



CALIFORNIA
PSYCHIATRIC
ASSOCIATION

CAPITOL INSIGHT

Budget Drama and Health Reform Trauma

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Budget Drama

While the yearly budget drama in the state Capitol may have lost its ability to dismay the electorate after 8 or so years of sometimes staggering but always severe state income deficits, the Governor's proposed budget for 2011-2012 and indications for proposal in 2012-2013 are some of the most far reaching seen for mental health services in decades.

The Legislature passed AB 100, a mental health budget trailer bill (called a trailer bill because it "trails" the main or primary budget bill) which uses \$861 million in Mental Health Services Act funds (MHSA, Proposition 63) as one time "bridge" funding for one year of "realigned" programs to counties from the state in April. The specific meaning of realigned here simply means that formerly state administered programs delivered by counties will become wholly county administered programs with dedicated funding streams attached to each with minimal state involvement.

Three mental health programs are part of a much larger public safety realignment scheme, one key feature of which is the reduction of state prison inmate populations by keeping low level offenders housed in local jails instead of state prisons.

The three mental health programs are Early Periodic Screening Detection and Treatment (EPSDT) which funds a decade long expansion in children's mental health services; Medi-Cal Mental Health Specialty Managed Care funds which pays for county inpatient psychiatric care and medications; and AB 3632 programs in which

counties provide mental health services to pupils in schools. Funding supporting these programs after the year of "bridge" funds from the MHSA was supposed to come from a tax extension that never found enough traction in the Legislature to muster the 2/3's vote necessary

for new taxes. Subsequently, after new and rosy income projections, a final budget bill signed by the Governor contains a formula which draws on over \$4 billion in increased revenue to the state that is projected to fund these and other realigned programs in 2012-2013. The assumptions of increasing revenues to the state over the next year may be more optimistic and wishful thinking than not.

In the Governor's May 16, 2011, Revised Budget, further reorganization of mental health services were proposed by the Governor and acted on by the Legislature. Specifically, the proposal transfers Mental Health Specialty Medi-Cal to the state Department of Health Care Services, along with the Drug Medi-Cal program run by the state Department of Drug and Alcohol Programs. This reorganization makes sense in that it consolidates all Medi-Cal programs in one agency.

However, in a stunning reversal the former AB 3632 mandate on counties' Departments of Mental Health to provide mental health services to pupils was transferred to and became a mandate on schools.

The federal Individuals with Disabilities Education Act (IDEA) of 1975 ensures services for children whose disability, including severe emotional disturbance, adversely affects educational performance. AB 3632 is a Califor-



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nia law which reversed decades of neglect of pupil mental health by school districts and was enacted in response to a 1983 lawsuit that uncovered facts indicating that school districts failed to meet IDEA obligations with regard to mental health services.

This budget proposal reinstates pre-AB 3632 conditions and has many worried that the same neglect which made AB 3632 necessary will ensue again with a decline in access to and quality of mental services for pupils.

However, in a striking departure, the Governor's budget also contained a notice of intent in the 2012-2013 budget proposal to eliminate the state Departments of Mental Health and Drug and Alcohol Programs, and establish a state Department of State Hospitals. The thinking behind the elimination of these departments by the administration seems to be that once Medi-Cal is consolidated in DHCS, and the newly realigned community programs join the mental health programs realigned in 1991, there will not be much left to administer at the state level – state hospitals being a large and specialized operation, divorced from community mental health programs, so it makes sense to have a sole agency in charge of this function.

Nonetheless, this notion is being challenged by the CPA and others who point to decades of adopted statutes which define various roles and functions for the state Department of Mental Health, the sum total of which constitutes a long list. Ron Thurston, MD, the CPA President-elect and CPA Government Affairs Committee Chair, writes elsewhere in this issue about the CPA Council adopted guiding principles in what will likely be ongoing negotiations by the CPA and others with the administration over these functions.

One of the features of AB 100 was language which required the state Department of Health Care Services to engage in a stakeholder process to design a transition process and timelines with a report back to the Legislature at intervals throughout the fall. The CPA will participate in that process.

