NMHA
State Advocacy Update
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Advocates Survive Significant Challenges This Session

As states have faced $40 to $50 billion in budget shortfalls over the past year, the mental health community has increased its struggle to receive basic services, medication and treatment. In contrast to the economic wealth experienced just a few legislative sessions ago, states now have major budget gaps to fill. In response, states have eliminated funding for discretionary programs such as mental health and other human service programs, and established policies that threaten access to medications and other optional benefits under state Medicaid programs. Some state policymakers are using these budget concerns, as well as pending federal legislation, to slow efforts to pass mental health and substance abuse parity.

Other states have weathered this "perfect storm," restoring budget cuts for mental health programs, protecting access to medications, and moving forward to end insurance discrimination against people with mental illnesses. Mental health advocates'continuing efforts to work together with their coalitions to educate policymakers and protect the fragile mental health system are creating seeds of opportunity during these times of crisis.

Surviving the "Perfect Storm": State Budgets

As the majority of legislatures adjourn and the new fiscal year begins in all but a handful of states, policymakers are licking their wounds from divisive budget battles and bracing themselves for worse next year. All but five states are confronting budget deficits totaling more than $45 billion dollars. Preliminary reports from the National Conference of State Legislatures (NCSL) estimate that the aggregate budget deficit for Fiscal Year 2003 may be as high as $58 billion. Healthcare expenditures are one of the biggest cost drivers, particularly in the Medicaid program, where state deficits total more than $7 billion for fiscal year 2001-2002. The National Association of State Budget Officers (NASBO) expects the states' fiscal crisis to continue for 12-18 months after economic recovery.

This dismal budget situation threatens funding for discretionary programs such as mental health and other human service programs. Since Medicaid now pays for more than half of public mental health spending, mental health consumers are disproportionately targeted by these cuts. But, in 2002, mental health advocates in several states have successfully deflected cuts.

Continued on next page

In this issue...

Summer Healthcare Reform Advocacy Trainings Call Advocates to Action 5-a

Waiver Watch: Growing Number of States Seek to Expand Services Through HIFA, 1115 Waivers 6-a

Advocacy Resources 8-a

The 2003 Legislative Session Is Around the Corner!

What does your coalition need to prepare for the next session?
What policies or laws need to change in your state?
What bad policies or bills does your coalition need to stop?
Do you seek to create or expand your mental health coalition?

NMHA is ready to help. Please feel free to contact us for assistance.
For more information, contact Erica deFur Malik, program director, Healthcare Reform at 703-837-3360, or e-mail her at emalik@nmha.org.

Advocates Survive Significant Challenges This Session

continued from SAU front page

In **Ohio**, a strong coalition convinced Governor Bob Taft to exempt the mental health agency from across-the-board agency cuts. Such an exemption is unlikely in future years, however, and advocates are already preparing for the fight in 2003.

In **Illinois**, the legislature restored $12 million in general cuts and $7.6 million in cuts from Health and Human Services originally proposed by Governor George Ryan for the state's FY 2003 budget. The proposed cuts would have affected 200 mental health agencies. In **Maine**, Governor Angus King's revised budget restored almost all of the cuts proposed for Medicaid and the Department of Behavioral and Developmental Services, including an $11.9 million cut to mental health programs.

Although **Colorado** faced a $385 million deficit (with $135 million shortfall in the mental health budget alone), advocates were successful in garnering more than $4.5 million in new appropriations. The increases included a 2 percent cost-of-living increase (COLA) for Target Services, as well as new money for indigent adults, general fund money appropriated to fund Alternatives to Adult and Adolescent Inpatient Hospitalization and an increase in the amount requested for early intervention. Unfortunately, 4 percent cuts are now projected for fiscal year 2003, which will cause Colorado's mental health budget to lose an estimated $2-3 million. In response to these cuts, advocates will continue to collect data on the effects of an underfunded mental health system and publicize this information in preparing to request restoration when the legislature reconvenes.

Advocates Protect Access To Psychotropic Medications

State policymakers have singled out increased pharmacy budgets as a main cause of rising healthcare costs. More than 16 states considered restricting access to medications through preferred drug lists (formularies), prior authorization requirements, prescription limits and other mechanisms. By implementing tighter controls on access to medications, states hope to reduce costs in their Medicaid pharmaceutical line items. For example, seven states took steps to curtail the cost of prescription drug benefits and 16 states have approved legislation to modify their Medicaid pharmaceutical benefits.

Time Is Running Out!

There are just a few more weeks left in this congressional session. Be sure to contact your congressional representatives and senators, and urge them to support the Mental Health Equitable Treatment Act (H.R. 4066 and S. 543).

