MINUTES OF THE MEETING

OF THE

SUBCOMMITTEE OF THE LEGISLATIVE COMMITTEE ON HEALTH CARE

TO ADDRESS INSURANCE ISSUES REGARDING MENTAL HEALTH

(*Nevada Revised Statutes* 439B.200)

August 17, 1998

Carson City, Nevada

The first meeting of the Subcommittee of the Legislative Committee on Health Care to Address Insurance Issues Regarding Mental Health was held on Monday, August 17, 1998, at 9:30 a.m., in Room 4100 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. This meeting was video conferenced to Room 4412 of the Grant Sawyer Building, 555 East Washington Avenue, Las Vegas, Nevada. Pages 2 and 3 contain the "Meeting Notice and Agenda."

SUBCOMMITTEE MEMBER PRESENT IN CARSON CITY:

Assemblywoman Vivian L. Freeman, Chairman

COMMITTEE MEMBERS ABSENT:

Senator Bernice Mathews

LEGISLATIVE COUNSEL BUREAU STAFF PRESENT:

Juliann K. Jenson, Senior Research Analyst

Marla McDade Williams, Senior Research Analyst

Risa L. Lang, Principal Deputy Legislative Counsel

Roxanne Duer, Senior Research Secretary

MEETING NOTICE AND AGENDA

Name of Organization: Subcommittee of the Legislative Committee on Health Care (*Nevada Revised Statutes* 439B.200) to Address Insurance Issues Regarding Mental Health

Date and Time of Meeting: Monday, August 17, 1998

9:30 a.m.

Place of Meeting: Legislative Building

Room 4100

401 South Carson Street

Carson City, Nevada

Note: Some members of the subcommittee may be attending the meeting, and other persons may observe the meeting and provide testimony, through a simultaneous video conference conducted at the following location:

Grant Sawyer State Office Building

Room 4412

555 East Washington Avenue

Las Vegas, Nevada

A G E N D A

I. Opening Remarks by the Chairman

Assemblywoman Vivian L. Freeman

II. Presentation Regarding the Need for Mental Health Benefits in Insurance Policies

Rosetta Johnson, President, Alliance for the Mentally Ill of Nevada

III. Remarks Concerning the Status of Mental Health Benefits in Nevada

Sharen Weaver, Manager, Health Insurance Portability and Accountability Office, Division of Insurance, Department of Business and Industry

IV. Discussion of Impact of Mandated Mental Health Benefits on Health Insurance Policies and Providers in Nevada

A. Marie Soldo, Executive Vice President, Government Affairs, Sierra Health Services, Inc.

B. Jeannette K. Belz, President and Chief Executive Officer, Nevada Association of Hospitals and Health Systems

V. Public Testimony

VI. Adjournment

Note: We are pleased to make reasonable accommodations for members of the public who are disabled and wish to attend the meeting. If special arrangements for the meeting are necessary, please notify the Research Division of the Legislative Counsel Bureau, in writing, at the Legislative Building, 401 South Carson Street, Carson City, Nevada 89701-4747, or call Jo Greenslate or Roxanne Duer, at 684-6825, as soon as possible.

Notice of this meeting was posted in the following Carson City, Nevada, locations: Blasdel Building, 209 East Musser Street; Capitol Press Corps, Basement, Capitol Building; Carson City Courthouse, 198 North Carson Street; Legislative Building, Room 1214, 401 South Carson Street; and Nevada State Library, 100 Stewart Street. Notice of this meeting was faxed for posting to the following Las Vegas, Nevada, locations: Clark County Office, 500 South Grand Central Parkway, and Grant Sawyer State Office Building, 555 East Washington Avenue.

OPENING REMARKS BY THE CHAIRMAN

Chairman Freeman welcomed those individuals attending the subcommittee meeting and commented that mental health

parity is an issue that has not been extensively addressed by the Nevada Legislature. Mrs. Freeman referred to a handout (please refer to Exhibit A) from Ms. Rosetta Johnson, President of the Alliance for the Mentally Ill of Nevada (AMI Nevada), and summarized the legislation that has been enacted in 11 states, and the fact that some level of insurance coverage is now required for the following mental illnesses:

- Anorexia and bulimia;
- Bipolar affective disorders (also known as manic-depression);
- Major depressive disorders;
- Obsessive-compulsive disorders;
- Panic disorders;
- Paranoia and other psychotic disorders;
- Pervasive development disorder or autism;
- Schizoaffective disorders; and
- Schizophrenia.

