

Challenges and Opportunities of Federal Mental Health Parity Implementation; Impact on California's Public Mental Health System

**Assembly Select Committee on Alcohol and Drug Abuse
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**Testimony of Patricia Ryan
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Mr. Chair and Members of the Committee,

I am Patricia Ryan, Executive Director of the California Mental Health Directors Association. On behalf of CMHDA's 58 county and two city local mental health directors, thank you, Assemblyman Beall, for holding this hearing and for your outstanding leadership on this issue, and for the opportunity to provide testimony regarding implementation of the Wellstone-Domenici Mental Health Parity and Addiction Equity Act of 2008. The Act, which goes into effect January 1, 2010, is estimated to help improve coverage for approximately 113 million Americans. As you know, today, despite the fact that many states, including California, have passed some version of mental health parity legislation, many health plans fail to provide as much coverage for -- or access to -- mental health or substance abuse services as they do for other health care.

Prevalence and Current Coverage Facts

Nationwide, we know that:

- Almost half (46.4 percent) of all Americans will experience a mental illness or substance use disorder during their lifetime.
- One in four Americans experience mental illness each year.
- Mental health and substance use conditions cause more burden of disease than any other health condition – twice as much as cardiac disease.
- Nine percent of the population ages 12 and older, over 22 million Americans, were classified with substance use or dependence in 2007.
- The economic impact of addiction alone is staggering, at an estimated \$250 billion a year. Persons with severe mental illnesses accounted for \$193 billion dollars in lost earnings in 2002 – more than the gross revenue of every Fortune 500 company except Wal-Mart.
- Less than half of those with mental health conditions and less than one-fifth of those with substance use conditions receive any care at all.
- Mental and substance use conditions are major risk factors for many severe chronic illnesses—asthma, diabetes, and heart disease.
- And, most disconcerting, public mental health clients die 25 years younger than other Americans because they do not receive appropriate primary care.
- The faces and voices of mental health/substance use disorders span all facets of the population: rich, poor, young, aging, working and unable to find work.

Despite these facts:

- The proportion of private insurance spending on substance use disorders has significantly declined over the last decade as public expenditures have risen and spending for mental health has grown very little.

- The rate of out-of-pocket spending on mental health/substance use disorders is higher than for other medical conditions. For example, among employees with substance use disorder coverage, only 19 percent were enrolled in a plan that did not limit the number of hospital stays or office visits. In contrast, nearly all workers covered by medical insurance had unlimited hospital stays and office visits.
- Mental health treatment, while included in most health plans, is limited in the scope and duration of treatment and often involves higher co-pays and treatment frequency limits than general health services.

Together, these facts present a very troubling picture of our current health care insurance and delivery system. The new federal parity law, ***if implemented correctly***, will help us make significant progress in changing these terrible realities.

What the Federal Law Does

The new law requires large group health insurance plans that include coverage for mental health or substance use disorders to provide these benefits at parity with the plans' medical/surgical benefits. Small groups and individual policies are not included. For large plans, the financial requirements and treatment limitations (if any) must be the same for mental health/substance abuse as for medical/surgical care. The law prohibits inequitable coverage with respect to co-payments, coinsurance, deductibles, out-of-pocket expenses, number of covered visits and days of coverage, or other similar restrictions on the scope or length of treatment.

Specifically, group health plans covered by the law are prohibited from requiring more restrictive cost-sharing for mental health/substance use benefits than the predominant (or most common) financial requirement applied to medical/surgical benefits. The same rule holds true for any treatment limitations, such as the frequency of treatment, number of visits or days of coverage, or other similar restrictions on the scope or duration of treatment. A plan may not have any treatment limitations applicable to mental health or substance use disorder benefits that are not applicable to medical or surgical benefits. These requirements apply individually to a plan's separate benefit packages.

If the plan provides out-of-network coverage for medical/surgical benefits, it must provide out-of-network coverage, at parity, for mental health/substance use disorder benefits.

This new law builds on the Mental Health Parity Act of 1996 (Public Law 104-204), which mandated parity for lifetime and annual dollar limits. In addition to the requirements in this law, the parity provisions of the 1996 Act will remain in effect. The sunset date in that law (extended several times) is eliminated, effective January 1, 2009.

Plans are given discretion to determine which mental health and substance disorders to cover, and they retain the ability to make determinations about coverage based on medical necessity in a particular case. Medical necessity criteria used by the plan for mental health/substance use disorder benefits must be shared with the beneficiary (current or potential) and contracting providers upon request. Additionally, the explanation for any payment denials for mental health/substance use services must also be available to the beneficiary upon request.

