you need
17 to do, that we need to do, and we certainly will help
18 you with that. Thank you very much.

19 REP. KENNEDY: Thank you. And I think,
20 Neil, also it's interesting because we want to adopt
21 the evidence-based and what's most efficacious in
22 terms of treatment because the insurance industry has
23 been paying for often what's most expensive but not
24 as effective. Community-based support models, family
25 interventions are, number one, most effective in

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1 terms of community-based interventions treatment for
2 drug and alcohol abuse and yes we still pay for 30
3 day treatment, in-house patient and that doesn't do
4 it, that's not effective treatment by many models of
5 care.

6 With families it he most effective base,
7 at people's, where they live, in their own life, in
8 their own reality, in their own community, in their
9 own home, not off someplace else where some day
10 they'll have to come back. So we are so built on
11 this arbitrary number of days set by an insurance
12 reimbursement system that is antiquated based upon
13 only what they'll reimburse for, so we are dealing
14 with numbers that were established by reimbursement
15 numbers, not by evidence-based.

16 So, ironically, the insurance system is
17 driving the science which it shouldn't be doing, the
18 science should be driving the insurance and, in that
19 case, we could probably be getting a lot more for our
20 dollars than we are currently getting, ironically.

21 We'll just conclude now with Rick Harris
22 and Rich Goldberg.

23 MR. HARRIS: My name is Rick Harris, I'm
24 the Executive Director of the National Association of
25 Social Workers of Rhode Island. That's not how I'm

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1 representing today, I'm representing myself as a
2 family member.

3 I have two short stories and good and
4 short because it's near the end here, one tragic, one
5 happy ending. I had a brother once, so very much
6 alive in my heart but not alive in the world, and he
7 went to, I grew up in Iowa, just an average citizen
8 from there and my brother went to the University of
9 Northern Iowa, went through three years with straight
10 As. He quit his final year, something that none of
11 us really understood what was going on.

12 Continued his life as a drifter, a
13 homeless person and occasionally playing guitar, a
14 bottleneck guitar with some very famous country
15 western bands, he was an excellent musician. He died
16 in 1981 and someone I miss very much, he was the best
17 friend I ever had. And there is not a day I don't
18 think of him, and he died because he was never able
19 to put his life together and now it's ironic that, in
20 1980, I started my long profession in the mental
21 health profession and I had come to recognize what
22 the symptoms were and they were definitely major
23 depression, recurrent, and he just wasn't able to put
24 his hands around that and survive.

25 And that was the unfortunate result of

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1 his short life, someone who was much smarter than I
2 was and a heck of a lot better musician than I am and
3 could have done a lot more than he was allowed to
4 because it just wasn't recognized at the time, mental
5 health, and I do think that story is repeated many
6 times now, even now, even though we talk about mental
7 health, it's become more prevalent, services are more
8 available. I believe that story is repeated every
9 day of our lives and we don't hear about them, you
10 just don't hear about them unless someone like myself
11 comes forward and says something about it.

12 The other story, a very close family
13 member, I can't get into much detail, was a tradesman
14 for over 50 years and, near the end of that time, his
15 marriage partner came to me and said that, you know,
16 ever since we've been married, and they had been
17 married a long time, he spends days that he doesn't
18 get out of bed. He pulls the shades down in his room
19 and he won't eat for days on end, he misses work, he
20 loses jobs and he gets jobs again because he is in a
21 very high demand trade, and he won't, he refuses to
22 go to mental health and receive help, mental health,
23 he says that is not, I can't do that.

24 There was a very high stigma from his
25 point, as well as I believe in our society and I

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1 think this is what the story portrays is the stigma
2 prevents people from getting the services they need.

3 I did something very unsocial work-like, I did
4 something like a family member does, I called up the
5 physician and I said you need to present this. I'll
6 use the word Bruce, I'll call him Bruce, that's not
7 his real name. You need to present this to Bruce,
8 that this is just like the heart medication he takes,
9 give him some antidepressant and see what happens.