It was also noted that:

- Coverage for these mental illness disorders is considered no less extensive than coverage provided for other physical illnesses;
- Some states include coverage for alcohol and substance abuse;
- In the state of Maine, organizations with 20 or fewer employees are exempt from the provisions of the law, while Texas exempts businesses with fewer than 50 employees and sets annual limits of 45 days for inpatient treatment and 60 outpatient visits;
- Some measures only apply to group plans and health maintenance organizations (HMOs) without regard to plan size; and
- A number of states apply the same dollar limits, deductibles, coinsurance factors, and restrictions as those applied to other covered illnesses.

PRESENTATION REGARDING THE NEED FOR MENTAL HEALTH BENEFITS IN INSURANCE POLICIES

Rosetta Johnson

Ms. Johnson, identified on page 3, stated that AMI Nevada represents approximately 50,000 people with brain disease and is Nevada's only grassroots organization solely dedicated to assisting individuals with severe mental illnesses. It was noted that AMI Nevada also offers: family support; advocacy for nondiscriminatory and equitable federal, state, and private sector policies; research for the causes, symptoms, and treatment for brain disorders; and public education to eliminate the stigma surrounding severe mental illness. During her testimony (please refer to Exhibit B), Ms. Johnson asked that the committee consider the following issues:

- Eliminate discrimination toward people with mental illness; and
- Introduce insurance parity legislation for mental illness, thus reducing the expense borne by the taxpayer and eliminating the need for individuals with biologically-based brain disorders to access available public services in

order to acquire medical coverage.

Discussion ensued, which addressed the following points:

1. It is generally recognized that mental illness is treatable, and yet insurance coverage is limited with copayments often set at 50 percent rather than the standard 80 percent. In addition, there are imposed limits for doctor's visits and hospital stays that are different from the coverage provided for other serious physical illnesses (i.e., cancer, diabetes, heart disease).

2. Health insurers often discriminate against individuals with serious mental illnesses by prematurely capping their insurance coverage.

3. Children's mental health should be included in insurance parity legislation since mental illness is difficult to diagnose at an early age and may not be apparent until a child reaches adolescence.

4. Employers are under the impression that insurance rates will escalate if insurance parity is implemented; however, the dollar amounts being provided are based on figures from the 1980s when "talk therapy" was in vogue, and prior to the introduction of the new and effective medications now in use.

5. Alcohol and substance abuse is often used to conceal the symptoms of mental illness.

6. There is a high incidence of depression and suicide among the elderly.

In conclusion, Ms. Johnson emphasized the fact that insurance rates have decreased in states where equal insurance coverage has been implemented. She offered to provide the committee with supporting documentation from the 19 states that currently exercise insurance parity reform. Mental illnesses cannot be cured, but long-term, "excellent" results can be realized from effective treatment.

REMARKS CONCERNING THE STATUS OF MENTAL HEALTH BENEFITS IN NEVADA

Sharen Weaver

Ms. Weaver, Manager, Health Insurance Portability and Accountability Office, Division of Insurance, Department of Business and Industry, spoke to the mental health benefits currently offered by employers in Nevada (please refer to Exhibit C).

Responding to Mrs. Freeman's question regarding inpatient and outpatient treatment, Ms. Weaver indicated that the trend seems to be moving away from an inpatient setting. In Chapter 449, "Medical and Other Related Facilities," of *Nevada Revised Statutes* (NRS), various outpatient facilities are defined, all of which provide additional cost savings.

Ms. Weaver explained that the federal Health Insurance Portability and Accountability Act (HIPPA) did not include mental health benefits, and that the Mental Health Parity Act of 1996 (MHPA), which, in Nevada, is implemented through Assembly Bill 521 (Chapter 586, *Statutes of Nevada 1997*), provides mental health benefits. The MHPA applies to group health insurance plans that consist of 51 or more employees, and prohibits employers from imposing annual or lifetime dollar limits that are lower than dollar limits for medical and surgical benefits.