Relationship to SCHIP and Medicaid

The parity law applies to State Children's Health Insurance Program (SCHIP) plans and to Medicaid managed care plans, as required under the Balanced Budget Act of 1997 (Public Law 105-33). SCHIP plans could, however, still provide substantially less mental health coverage than medical/surgical, which could occur if a state chooses not to include mental health services in the SCHIP plan, as

allowable under SCHIP law. Based on our understanding, this is not the intention in California. We expect that Healthy Families plans will be required to comply with the federal parity law.

County mental health departments here currently serve as the “serious emotional disturbance” (SED) providers under Healthy Families Program. This means that children who meet the state’s definition of SED may be referred by health plans to county mental health departments for provision of needed mental health services, pursuant to the Bronzan-McCorquodale Act. In truth, coordination between the Healthy Families health plans and counties with regard to mental health services has not always been smooth. This is due both to low capitation rates for Healthy Families plans for the mental health services they are currently required to provide. For services provided by counties, issues include reduced availability of local/county funds for match, lack of federal reimbursement for psychiatric pharmacy and labs, and hesitation of families to accept referral to county mental health departments due to stigma and other issues. We have discussed these issues with MRMIB and the health plans, and we anticipate that new memorandums of understanding (MOUs) will be developed between the health plans and counties regarding who provides and pays for SED services to Healthy Families beneficiaries. This will be both an opportunity and challenge when it comes to implementation of the new federal law. CMHDA will work collaboratively with MRMIB during this transition to ensure that the mental health needs of beneficiaries with SED are met.

Effective Date and Regulations

The Departments of Labor, Treasury and Health and Human Services are required by the Act to issue regulations implementing the law, and must do so no later than one year after enactment, or by October 2009. The Secretaries of the three departments are supposed to ensure coordinated implementation and enforcement and avoid duplication of their rules through the execution or revision of an interagency memorandum. We have heard, however, that it is highly unlikely that proposed regulations will be promulgated this October, as required. We may even be faced with a scenario where the law goes into effect January 1, with no regulations for health plans to follow.

Status of State Parity Laws in Context of Federal Law

State parity laws have limited reach because they cannot apply to ERISA plans. This new parity law does apply to ERISA plans, and will not supersede state parity laws that provide stronger protections and rights for individuals with respect to their mental health or substance abuse coverage. This is accomplished by applying the preemption rule in the Health Insurance Portability and Accountability Act of 1996 (“HIPAA,” Public Law 104-191).

The impact of the federal parity statute depends on an analysis of whether the particular provision of the State law is more or less stringent than the federal parity statute.

This provision works, for example, like this:

- State laws that address mental health coverage in plans that are not affected by the federal law (that is, individual health insurance plans or plans of employers with fewer than 50 employees) will remain in force;
- State laws that mandate coverage for mental health services in health plans but require only a limited benefit will be overridden. Plans covered by that state law will have to provide mental health benefits (under the state law), and provide them at parity as defined in the federal law;
- State laws that mandate parity for certain specific mental health diagnoses will be overridden. ***This would appear to apply to California, because our parity law specifies specific diagnoses.*** Diagnoses covered under these state mandates will be those defined by the health plans, as under the federal law;

- State laws only requiring that *if* a plan includes mental health benefits it must include a specified minimum level of benefits will be overridden by the new federal law (within the constraints in the law, such as size of employer, parity benefits only if the plan includes mental health coverage, etc.).

California's Parity Law (AB 88, Thomson)

California's first mental health parity law, AB 88 (Thomson), which was enacted in 1999 and became effective on July 1, 2000, arose from decades of discrimination against individuals with severe mental illness. Under AB 88, health care service plans are required to provide coverage for the diagnosis and "medically necessary" treatment of individuals with severe mental illnesses, and for diagnosis and treatment of serious emotional disturbances of children, and do so under the same terms and conditions of other medical conditions—essentially parity. The minimally required covered benefits include (*but are not limited to*): outpatient services, inpatient hospital services, and partial hospitalization services.

Under AB 88, a certain category of "severe" mental disorders and serious emotional disturbances for children must be covered on a "parity" basis with other disorders. Those disorders include, but are not limited to: Schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, and bulimia nervosa. *As mentioned above, the limited diagnoses covered in the state law may be overridden by the federal law because state law is more limiting than the federal law.*

Experience and Lessons Learned

While many of us in the mental health and substance use advocacy field had high hopes for improved access to and treatment of behavioral health disorders for those who were insured by private health plans as a result of AB 88, there have been many frustrations and disappointments, primarily related to difficulties for beneficiaries in accessing covered benefits, and failure of many plans to provide the kinds of services that are effective in treating serious mental illnesses. *Additionally, a big gap in California's parity law is that it does not cover substance use disorders.*

When Rep. Patrick Kennedy (D-RI) began working on what eventually became the Wellstone-Domenici Parity Act, he reached out to many of us who had had experience in our own states with parity laws, to discover some of the lessons learned. Among the issues CMHDA identified for him were the following:

Access Is Limited and the Health Care System is Difficult to Navigate

There are a number of factors that negatively impact access to mental health care for individuals with mental illness, even under our parity law. Limited and reduced access to mental health care creates barriers for individuals requiring early and prompt mental health treatment.