10 That was 30 years ago or 20 years ago, he
11 is now 80 years old. He hasn't had one of those days
12 again in his life and it's sad that he went through
13 50 years of employment like that for all those years
14 of not getting the help because of stigma, and his
15 own stigma and what he had been brought up as. So
16 those are two of my family stories. I think that
17 it's a misconception and a dangerousness not to
18 recognize the connections that people have to
19 addictions and to mental health in this world.
20 Everybody here, everybody here will have a
21 connection, that's one of the reasons we are here.

22 But I guarantee you, if you go down to
23 the Providence Place Mall right now, it's right down
24 there, Senator, if you go down to that Providence
25 Place Mall right now, you can pick 100 people out and

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1 that 100 people will have a friend or a family member
2 connection that's been harmed by addictions or by
3 untreated mental health. And I guess that's the
4 story I wanted to bring to you and I thank you very
5 much for allowing me to be part of this.

6 (Applause)

7 MR. GOLDBERG: Hi. I'm Dr. Richard
8 Goldberg and I'm the Psychiatrist in Chief at two of
9 the general hospitals here in Rhode Island, Rhode
10 Island Hospital and the Merriam Hospital and I'm a
11 Professor of Psychiatry at Brown. I want to start by
12 thanking Representative Kennedy for all you've done
13 for the State of Rhode Island and for the leadership
14 that both you and Congressman Ramstad are providing
15 in this area. Of course I strongly support this
16 campaign and the comments we've heard today. I'm
17 going to be brief, I know I'm the last person here,
18 everyone is ready for lunch.

19 A few comments at the margins. Our
20 program provides psychiatric consultation in the
21 correctional system. We have a child psychiatrist
22 consulting in the training school to adolescents and
23 a number of psychiatrists consulting in the adult
24 correctional institute. Whenever you drive by Route
25 95 and you see that, most people in Rhode Island

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1 don't think of that as a mental hospital with 1,400
2 people in it. Out of the 3,500 inmates, 90 percent
3 have substance abuse problems, half have mental
4 health problems. Some people leave there.

5 What I would like to see, and I don't
6 know if it's too late, legislation or someone to
7 consider, after people get out of the prison, a way
8 to incentivise the integration of probational
9 vocational substance abuse and mental health
10 treatment in the community, some kind of integrated
11 community capability that brings those things
12 together or are somehow forced together by the
13 legislation because otherwise centrifugal forces will
14 take them apart. The other comment is on the so-
15 called hidden mental health system. As big a problem
16 as mental health disorders are in the mental health
17 sector, there's even more mental health problems, the
18 so called hidden mental health system in general
19 medicine and really little attention is being paid to
20 that.

21 A brief story. I was called to see a
22 case in the emergency room at Rhode Island Hospital,
23 a guy in his mid 40s, he was about to get his sixth
24 admission to the coronary care unit in the last year.
25 They called me out of frustration because he seemed,

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1 nobody could figure out why was this guy using so
2 much space in the coronary care unit. Within three
3 minutes of interviewing him, he says to me every time
4 I fight with my wife I get chest pain. So, for the
5 last year, no one had really addressed this basic
6 issue, the guy is fighting with his wife, he gets
7 chest pain and ends up in the CCU. You figure it
8 out, do the math, what that costs.

9 So I would like to see somehow that the
10 benefits are structured in a way to incentivise more
11 the coordination of care with the general medical and
12 the mental health system and certainly if the first
13 battle we have to win is parity in the mental health
14 sector, let's win that battle, but there is another
15 huge battle that may be related where the benefits
16 allow some kind of coordination, communication or
17 integrated care for patients like the story I just
18 mentioned.

19 So, in the interest of time, I'll stop
20 there and thank you very much for the opportunity to
21 address you.

22 (Applause)

23 REP. KENNEDY: Thank you very much, I
24 appreciate that. I certainly again would like to
25 welcome all of you to offer your testimony and

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1 stories and encourage you to continue to participate
2 as this continues for us.

3 I would like to again thank Michael
4 Zaymore from my office and we are going to have right
5 now an opportunity to answer some of the press
6 questions.

7 MS. LUNT: My name is Lisa Lunt and I'm a
8 Rhode Islander and resident of the City of
9 Providence. I would like to thank you, Congressman
10 Kennedy and Congressman Ramstad, for holding these
11 hearings and giving attention to these issues.
12 Having navigated mental health systems as a patient,
13 parent and professional, I understand first hand the
14 importance of what you are doing. I am here to talk
15 about my ten year old son and our experience
16 accessing mental health services, I also have
17 experience as a social worker and advocate with local
18 agencies working with mental health issues as they
19 relate to education, poverty and parenting.