Ms. Weaver stated that MHPA requires parity, but with some exceptions:

- The increased cost exemption must be based on actual claims data, and not on an increase in insurance premiums;

- Provisions of the law must be implemented for at least six months, with the 1 percent cost exemption calculation based on six months of actual claims data with parity in place;
- Once a plan qualifies for the 1 percent cost exemption, it does not have to comply with parity requirements for the life of MHPA provisions, which sunset September 30, 2001;
- Cost sharing measures can be imposed; and
- The coverage for number of visits or days is limited.

General discussion continued regarding exclusionary contract language, specifically: (1) what exclusions would be considered acceptable; (2) what is considered minimum days; (3) benefits for outpatient and inpatient treatment relating to co-insurance; and (4) lifetime maximum benefits.

Commenting further, Ms. Weaver explained that under HIPPA coverage, the Committee on Health Benefit Plans, which was formed under NRS 689C.960, "Creation; members; term; vacancy," was given the task of creating a basic and a standard affordable health benefit plan for participants. The plan was designed primarily for small employers, less than 51 employees (the federal parity for mental health applies to employers with 51 or more employees) and eligible persons. However, the basic plan does not include benefits for mental health, while the standard plan includes an annual maximum of 20 outpatient sessions and 30 inpatient days per calendar year. The lifetime maximum, including all covered benefits, is $1 million for insurers, and no lifetime maximum for HMOs.

Using the following insurance providers as an example, Ms. Weaver provided the committee with two mental health benefit packages:

- Human Behavioral Institute (HBI), Las Vegas, a licensed Prepaid Limited Health Service Organization, offers:

  (1) Outpatient benefits with a minimum of 20 individual visits and 20 group visits;

  (2) Individual visits that may be exchanged for additional group visits;

  (3) A $20 copayment for each visit;

  (4) Inpatient treatment with 30 inpatient days and a $200 per admission deductible;

  (5) Inpatient days that may be traded for partial days, which means treatment from 8 a.m. to 5 p.m. instead of an overnight stay; and

  (6) An Employee Assistance Program.

- St. Mary’s Health First, Reno, Nevada, a licensed HMO, offers:

  (1) Outpatient treatment for 25 visits per calendar year;

  (2) A $25 copayment per visit;

  (3) 21 inpatient days per calendar year with no copayment;

  (4) No lifetime maximum for inpatient or outpatient services; and

  (5) A day treatment program.

Ms. Weaver then focused her comments on the fact that Nevada does not provide for a standard mental health benefit package, and that MHPA does not include chemical dependency and substance abuse as a mental health benefit. Under NRS 689B.036, "Required provision concerning coverage for treatment of abuse of alcohol or drugs," Nevada's drug and alcohol abuse provision requires:

- $1,500 for the treatment of withdrawal related to chemical dependency;
- $2,500 for individual, group, or family counseling;
- $9,000 for treatment when admitted to a facility; and
- That benefits be paid in the same manner as any other illness.

Discussion continued regarding the possible impact to employers, employees, and insurers/HMOs if Nevada were to mandate mental health benefits. It was noted that the smaller employer (50 or less employees) and its employees may incur the greatest increase in premium costs.

Responding to Mrs. Freeman's inquiry regarding the approval of a benefits proposal, Ms. Weaver stated that the HIPPA committee would reconvene to review any new proposal, and that the standard plan would automatically be amended to comply with the new legislation.

In closing, Ms. Weaver then referred to Nevada's mandated insurance benefit laws as they relate to mental health and unfair discrimination.

In response to Mrs. Freeman's question regarding the 15 states that have passed parity legislation and the financial impacts associated with implementing parity mental health benefits, Ms. Weaver stated that she would contact the states to determine how long parity legislation has been in effect and to ascertain the costs incurred.