Health Reform Trauma: Access Denied is Parity Denied

One of the key issues pinpointed both by the experience of California psychiatrists, but also embedded in the regulations for the federal Wellstone-Domenici Mental Health Parity Act of 2008 in the battle to “achieve” parity is the acknowledgment that while it's an important starting point to offer mental health benefits on the same

terms and conditions as other health conditions, ending discrimination against mental health treatments in health insurance requires going much further. One familiar example of a barrier to access to care that proves the case is the presence of phantom panels (i.e. lists of psychiatrists offered by health plans, with few if any accepting new patients) which have been discussed in this newsletter repeatedly over many years.

Another example is on the other side of the coin, in which patients cannot obtain insurance and are arguably more disadvantaged than their peers who have insurance but cannot obtain care. Typically insurance is unobtainable when the individual is priced out of the market by policies they cannot afford. In California 24.2 million individuals have either insurance or a health service plan, however, more than 7 million Californians remain without health insurance because it is too expensive to purchase. There is no parity if there is no access and there is no access if there is no insurance.

There is however, an attempt to make insurance and health service plans, if not more affordable, at least less expensive.

In one of the more vigorously contested and widely watched contests between competing interests in the State Capitol, Assembly Bill 52 was scheduled to be voted in the Senate Health Committee at press time. Subject to an unusual special order of business hearing the week before in which no vote took place and which dominated the agenda of the Senate Health Committee for over 3 ½ hours (causing many other bills to be rescheduled for hearing the next week), AB 52 (co-authored by Mike Feuer, D-Los Angeles, and Jared Huffman, D-San Rafael) seeks to grant state regulators the authority to review rate increases in health insurance and deny unreasonable increases.

Adding fuel to the fire, news stories in late June and early July indicated that insurance companies and health plans are proposing to increase small group and individual market premiums from as little as 3 percent to, in one case, 92.5 percent according to California Department of Insurance data. The national rate for premium increases per year for all insured lives is 3.5%.

This legislation sought by former Assembly Health Committee Chair and now California State Insurance Commissioner, Dave Jones, is actually his fourth try at legislation on this subject in as many years. The issue at stake

is variously described as “rate setting” or “rate review” depending on whether voiced by opponents or proponents. AB 52 requires insurers to submit evidence and a rational basis for any new rates and allows the Insurance Commissioner or the Director of the Department of Managed Health Care to reject rate increase proposals that are “excessive, inadequate or unfairly discriminatory.” It allows an insurer to resubmit a request for a rate increase with additional supporting evidence, or to request an arbitration hearing with an administrative law judge.

The California Medical Association (CMA) points to current low levels of reimbursement to physicians and asserts that, if AB 52 passes, HMOs will pass through the effects of rejected rate increases and force physicians to bear the burden of limiting premiums. CMA points out that physicians have very little leverage in negotiating contracts with carriers and if premiums are set below cost by regulators, then physicians and other providers will have no option but to accept reductions in reimbursement as plans

and insurers institute cost cutting measures in the face of rejected rate increase proposals. CMA also argues that if that were the case, there would be fewer contracted physicians, reduced access to physicians, and less physician time spent with patients.

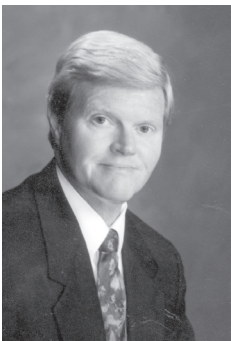
Nonetheless, these issues arise at a time in which health insurance companies are declaring record profits for shareholders and executive pay climbs to new heights. As well, at least 30 other states allow various forms of rate regulation.

The battle over AB 52 is bitterly contested. Consumer advocates, labor and other groups are lined up in support, medical and business organizations, insurers and numerous chambers of commerce are in opposition.

Even if successfully signed into law, AB 52 implementation will face exacting challenges.

Stay tuned. I hope to give an optimistic report on a bill to establish a physician health plan in the next issue.

Access To Care: A Grass Roots Initiative for Health Care Reform



Joseph R. Mawhinney, M.D.