800-866-PARITY

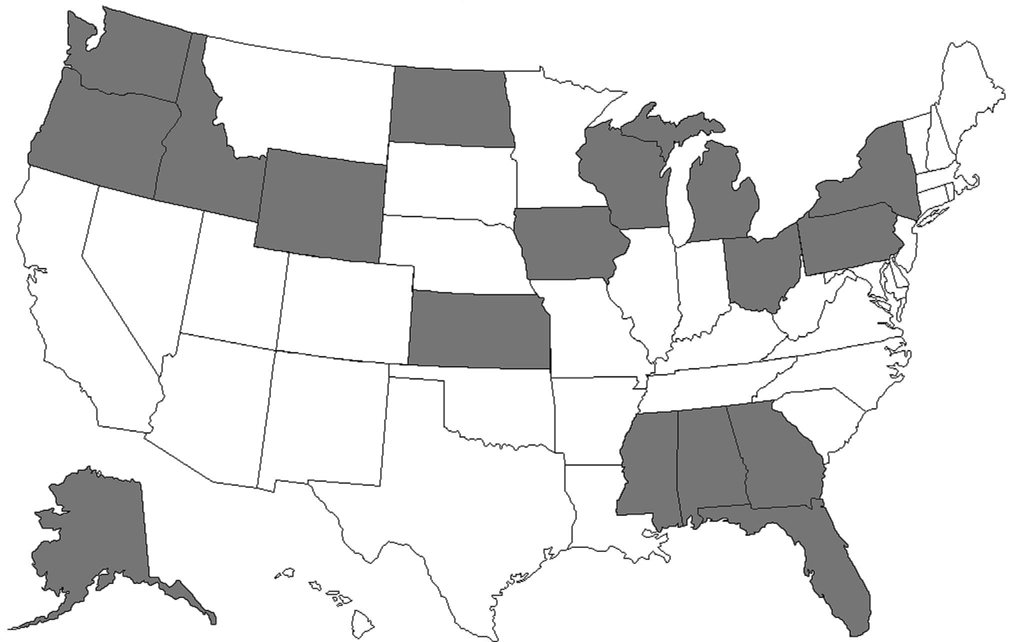
For more information about the Mental Health Equitable Treatment Act, call NMHA at 800-969-NMHA (6642) or visit http://www.nmha.org.

Unfortunately, these efforts may prove to be penny-wise and pound-foolish. Research clearly indicates that such efforts not only jeopardize consumer health but also fail to reduce costs because expenses for hospitalization, community mental health services, and emergency care increase when prescribers and consumers are unable to choose appropriate treatments.

Mental health advocates have been successful on many fronts during this session in averting restrictions that affect psychotropic medications. Although halting all restrictive policies is the real goal, advocates in several states have exempted psychotropic medications from these policies in 2002.

States Without Parity Statutes

Shaded, as of 10/1/02



Legislation that **Indiana** enacted this year remains the gold standard. Advocates have secured regulatory and legislative language prohibiting the Medicaid program from implementing prior authorization or other restrictions for brand name anti-anxiety, antidepressants, antipsychotic drugs, and drugs for the treatment of mental illness under the fee-for-service Medicaid and SCHIP programs. The state's H.B. 1233 uses the most comprehensive definition of medications used to treat mental illness, including those prescribed for cross-indications (see inset below). Six other states successfully passed legislation this session that exempted psychotropic medications from prior authorization requirements.

The scope of these exemptions differs widely, however. For example, **Connecticut** and **Ohio** use broad definitions: Connecticut H.B. 6002 cites "mental health related drugs," while Ohio S.B. 261 exempts drugs approved for treatment of mental illness (defined as "a substantial disorder of thought, mood, perception, orientation, or memory that grossly impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life").

Although less broad, legislation enacted in **Illinois** and **Kansas** takes into consideration medications that are cross-indicated for treatment of mental illness. Kansas S.B. 422 exempts from prior authorization or other restrictions medications used to treat mental illnesses such as schizophrenia, depression or bipolar disorder. The exemption applies to atypical antipsychotic, conventional antipsychotic and other medications. Illinois S.B. 2201 defines the exempted medications as "anti-retroviral or any atypical antipsychotics, conventional antipsychotics or anticonvulsants used for the treatment of serious mental illness."

Minnesota and **Vermont** enacted more limited language. Minnesota S.B. 3099 limits the exemption to antipsychotic medications and only when a generic equivalent is

continued on page 4-a

Protecting Access to Medications:

Indiana's H.B. 1233

- Defines mental health medications broadly to include antidepressants, antipsychotics, and anti-anxiety drugs, and includes cross-indications, new drugs, and new drug categories as they are discovered.
- Ensures that brand-name drugs will not require prior authorization in favor of generic medications.
- Permits limitations on mental health medications only to prevent fraud, abuse, waste and inappropriate utilization, or to promote disease management, and allows such limitations only when it is in the best interest of the recipient and quality of care.

Advocates Survive Significant Challenges This Session

continued from page 3-a

unavailable. In Vermont, H.B. 31 exempts “prescription drugs prescribed for the treatment of severe and persistent mental illness, including schizophrenia, severe depression or bipolar disorder.”

Mental Health and Substance Abuse Parity: It's Fair, It's Affordable, It's Time

With 28 states introducing parity, or mandated offering or minimum mandated benefit bills, mental health advocates and policymakers throughout the country continued to focus on mental health and substance abuse parity in 2002. Advocates nationwide have consistently made the case that parity is a straightforward choice for policymakers.