DISCUSSION OF IMPACT OF MANDATED MENTAL HEALTH BENEFITS ON HEALTH INSURANCE POLICIES AND PROVIDERS IN NEVADA

Sue Hockenson

Ms. Hockenson, Director, Government Affairs, Sierra Health Services, Inc., representing Behavioral Health Care Options, spoke on behalf of Marie Soldo, Executive Vice President, Government Affairs, Sierra Health Services, Inc., and asked to clarify terminology relating to mental health. She noted that there are two concepts: mandated mental health benefits versus parity mental health benefits. Mandated benefits require that certain benefits be provided, while parity benefits are structured and offered to employers and their employees. It was noted that the Employment Retirement Income Security Act (ERISA) benefit plans would not come under the purview of legislation that is passed in Nevada, so mandated mental health benefits would not be addressed. Ms. Hockenson reiterated that any health insurance mandate would increase premiums, and that there is always the risk of pricing smaller employers out of the health coverage market. Currently, in Nevada, a significant number of employers do not offer dependent coverage and limit their employees' copayment benefits. It is anticipated that if mental health benefits are mandated and insurance rates increase, benefits would decrease. It is for these reasons that the health plans of Nevada would not support mandating mental health benefits.

Mike Adams

Mr. Adams, President and CEO, Behavioral Health Care Options, discussed biologically-based mental illnesses and outlined the health coverage provided by the four systems in the State of Nevada: (1) the state-funded mental health system; (2) the Medicaid system; (3) the Medicare system; and (4) the private insurance sector. In Mr. Adams' opinion, the connection between insurance coverage for active treatment services and psychosocial rehabilitative services is crucial. He noted that services for psychosocial rehabilitative services have not been forthcoming in many states,

including Nevada, and suggested that any changes made in terms of parity must include all four systems as would any type of reform. Basically, specific individual treatment issues need to be coordinated with the enhancement of the provision of psychosocial rehabilitative services.

Jeannette K. Belz

Ms. Belz, President and Chief Executive Officer, Nevada Association of Hospitals and Health Systems, introduced Dr. Reta Harris, Medical Director, Life Skills Center, Washoe Medical Center, who is responsible for the mental health and chemical dependency services provided by the center in an inpatient and outpatient setting.

Dr. Reta Harris

Dr. Harris, identified previously, commented on the changes in mental health coverage and delivery over the past ten years. Reference was made to an article titled "Behavioral Health Benefits Plummet" (please see Exhibit D), and a study released in May 1998, which depict the changes in health care over the past decade. It was noted that:

- Overall employer spending for all health care benefits decreased by 10.2 percent; however, an analysis indicated that general medical benefits were reduced by 7.4 percent with a decrease in behavioral health benefits of 54.1 percent. As a result of the disproportionate cutbacks, behavioral health benefits dropped from 6.1 percent in 1988, to 3.1 percent in 1997.

- Limits have been placed on the number of days allowed for inpatient care, increasing from 38 percent to 57 percent for all plans. The percentage of plans with any restrictions on inpatient care rose from 63 percent in 1990, to 86 percent in 1997.

- Outpatient visits have also been affected. In 1988, 26 percent of health plans had a limit on annual visits, and that number increased to 48 percent by 1997. The actual limit on visits has also decreased, from an average of 50 yearly visits to 20.

- A decrease in the number of plans imposing annual and per-visit dollar "caps" on outpatient care has occurred. In 1988 and 1997, most plans had outpatient limits of $2,500; however, in order to account for inflation, the plan that allowed $2,500 in 1988, should have increased its outpatient limit to $4,933 in 1997.

- Inpatient and outpatient utilization and inpatient lengths of stay have decreased for behavioral health, and yet, for general medical care, outpatient utilization has increased. Inpatient utilization for behavioral health has been reduced by 36.4 percent, while general medical care has only been reduced by 13.2 percent.

Dr. Harris then discussed the issue of "cost shifting" from the private to the public sector. As an example, Washoe Medical Center receives admissions of several suicide attempts per day. The vast majority of these individuals have no insurance benefits for mental health. After a consultation screening is completed, and if the patient appears to be in control, a referral is issued for outpatient treatment. If the individual is without mental health benefits, he will not receive the needed outpatient treatment. If in the screening process the individual is not able to maintain control, he is then transferred to the Nevada Mental Health Institute. Such cost shifting is also experienced by incarceration of the mentally ill in jails and prisons, as well as juvenile detention centers.