For example, the enrolled providers listed in client health provider resource directories are often not accepting any new clients. This, in turn, creates an incredibly long waiting list for individuals with mental illness to obtain an appointment with a mental health provider who is accepting new clients. Left untreated, symptoms associated with mental illness can dramatically worsen—depression, for example, can soon lead to suicidal ideation, suicide attempts, and, tragically, suicide if not treated in a timely manner.

Limitations on visits (pursuant to stringent utilization review practices) and limited hours of operation further exacerbate this scenario as clients in urgent need of mental health services face numerous barriers to access mental health treatment and care. It is not uncommon, for example, for a client to experience a 90-day wait period for a medication evaluation. Challenges for clients continue to escalate

as navigating the health insurance plan system has become increasingly difficult. Many clients, especially in times of crisis, are faced with navigating a maze of telephone recordings in search of locating a “live” person who is responsible for making authorizations for mental health treatment. And, for an individual facing a mental health crisis, the need for services often occurs at times of the day that fall outside the traditional 9 a.m. to 5 p.m. workday. Even though AB 88 requires that health insurance plans maintain emergency hours of operation, many fail to do so.

Finally, even if a beneficiary is able to access mental health services, the array of services typically available does not reflect current evidence-based or promising practices for helping individuals to recover from their mental illness/serious emotional disturbance, such as the rehabilitation services available under county mental health plans.

Impact on California’s Public Mental Health System

As a result, privately insured clients in crisis often find themselves seeking mental health services from county mental health departments, which are required – under federal Medicaid law -- to maintain access lines that are available 24/7, rather than one of their own health plan’s enrolled providers. This dilemma directly impacts the costs to county mental health. For example, while county mental health will attempt to obtain prior authorization from a health insurance plan to provide services to an enrollee, many health insurance plans are unavailable in a timely manner, or will deny covering the services provided if a prior contract between county mental health and the insurance provider is not in place.

Compounding this dilemma is the fact that county mental health is often not reimbursed by health plans for crisis services or other mental health treatment that it provides in the absence of services provided by their individual health insurance plan. The public mental health system continues to shoulder a significant burden in providing unreimbursed mental health care to health care plan enrollees. Some of the reasons attributed to this situation are that counties may not have a negotiated contract in place prior to a client’s need for treatment, or counties are unable to obtain prior authorization for services, which they often attempt and fail to receive.

The cost for doing so is very expensive and it comes at taxpayer expense when health insurance is available and should be the responsible entity for paying for the mental health services provided. In fact, many counties assert that they are seeing even more privately insured clients than before the mental health parity law was enacted.

Insufficient Enforcement of HMOs and PPOs

Another key issue that is a significant contributing factor to the situations experienced by clients has been a lack of adequate or effective enforcement by the state Department of Managed Health Care (DMHC) and the Department of Insurance (DOI). DMHC provides oversight of health maintenance organizations (HMOs); the DOI provides oversight of preferred provider organizations (PPOs). Although progress has recently been made, the current oversight process of HMOs and PPOs within each of the respective state agencies tends to focus on self-monitoring and reporting by the health insurance plans themselves. This does not provide a full or accurate portrayal of health insurance plans’ adherence to the provisions of AB 88.

Involvement in the Federal Parity Regulatory Implementation Process

CMHDA intends to monitor and significantly participate in discussions related to the development of regulations that implement the Wellstone-Domenici Mental Health Parity Act. We will do this in collaboration with mental health and substance use advocacy organizations in California, as well as at the national level through our involvement with the National Association of County Behavioral Health and Developmental Disability Directors (NACBHDD) and other national advocacy organizations. As a

member of the NACBHDD Executive Committee, I can assure you that we will be intimately involved in these discussions.

In summary, we are very excited about the tremendous potential that implementation of the Wellstone-Domenici Mental Health Parity and Addiction Equity Act of 2008 presents. We are truly fortunate to have such passionate advocates for addressing the historical and discriminatory treatment of those with mental health and substance use disorders in this country – both at the federal and state levels. We particularly want to recognize Assemblyman Beall for his tireless attempts to improve California's parity law.

Thank you for the opportunity to share our thoughts today.