20 These life experiences have given me some
21 perspective on social service systems and how they
22 are working for every day Rhode Islanders living with
23 mental health issues. My son, like 1 in 166 other
24 Americans, has an autism spectrum disorder, he has
25 struggled with developmental problems since he was a

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1 toddler. While I am deeply grateful for the many
2 people and institutions that have helped us, I am
3 painfully aware of the need for increased access and
4 capacity in Rhode Island.

5 This also makes financial sense, as
6 studies have shown that the cost of lifelong care of
7 autism can be reduced by two thirds with early
8 diagnosis and intervention. Right now my son stands
9 at a crossroads, as we speak, he is inpatient at
10 Bradley Hospital. I feel that the best place for my
11 son to be cared for is at home with proper treatment
12 staffing, it is better for him, better for me, better
13 for the community and it is less costly for the state
14 than institutional care. However, it has been a
15 full-time job for me to secure and maintain these
16 services.

17 Currently, Rhode Island families wait one
18 to three years to even begin home-based treatment
19 services, we waited for over a year. Now we face the
20 challenge of adequately staffing his treatment plan.

21 If we cannot recruit enough qualified personnel
22 within the next two weeks, we will be forced to place
23 my son in residential treatment. It would take me
24 hours to recount all of the steps and stages of our
25 health care odyssey.

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1 As there is not time for this now, just
2 let me say this, for years I have had to improvise
3 and work very hard to access treatment for my son,
4 and yet there are still gaps in the services. I have
5 had to be very persistent, creative, determined and
6 at times aggressive, it should not be so difficult,
7 yet I consider myself to have two advantages. Number
8 one, I know that the right care at the right time
9 will make a huge difference in his life so I am
10 motivated to fight to get it for him. Number two, I
11 have learned to navigate multiple systems of care in
12 order to get the help he needs, but it is far from
13 easy and fighting to gain services while raising a
14 child with multiple disabilities and living with
15 limited financial resources takes its toll.

16 Not every family knows what a difference
17 good mental health care and early intervention can
18 make and even fewer people know how to go about
19 getting it. My point is that people can't be
20 expected to know these things and they shouldn't have
21 to, that is why I offer the little I can give back to
22 help other Rhode Island families. Helping those with
23 mental illnesses and developmental disabilities
24 access the care they need can change their lives and
25 enrich our society.

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1 Our small state has been a national
2 leader when it comes to mental health parity law and
3 grassroots agencies devoted to assisting families
4 with these issues, but I also know from personal
5 experience that we need increased funding and
6 capacity to go along with these laws. Ideally, we
7 need good federal laws that apply to Rhode Island and
8 the whole country.

9 Again, I thank you, Congressman Kennedy
10 and Congressman Ramstad, for giving attention to
11 these very important issues.

12 REP. RAMSTAD: Thank you very much for
13 coming forward.

14 (Applause)

15 REP. RAMSTAD: I just want to mention
16 another piece of legislation that Patrick and I are
17 working on that now has a chance of passage in the
18 Congress and that is the Keeping Families Together
19 Act. I don't know if you are familiar with it,
20 Patrick and I will reintroduce the bill next week,
21 along with Pete Stark and many other cosponsors.
22 This legislation, simply stated, provides grants to
23 support families like yours caring for children with
24 mental illness and so we are working on this in a
25 comprehensive way and, again, we appreciate your

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1 courage in coming forward. It's people like you who
2 are going to reduce the stigma out there and that's
3 so important, so thank you very much.

4 MS. LUNT: Thank you.

5 REP. KENNEDY: Denise Penichous?

6 MS. PENICHOUS: Good morning. My name is
7 Denise Penichous and I am the Director at the
8 Samaritans of Rhode Island and Congressman Kennedy
9 knows the Samaritans. We are the state's only
10 nonprofit organization exclusively dedicated to
11 suicide prevention and we do that through volunteers
12 with a program that began actually in England in the
13 1950s. I would like to, my brief remarks will segway
14 from your comments about stigma. I have a
15 relationship with many people in this room who we
16 collaborate with to make sure that that issue of
17 stigma is broken. The Samaritans has been around, we
18 are now celebrating our 30th anniversary, it is a
19 volunteer-based organization.