Testimony continued regarding mandated mental health benefits and its impact on the health care industry. Referencing an article titled "Use of Health Services by Hospitalized Medically Ill Depressed Elderly Patients" (please refer to Exhibit D), Dr. Harris commented that if the appropriate and adequate mental health treatment is provided, a reduction in general medical care is expected to result as a cost offset, thus reducing the amount of physical health care required. The article also itemized the following annual cost savings totaling $8.7 billion:

- Criminal justice system costs — $0.2 billion;

- General medical costs — $1.2 billion;

- Incarceration costs — $0.1 billion;
- Morbidity costs — $6.8 billion;
- Mortality costs — $0.2 billion; and
- Social welfare costs — $0.2 billion.

Dr. Harris explained that major depression is considered a biologically-based illness that affects women and children to a greater extent than adult males. As an example, of the 17.6 million people who suffer from depression, 11.6 million are women, with the highest peak of depression for women during the childbearing and child rearing years. For people ages 30 to 44, the rates of depression are nearly three times as high for women as for men. Dr. Harris pointed out that biologically-based illnesses can be successfully treated at an efficacy rate of 60 to 80 percent, and that mental health costs are less than 1 percent of current premiums.

Additionally, Dr. Harris referred to a publication titled "Mental Health Parity Under Managed Care Results to Date and Implications" (please refer to Exhibit D), which projects that, on an average, in states where there has been complete parity of mental health and substance abuse, the increased cost in premiums was 3.6 percent.

In conclusion, Dr. Harris stated that mental health benefits in Nevada should be mandated. Of greatest concern are those individuals who have no mental health coverage and must deteriorate to the point of requiring the tertiary care provided at the Nevada Mental Health Institute. That form of treatment is far more costly than if health care was provided at the outset of the illness.

Ms. Johnson reiterated the fact that cost shifting will continue until parity insurance is an option in Nevada. According to Ms. Johnson, nine major employers in the United States had recently been recognized by the National Alliance for the Mentally Ill (NAMI) for their parity insurance programs (please refer to Exhibit B).

PUBLIC TESTIMONY

Richard Passo

Mr. Passo, Disability Rights Attorney, Nevada Disability Advocacy and Law Center, submitted fact sheets and reports regarding mental health parity to the subcommittee (please see Exhibit E). Mr. Passo explained that he is also active in Consumers Against Unfair Stigma through Education (CAUSE), a statewide consumer-oriented mental health group. He asked that the committee consider a statewide task force to focus on the many issues associated with mental health parity. Mr. Passo relayed to the committee that in 1988, at the age of 23, he was diagnosed with a manic depressive disorder (bipolar affective disorder), and noted that due to a preexisting condition, he was unable to obtain health insurance, and literally became a "guinea pig" when seeking mental health treatment.

Discussion then focused on the Mental Health and Substance Abuse Parity Amendments of 1998 (H.R. 3568), which is pending in the United States Congress. Among other things, this bill proposes to eliminate provisions that permit exemptions from parity. Mr. Passo also referenced a forthcoming National Institute of Mental Health (NIMH) study that has previewed state systems that have implemented parity insurance and incurred a total health care cost of less than 1 percent during a one-year period.

Reference was made to an article titled "An Evaluation of Contracts Between Managed Care Organizations and Community Mental Health and Substance Abuse Treatment and Prevention Agencies" (please refer to Exhibit E), that contains contract language to be utilized by advocates and policymakers in negotiations with managed care organizations.

In closing, he indicated that as an individual who has spent several of the past 18 years uninsured and not able to purchase private disability insurance, much less private health insurance, the impact to the employee could be

"priceless" in terms of having access to treatment.

Chairman Freeman suggested that Mr. Passo contact Senator Raymond D. Rawson, Chairman, Legislative Committee on Health Care, and offer his services to assist in the establishment of a statewide task force to address issues associated with mental health parity.

Gary Lenkiet, Ph.D.

Dr. Lenkiet, representing the Nevada State Psychological Association, made reference to mental health parity as a benefit mandate. He reported that most mental health parity laws in various states are not mandated and employers can elect to eliminate a requirement by not offering mental health coverage. He stated that this seems to be a risky proposition since it is estimated that approximately 60 percent of physician visits involve some type of mental health concerns. Mr. Lenkiet indicated that there are models available for mental health parity laws that have passed in other states, i.e., Minnesota and Vermont that could provide models for implementation of parity laws in Nevada. In closing, Mr. Lenkiet commented that parity coverage for mental disorders should be based on services and not on diagnosis since there are many mental health issues that do not present clear biological underpinnings. As an example, there is some controversy as to what the level of biological basis is for attention deficit hyperactivity disorder, a disorder that is eliminated from most severely mentally ill parity laws.

