Testimony
Department of Human Services
Health Services Committee
Senator Judy Lee, Chairman
April 12, 2012

Chairman Lee and members of the Health Services Committee, I am JoAnne Hoesel, Director of the Division of Mental Health and Substance Abuse Services for the Department of Human Services. I am here today to provide information on the funding sources of mental health services and information regarding mental health parity and services for adults and children.

Mental Health Services Funding Sources

The primary funding sources for public mental health services are general fund, Medicaid, the community mental health block grant, and third party insurance.

Mental Health Parity

On October 3, 2008, the Mental Health Parity and Addiction Equity Act of 2008 was signed into law. This new federal law requires group health insurance plans (those with more than 50 insured employees) that offer coverage for mental illness and substance use disorders to provide those benefits in a way that is no more restrictive way than all other medical and surgical procedures covered by the plan. The Mental Health Parity and Addiction Equity Act does not require group health plans to cover mental health and substance use disorder benefits, however, when plans do cover these benefits, mental health and substance use disorder benefits must be covered at levels that are no lower and with treatment limitations that are no more restrictive than would be the case for the other medical and surgical benefits offered by the plan.

Group health insurance plans can still manage the use and cost of the benefits they provide by determining both the medical necessity criteria and the scope of coverage and when prior authorization for treatment is required. However, under the federal parity law, large group plans are required to provide participants and beneficiaries with the medical necessity and managed care criteria used to make decisions about coverage and, if mental health and substance use disorder benefits are denied, with the reasons for denial of benefits.

Federal interim final regulations went into effective on April 5, 2010. Under the parity law and the interim final rules, a group health plan generally cannot impose financial restrictions (such as a co-payment or coinsurance) or quantitative treatment limits (such as a limit on outpatient visits or inpatient days covered) on mental health and substance use disorder benefits in any of six classifications that is more restrictive than the financial requirements or quantitative treatment limits that apply to at least 2/3 of medical/surgical benefits in the same classification. For example, if a plan applies a $25 co-payment to at least 2/3 of outpatient, in-network, medical/surgical benefits, a higher copayment could not be imposed on outpatient, in-network mental health and substance use disorder benefits. The six classifications of benefits defined in the interim final rule are: (1) inpatient, in-network; (2) inpatient, out-of-network; (3) outpatient, in-network; (4) outpatient, out-of-network; (5) emergency care; and (6) prescription drugs.

I would be happy to answer any questions.