20 Volunteers can make a difference in
21 everything that you are talking about because while
22 we have hearings, and while we have lunches and while
23 we discuss, the issues still go on. We at the
24 Samaritans are there when all of the agencies who are
25 closed at 5:00 aren't there to take the calls and, as

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1 it relates to best practices, Congressman, it is
2 interesting to me that we continuously get challenged
3 about whether we are saving lives and I often say
4 that that question should be asked of the
5 professionals and not of the volunteers. The
6 interesting part is that the phones never stop
7 ringing.

8 The World Health Organization says one of
9 the biggest risk factors for suicide is the lack of
10 connectedness and the Samaritans are there for people
11 who are in care, out of care and when care is never
12 going to be an option, and there are so many people
13 for whom care will never be an option. There are
14 three things that I have learned about the suicidal,
15 they are hopeless, they believe that no one cares if
16 they live or die and that eventually they will be
17 doing all of us a favor if they died by suicide.

18 And the myriad issues that people call
19 our hot line about, from financial, to substance
20 abuse, to marriage issues, to child issues, go on and
21 on. The amount of care givers that call us go on and
22 on. Most people who call our hotline are in care
23 which means that the kind of professional care that
24 we are discussing today is not the only thing that
25 people find useful. What I am proud of, Congressman

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1 Kennedy, is that the message that you are delivering
2 today is that you do care and that you, Senator or
3 Congressman, are also telling people in your district
4 that you care. That is the single biggest first step
5 to suicide prevention.

6 I would also like to mention that our Web
7 site which we launched three years ago, I had no idea
8 what the impact would be. In the first year, and it
9 was a calendar year, we had 6,800 visitors to the Web
10 site. The second year, 2005, we had 9,800 visitors
11 to the Web site. This year, the end of 2006, we had
12 over 14,000 visitors to the Web site and we do this
13 without any third party reimbursements, we are not
14 eligible for anything but philanthropic support. I
15 cannot thank you enough for doing everything you can
16 to break the stigma and raising awareness about
17 suicide prevention.

18 Thank you.

19 (Applause)

20 REP. KENNEDY: Thank you very much,
21 Denise. I'll just say you talked about philanthropic
22 support, when you think about how many people are
23 effected by mental illness, obviously the numbers are
24 overwhelming. It is just amazing that we don't have
25 more money going into research of the brain because

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1 so many people are suffering out there that needn't
2 suffer, if we understood more the genomics, the brain
3 and the neurocircuitry of the brain. We are finding
4 out incredible advances right now in treatment of
5 depression, in the linkages between genes and the
6 ability for us to determine, ahead of time, people's
7 predisposition to certain types of mental illnesses.

8 It really offers us such opportunities
9 and it also should destigmatize the illness even
10 further, and yet the dollars aren't there because the
11 stigma is still such a barrier. And it is just so,
12 it is so disheartening when you think that people
13 think nothing of putting up money for endow a chair
14 for x or y disease, and yet it's so difficult to
15 raise money in the area of mental health, and yet it
16 impacts every family. And the difference that the
17 dollars that we could invest in mental health could
18 do in terms of pursuing happiness and better quality
19 of life in this country are enormous, and I am just
20 so surprised, with this country being so consumer
21 oriented, that we don't have a better sense that this
22 is something we should make a greater priority of, so
23 thank you both for being here.

24 So we have now some questions from the
25 press? I want to also thank, while the press come

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1 up, in addition to thanking Mike Zaymore from my
2 staff for all of his help in putting this together, I
3 want to thank Andrew McKechnie from Jim Ramstad's
4 staff for all of his help in putting this together.
5 And we are going to be going to Jim's district next
6 week to hold hearings out there and then, from there,
7 we'll be going on to several other cities including
8 going to Washington State, California, Chicago,
9 Illinois, Maryland and many other states that we are
10 in the process of scheduling right now.

11 (Whereupon, at 12:16 p.m., the hearing
12 was adjourned.)

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