Responding to a question by Mrs. Freeman, Mr. Lenkiet indicated that a definition for "services" needs to be defined in state law.

William Hausman

Mr. Hausman, Coordinator of Managed Care, Health Advocacy Services, American Association of Retired Persons (AARP), stated he supported the testimony presented during this meeting and, in particular, the comments of Ms. Johnson and Dr. Harris. Mr. Hausman, pointed out that, as a psychiatrist, he is concerned that as managed care becomes the predominant model of insurance coverage in the United States, the improper care of people will increase. Given these facts, the need for parity and mandated mental health treatment is apparent. Seniors are particularly at risk in this area, given their high incidence of chronic psychoses, dementia, depression, and suicide. Mr. Hausman reiterated that insurance costs need not increase appreciably if mental health treatment is mandated.

C. Edwin Fend

Mr. Fend, Coordinator, Capitol City Task Force, AARP, commented that AARP definitely supports mental health parity legislation and, in particular, for senior citizens. As Nevada's population continues to age and more seniors choose to live in the state, it will be necessary to provide these services to the senior population. Mr. Fend addressed the lack of prescription drug availability and that many of the diseases associated with the elderly could be improved with early treatment utilizing medication.

Responding to Mrs. Freeman's question regarding a partnership with Nevada's Congressional Delegation to assist in obtaining funding for prescription medication for the elderly, Mr. Fend stated that it would be extremely helpful since individuals who receive Medicare treatment are not eligible for prescription medication.

Jennifer Ruhberg

Ms. Ruhberg, a private citizen, described to the committee her story of living with a brain disorder and her attempted suicide two years ago. Diagnosed with bipolar affective disorder and panic anxiety disorder, there are days when it is impossible for her to get out of bed or leave the house due to the panic anxiety disorder. Ms. Ruhberg explained that she has Blue Cross/Blue Shield health insurance coverage, but it does not cover mental health disease. The health plan covers $1,500 per year for total billing; a $1,000 deductible, of which 50 percent is paid; and a $25,000 lifetime limit (it was noted, that an individual with a bipolar affective disorder will exceed that limit in a few years). In the course of one year, she incurred unpaid medical expenses of $12,000 for counseling and $40,000 in medical bills. The medical bills consisted of unnecessary surgeries and treatments due to misdiagnosis. It was emphasized that persons with brain disorders need individual counseling as well as family counseling and support in order to cope with their disease.

Ms. Ruhberg conveyed to the committee that in a recent article she had read regarding mental health coverage, it stated that "a normal employee in a basic year would cost an employer $300 per month; if coverage was not provided, it could cost an employer up to $3,000 per month per employee." If the proper insurance coverage were mandated and programs made available, these individuals would be able to function at their jobs and contribute to society. Ms. Ruhberg urged the subcommittee to support parity insurance and provide assistance for those who need it.

Philip Rich, M.D.

Dr. Rich, testifying as a private citizen, stated that he is a psychiatrist in Reno, and supports parity legislation. Dr. Rich also represents the American Psychiatric Association and noted that an issue that has been brought to his attention is that Nevada incarcerates a high percentage of individuals with mental illness. This method of treating mental illness is not cost-effective, and it is hoped that the individuals who are receiving treatment in the prison system are not breaking the law in order to receive medical treatment.

Chairman Freeman thanked those in the audience who provided testimony and explained that the information presented to the subcommittee would be given to Chairman Rawson so he could determine if another meeting would be scheduled.

There being no further business, the Chairman adjourned the meeting at 12:05 p.m.

Respectfully submitted,

Roxanne Duer

Senior Research Secretary

APPROVED BY:

_____

Assemblywoman Vivian L. Freeman, Chairman

Date: _____

LIST OF EXHIBITS

Exhibit A is material regarding parity legislation in various states titled, "News From Your State, Open Your Mind," provided by Rosetta Johnson, President, Alliance for the Mentally Ill of Nevada.

Exhibit B was submitted by Rosetta Johnson, President, Alliance for the Mentally Ill of Nevada, and contains the following items:

1. Testimony of Rosetta Johnson, dated August 17, 1998.

2. A science and treatment fact book from the National Alliance for the Mentally Ill, titled "NAMI'S Campaign to End Discrimination."