By Joe Mawhinney, M.D., DLFAPA
Area 6 Assembly Deputy
Representative

Those of us on the front lines providing direct patient care have long been aware of the many barriers to care, disparity in insurance coverage, discontinuity of coverage and general lack of access to appropriate care for many patients. Despite the hopes and promises of health care reform there continue to be many individuals suffering from mental disorders who have no insurance coverage. Many patients eligible for health care are unable to afford the escalating premiums. Many who have lost their jobs can't afford health care on COBRA and of those patients who have health insurance, many realize to their dismay that they are unable to afford to use their insurance due to high deductibles and co-pays. Continuity of care and access to appropriate medication or continuity of effective medication is often disrupted due to health plan changes and restricted formularies.

Public sector patients who have severe, chronic and disabling disorders, often unable to advocate for themselves, are arbitrarily given a limited number of visits with a psychiatrist, not based on clinical assessment but by administrative fiat. Parity violations are frequent and obvious but who has the time or energy to challenge the corporate bureaucracy.

Health care reform is a work in progress with a long way to go. Insurance companies, while reporting billions of dollars in profits, trumpet a trend of decreased health care utilization saying “managed care works” while those of us in the community, concerned about patient suffering, preventable disability and public health, recognize an access to care crisis. This crisis is not likely to be resolved by top-down mandates without improvement in the access to clinically appropriate care. Implementation of health care reform by for-profit managed care organizations, in government sponsored and regulated administrative structures, will only institutionalize the barriers to care that we currently see. Even as we explore the current problems in implementation of parity and access to care, the health insurance industry is trying to unravel key provisions in health care reform and parity legislation effecting treat-

ment of mental illness and substance use disorders.

The APA Assembly Executive Committee has responded to these concerns, recognizing the need for a grass roots initiative for access to care to begin as a pilot project in Area 6 (California). This project, a work in progress, will involve District Branch and CPA work groups involving outreach to advocacy groups, practicing psychiatrists, provider organizations, and other key figures in the community as determined by each District Branch or CPA Council based on the uniqueness, creativity and leadership of each group. It is expected that we will learn from each other.

A steering committee, composed of Assembly Reps and Deputy Reps as well as Representatives from the District

Branches and CPA, will serve to support the effort of each work group and to assist in reporting, sharing and collating data regarding the implementation of Federal Health Care Reform. This steering committee, together with the work groups, will develop relevant action papers and position statements for California and the APA Assembly to stimulate a grass roots dimension to health care reform, challenging and resolving barriers to care wherever possible and informing legislators and other policy makers of the realities of health care at the street level.

I hope that you, our members, will welcome this initiative and participate actively by sharing your experiences, your energy and your creativity with your District Branch and the CPA Access to Care work groups.

Calling all Colleagues to be Key Contacts Key Contact Sign Up and Update Form

Name: _____

Home Address: _____ City/State/Zip: _____

Home Phone: _____ Home FAX: _____

NOTE: Home information is needed as that is usually the address at which you are registered to vote and will enable us to match you with your correct legislative representative. It is held in strictest confidence.

Office Address: _____ City/State/Zip: _____

Office Phone: _____ Office FAX: _____

Is your FAX a confidential line ____ or in a multidisciplinary office ____ (check one)

E-Mail Address: _____ Is it confidential? _____

District Branch _____

Do you personally know a California legislator or her/his spouse? ____ If so, whom? _____

As a Key Contact, I would be willing to:

_____ Write letters to my state legislators _____ Meet with legislators

_____ Work on a campaign _____ Participate in public events

_____ Author a newspaper opinion piece or letter to the editor

_____ Be a legislative bill reader, if so, which topic(s) would you cover _____

_____ Other, please specify: _____

Please feel free to write down any suggestions you may have to help strengthen our Key Contact System:

If you know who your legislator is, please make note of it here:

Assembly Member: _____ Senator: _____

If you do not know which members represent your district, please call the California Psychiatric Association's toll-free number (800) 772-4271. Please FAX completed form to 916-442-6515.