"Measuring Parity Compliance in California"
Outline for Testimony Given at the California State Senate Select Committee on Mental Health on June 27, 2013
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I. A little bit about me

A. I am a person living with major depression, initially seeking treatment in 1996 (at the time, I was a graduate student with little mental health coverage). I paid for psychotherapy out of my pocket, despite my meager grad student stipend. My therapist, however, allowed me to pay what I could afford.

B. In 1997, I became employed and received insurance coverage through UC Berkeley. The plan was, according to my colleagues, the "best."

C. Also in 1997, I sought mental health services through my health plan. The arrangement with my first therapist had ended (he moved to Southern California) and according to my health plan literature, treatment for major depression was a covered benefit. I had one appointment with the therapist that my plan referred me to. He told me that I needed treatment but that the health plan would not agree. I believed him and sought treatment with a therapist outside my plan.

D. By 1999, my employer switched plans. The therapist I was currently seeing was on the panel of the new plan. We began billing the plan for my treatment. Almost immediately, the plan (according to my therapist) sought to end psychotherapy. However, they never outright denied coverage.

E. Since California's mental health parity law became effective; my plan has told me or my therapist various untrue statements to try to end therapy. Fortunately, I had become active as a mental health advocate and was able to tell the plan (or tell my therapist to tell my plan) that what they were saying was not valid. Among the many statements my plan made were (recall, my plan never disputed my diagnosis which is one of the covered diagnoses under California parity):

1. "Peter only gets 15 sessions a year." – California's parity law did away with limits on the number of sessions. Also, my plan documentation (the Evidence of Coverage) said nothing **in writing** about a session limit. This statement was made **verbally** to me and my therapist.

2. "We only cover short-term therapy." – As long as the therapy is medically necessary, it is covered under the law. A plan cannot "only cover short-term therapy," at least for the California parity diagnoses. Again, this assertion was made **verbally**. No plan documentation said this on paper.

3. “We think Peter has improved enough and no longer needs services. These next 5 sessions are the last we will authorize.” – My therapist emphatically disagreed with the plan’s determination to end therapy. After we had those “last 5 sessions,” my therapist went back to the plan which authorized another “last 5 sessions.” This game continued for over a year. Always, the plan said they were authorizing the “last 5 sessions,” always my therapist requested more, always the plan gave in and ended up authorizing another “last 5.” However, every time my therapist requested authorization, the amount of pressure applied to him would escalate. The plan would have him on the phone for over an hour as he was passed from person to person and asked to resubmit his clinical justifications for continuing treatment over and over.

4. “Peter, we can’t talk to you about your ongoing treatment.” – The plan told me this point-blank when I called them to question them about the repeated lies they had made when communicating with my therapist. On that call, I first asked them, “Does parity apply to me?” “Yes,” said the plan (after much typing on a computer. “Why are you telling my therapist that you only cover short-term therapy? Isn’t that prohibited by parity?” “We can’t talk to you about your treatment. We will only talk to your therapist,” said the plan and ended the call.

F. There came a time in 2005 when I needed treatment for alcohol addiction. The plan referred me to a treatment program which informed me that they were unable to treat someone like me who was taking medication for a co-occurring mental health condition.

G. With no help from the plan and much legwork on my own, in 2006, I finally found an alcohol treatment program that would treat me and that was in network. However, the plan refused to cover the level of treatment that the program thought I needed. I did the treatment anyway (paying a huge amount out of pocket). I have not had a drink since.

II. CCMH and the Community’s Consensus regarding Health Plan Treatment for Mental Health Conditions

A. The California Coalition for Mental Health is made up of over 30 statewide organizations representing thousands of mental health consumers, family members, providers, advocates and others. Membership includes MHA California, NAMI-CA, the professional associations (CAMFT, NASW-CA, both CPA’s, etc.), public mental health (CMHDA, the California Mental Health Planning Council, many others), consumer advocates (Disability Rights California, CAMHPRO, CAMHPRA, etc.), large providers (California Hospital Association, CASRA) and others.

B. The consensus at CCMH is that health plans are flouting the law and not providing adequate mental health care. **The tactics my plan has used regarding my care is extremely common.** They routinely steer people into cheaper levels of care that are less than what their treating clinicians think are necessary (group therapy instead of one-on-one therapy, meds-only when the member doesn't want them and their clinician believes they would be better treated with therapy, weekly outpatient therapy instead of intensive outpatient, etc.).

C. We have seen the Departments (DMHC and CDI) take little action regarding these problems (with the exception of the recent DMHC action on Kaiser which really the clinicians within Kaiser made happen – Google "Kaiser care delayed care denied"). There are reasons for this. While the Departments do conduct plan surveys/audits, their tools do not tease out the problems specific to the mental health arena. For example, a plan may point to a low number of grievances and complaints or to above average scores on the HEDIS (industry-standard and accrediting) measures. (Small digression: the HEDIS measures are very few and hopelessly flawed.) Much (maybe most?) of the audit relies on self-reported data from the plan. Personally, that seems dubious to me.

D. If the audits are not picking up the problems, then the Departments rely on complaints and grievances. Mental health consumers rarely complain for many reasons:

> 1. Stigma in our society is rampant. Consumers fear that their employers, friends, family members will find them out. While technically illegal, employers do discriminate and if a person loses their job, they may lose their insurance (and livelihood).
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> 2. People dealing with mental health challenges are often (maybe always) dealing with much larger issues in their life. Asking them to fight their health plan at such a time is a very tall order.
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> 3. The plans are often giving the member and their clinician (if they have one) misinformation (see my life story).

E. SB 22 will address many of the problems I have talked about by helping the Departments enforce state and federal parity. The bill requires plans to provide specific information to the Departments about the services they are providing. This information is based on a set of industry standard measurements (the URAC standards) which are much more comprehensive than the HEDIS measures I belittled earlier. Many of the plans already participate in the URAC program and are reporting these measures internally, or if they are not, they are not difficult numbers to obtain. An analysis of the bill by DMHC and CDI provided to the Senate Appropriations Committee states that the Departments believe that each of them will find at least one plan out of compliance with the law annually if SB 22 is passed and require corrective actions or face fines (or both) – exactly what the Departments should be doing.