

# Mental Health Parity Enforcement Budget Act

The *Mental Health Parity Enforcement Budget Act* is designed to dramatically improve consumer and provider transparency, a major focus in the final parity regulations issued in November, 2013.

The act would also adopt national standards and force health insurers and health service plans to submit documented evidence --surveys of consumers and providers and other analysis -- to prove they are complying with the law. Above all, it provides the funding, derived primarily from fees on insurance plans, to ensure regulators have the tools to enforce tougher standards and rules.

The Act integrates four key principles to successfully and effectively implement the federal Mental Health Parity and Addiction Equity Act of 2008 and the Affordable Care Act in California.

## Four Key Principles of Effective Parity Implementation

- 1) **Public Reporting:** The MHPAEA Final Rule imposes a new duty on plans and insurers to reveal internal parity analyses covering all of their operations. The analyses will be reported regularly both to regulators and made available to the public.
- 2) **Include Parity Specific Consumer Feedback:** Consumers experience parity and know what's working and what's not.
- 3) **Include Parity Specific Provider Feedback:** Psychiatrists and other licensed mental health professionals deliver the services and know what's working and what's not.
- 4) **Structure for Reporting:** There are national standards that can shape coherent, effective reporting to the public and regulators.

## CONSUMER AND PROVIDER FEEDBACK IN ENFORCEMENT– A Missing Link.

Currently health service plan or health insurer satisfaction surveys of consumers or providers contain few mental health specific questions and none specific to parity. The surveys fail to elicit sufficient information to evaluate compliance with the Final Rule from the level of those that benefit from or deliver services.

## EXISTING TOOLS

Focused Medical Surveys or Market Conduct Examinations. These tools allow regulators to look at a wide range of compliance issues at the health plan and insurer headquarters level. This information is necessary to gage the extent of compliance, yet is not complimented with information that would reveal the degree of parity compliance at point of service. The interval for surveys or exams is long – three years or more -- and parity specific surveys or exams are seldom undertaken.

Complaint System. Consumers of mental health or substance use services lodge complaints or appeals at a fraction of the rate compared with consumers of health services. Therefore, it is highly questionable to rely heavily on a complaint-driven system of enforcement to attack violations at the point of service level.

## **FEDERAL TRANSPARENCY REQUIREMENTS**

The Final Rule requires plans and insurers to reveal how they have attempted to provide parity in a very broad range of activities they undertake in the provision of benefits. In fact, this rule makes it clear that there are few aspects of plan or insurer operations which are exempt from parity analyses. While the Final Rule grants expanded rights to consumers to access parity specific information related to their care, obtaining this information relies on the consumer's initiative. The nature of mental disorders reduces this likelihood in many instances.

## **NATIONAL STANDARDS**

Several nationally recognized sets of evaluation standards exist which are parity relevant. The Utilization Review Accreditation Commission (URAC) and the National Committee on Quality Assurance (NCQA) have devised rational, methodically developed and organized means of evaluating parity in services delivered that are congruent with the Final Rule. This means that regulators need not reinvent the wheel in retooling enforcement procedures to be consistent with the Final Rule.

## **FISCAL EFFECT**

Minimum on-going general fund impact. The majority of the on-going cost to implement the stipulations in this Act are derived from insurance companies' and health service plans' fees that are deposited into the Insurance Fund and Managed Care Fund.

DMHC is currently revising early fiscal estimates. As result, DMHC estimates are subject to change.

1. One-time cost to CDI is \$131,000 in FY 2014-15 and up to \$76,000 in FY 2015-16 for collaborative rulemaking, development of standards for report, and initial review.

One-time Cost to DMHC is \$190,000 for collaborative rulemaking, development of standards for report, and initial review.

2. Annual cost to CDI is \$89,000 for on-going review.

Annual cost to DMHC is 180,000 for on-going review.

**Specifically, CDI and DMHC anticipate incurring the following costs:**

### **CDI**

One-Time Start Up Cost – Rule Making,	\$114,000.00
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Public Hearings, etc. FY 2014-15	
One-Time Start Up Cost – Review Annual Reports FY 2014-15	\$17,000.00
One-Time Cost – Rule Making FY 2015-16	\$76,000.00
Ongoing – Review annual reports	\$34,000.00
Ongoing – Public Hearings	\$55,000.00
<b>Total One Time &amp; Ongoing</b>	<b>\$296,000.00</b>

### **DMHC**

One-Time Start Up Cost – Rule making etc.	\$190,000.00
Ongoing Cost - Follow-up surveys/enforcement	\$180,000.00
<b>Total One Time &amp; Ongoing</b>	<b>\$370,000.00*</b>

\*Costs could exceed this level depending on plan compliance, consumer complaints, and enforcement actions. For example, if the filed reports raise concerns about the plans' provision of mental health services and the DMHC determines non-routine surveys are required, DMHC could incur contractor costs of up to \$75,000 for each survey. Such costs are paid out of the Managed Care Fund a special fund derived from insurers' fees and would have little to no general fund impact.

### **BACKGROUND**

The Affordable Care Act incorporates the federal Mental Health Parity and Addiction Equity Act of 2008. The ACA Essential Health Benefits mandate requires mental health and substance abuse coverage in individual and small group plans. Large group insurance and health service plan products as well as these individual and small group policies or plans are all subject to the MHPAEA Final Rule released on Nov. 7, 2013. Implementation of the Final Rule is a next step.

Consumers paying for insurance should have confidence that they are receiving all the services to which they are entitled. Transparency for parity in insurance and with health service plan operations is a federal requirement designed to ensure equity and fairness in the provision of those services.

Covered California has enrolled 650,000 individuals, many of whom now have health insurance for the first time. Stronger enforcement laws are needed to safeguard consumers from health insurers who routinely ignore parity laws.

In California severe mental illness impacts about 1 in 20 persons. About one in 5 Californians suffer from a diagnosable mental disorder. In any particular year 52 percent of California adults who could benefit from mental health care do not receive it. Another 25 percent get less than minimal treatment.

California's suicide rate rose from 9.7 to 10.3 persons per 10,000 in the four years prior to 2011, much of it attributable to untreated mental health issues. The incidence of those with mental disorders committing crimes is substantial, about 22 percent of the total population in state prisons (~25,000), and about 20% in local jails (~193,000). Homeless individuals who have a mental or substance use disorder make up 80% of the total homeless population.

California businesses lose an estimated \$12 billion in productivity each year due to mental illness. Workers in California lost an estimated \$23 billion in earnings due to diagnosable and treatable mental disorders. National data points to the fact that for every 100 employees, depression alone costs employers about \$62,000 annually, \$53,000 (86 percent) representing lost work time, and about \$9,000 for medical care.

Clearly, the consequences of untreated mental health are costly. The suffering not only takes its toll on the individual but also on his or her family members. Our community has become overwhelmed by the public health and safety impacts. States and counties, taxpayers and businesses foot the bill for those who are uninsured - or who don't or can't avail themselves of treatment - and end up with avoidable high cost care in hospitals and emergency rooms, jails and prisons.