3. A copy of the "Mental Health Parity Act of 1996 Summary of the Law," dated December 23, 1997.

4. An Interim Report to Congress by the National Advisory Mental Health Council titled, "Parity in Coverage of Mental Health Services in an Era of Managed Care."

5. A report by William M. Mercer titled, "Case Studies A Guide to Implementing Parity for Mental Illness."

6. A fact sheet from the National Alliance of Mentally Ill titled, "Schizophrenia in Monozygotic Twins."

7. Working Paper No. 107 from the National Institute of Mental Health titled, "Research Center on Managed Care for Psychiatric Disorders," dated January 1997, and revised in July 1997.

8. A document titled, "NAMI Awards Nine U.S. Corporations Leading the Way in Equal Insurance Coverage for Severe Mental Illness," dated July 23, 1998.

Exhibit C is a copy of the testimony of Sharen Weaver, Manager, Health Insurance Portability and Accountability Office, Division of Insurance, Nevada's Department of Business and Industry.

Exhibit D was submitted by Dr. Reta Harris, Medical Director, Life Skills Center, Washoe Medical Center, and contains the following items:

1. An excerpt from ECO American Psychiatric Association, Vol. 2, Number 4, containing the following articles: (a) "Behavioral Health Benefits Plummet"; and (b) "Substance Abuse and Mental Health Services Administration's Report on the Costs of Parity," dated August 1998.

2. A newspaper article from the *Reno Gazette-Journal* titled, "Mental-Health Coalition Waging Insurance Campaign," dated July 29, 1996.

3. A fact sheet highlighting parity laws in California and Connecticut from the American Psychiatric Association titled, "State Parity Page," dated July 1997.

4. A fact sheet from Lilly Neuroscience titled, "Depression in the Childbearing Years — In the Balance: Maternal Mental Health and Family."

5. A newspaper article from the *Reno Gazette-Journal* titled, "Importance of Self-Esteem," dated August 15, 1998.

6. An excerpt of an article reported by Frederick K. Goodwin, M.D., titled, "Cost Effectiveness of Treatment."

7. An article from the *American Journal of Psychiatry* 155:7 titled, "Use of Health Services by Hospitalized Medically Ill Depressed Elderly Patients," dated July 1998.

8. An article titled, "Research Shows Health Care Use Decreases After Marriage and Family Therapy," from *Family Therapy News*, dated October 1996.

9. A report from *Behavioral Healthcare Tomorrow* titled, "Mental Health Parity Under Managed Care, Results to Date and Implications," by Darrell A. Regier, M.D., M.P.H., dated August 1998.

Exhibit E includes the following items and was submitted by Mr. Passo, Disability Rights Attorney, Nevada

Disability Advocacy and Law Center:

1. Two fact sheets from the National Mental Health Association titled: (a) "Mental Health Parity Fact Sheet"; and (b) "Managed Care Consumer Protection Fact Sheet."

2. A newspaper article titled, "Mental Health Act Hailed" from the *Las Vegas Review-Journal,* dated December 29, 1997.

3. A fact sheet about Consumers Against Unfair Stigma through Education (CAUSE).

4. A fact sheet about the Nevada Disability Advocacy & Law Center.

5. Two articles from the National Mental Health Association's Strategies for Negotiations titled: (a) "II. Broad-Based Parity: A Quick Overview"; and (b) "III. Preserving Meaningful Parity Even During Compromise."

6. A handout from the Bazelon Center for Mental Health Law titled, "Contract Language on Standing."

7. A report from the Bazelon Center for Mental Health Law titled, "Protecting Consumer Rights in Public Systems, Managed Mental Health Care Policy," dated March 1997.

8. An article from the Center for Health Policy Research, the George Washington University titled, "An Evaluation of Contracts Between Managed Care Organizations and Community Mental Health and Substance Abuse Treatment and Prevention Agencies," dated April 1997.

Exhibit F is the Attendance Record for this meeting.

Copies of the materials distributed in the meeting are on file in the Research Library of the Legislative Counsel Bureau, Carson City, Nevada. You may contact the library at (702) 684-6827.