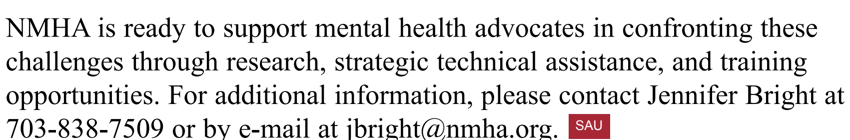
In 2002, after years of effort, **West Virginia** advocates succeeded in lobbying for passage of a limited parity law, which included substance abuse disorders and some children's disorders. In addition, **New Hampshire** expanded its parity law to include substance abuse disorders, post-traumatic stress disorders and eating disorders. Other states, such as Colorado and **Alabama**, expanded their existing laws to ensure they are implemented appropriately.

Mental Health Associations . . . are sending a clear message to their federal legislators that full mental health parity must be mandated at the federal level.

Mental Health Associations throughout the country continue to work on parity in their states, but all are also sending a clear message to their federal legislators that full mental health parity must be mandated at the federal level. For more information on NMHA's parity efforts on both the federal and state levels, visit the NMHA Web site at http://www.nmha.org.

Prepare Now for Next Year

Although budget challenges will continue, there is evidence that effective advocacy strategies are being implemented to divert the budget axe. And, although Medicaid cost containment is also a significant threat, advocates should continue calling for open access and examining other state strategies to ensure access to mental health medications. With federal action on parity pending, legislative attention to this issue continues and foreshadows a new round of legislation to address substance abuse and children's insurance parity.



NMHA is ready to support mental health advocates in confronting these challenges through research, strategic technical assistance, and training opportunities. For additional information, please contact Jennifer Bright at 703-838-7509 or by e-mail at jbright@nmha.org. SAU

Are you registered to vote?

This year:

- **11 states will elect or re-elect governors.**
- **33 states will elect or re-elect U.S. Senators.**
- **50 states will elect or re-elect all 435 members of the U.S. House of Representatives.**

Call NMHA's Voter Empowerment Project at 800-969-NMHA (6642).

Advocacy Begins at the Ballot Box

Summer Healthcare Reform Advocacy Trainings Call Advocates to Action

NMHA has co-sponsored more than 140 Healthcare Reform Advocacy Trainings with Mental Health Associations around the country. In collaboration with state and local affiliates, these meetings empower advocacy groups to counter state legislative and regulatory policies that threaten to limit access to quality mental health treatment and to promote effective investment in community mental health services. Healthcare Reform Advocacy trainings for summer 2002 include:

West Virginia — In July, the Mental Health Association (MHA) in the Greater Kanawha Valley, Inc. convened a meeting with members of the state's mental health coalition to examine Medicaid funding trends across the country. Participants developed strategies to increase investment in West Virginia's public mental health system and to offset proposed agency cuts to address projected Medicaid shortfalls. For more information on West Virginia's mental health coalition, e-mail the MHA in the Greater Kanawha Valley, Inc., at mha@wvinter.net.

Maryland — Also in July, the MHA of Maryland met with stakeholders to examine nationwide strategies to increase investment in children's mental health services. Stakeholders in Maryland are convening several follow-up meetings with key stakeholders to promote more effective use of funds for children's mental health services. To learn more about the mental health coalition of Maryland, e-mail the MHA of Maryland at info@mhamd.org.

Texas — Finally in July, the MHA in Texas met with the state mental health coalition to examine legislative strategies to promote Psychiatric Advanced Directives (PAD) as an alternative to Involuntary Outpatient Commitment (IOC) of mental health consumers. They focused specifically on the importance of consumer empowerment and on ways to address these issues during times of fiscal uncertainty. For more information on Texas'mental health coalition, e-mail the MHA in Texas at mhainfo@mhatexas.org.

Hawaii — In August, the MHA in Hawaii met with stakeholders to examine advocacy strategies to strengthen investments in the state's public mental health systems. To learn more about the mental health coalition of Hawaii, email the MHA in Hawaii at mha@I-one.com. SAU

mental health

MATTERS

Mental health matters to all Americans, yet it often takes a backseat to overall health. Due to insurance restrictions, limited access to care, and stigma, only one in seven people with a mental illness seek treatment.

Your contribution to the National Mental Health Association makes a difference by educating millions about mental illness, reducing barriers to treatment and services, and helping Americans with mental illnesses lead fulfilling, productive lives. Learn more at nmha.org.

CFC #0548

Call 800-969-NMHA or visit www.nmha.org/affiliates for the Mental Health Association near you.

Waiver Watch: Growing Number of States Seek to Expand Services Through HIFA, 1115 Waivers

A growing number of states are seeking to expand coverage for uninsured residents using Health Insurance Flexibility and Accountability (HIFA) and other Section 1115 Medicaid waivers. The chart below outlines recent waiver activity and the implications for mental health and substance abuse coverage. The good news is that most states are exempting behavioral health benefits from reductions. States may be forced to reevaluate benefits and cost sharing, however, if their expenditures during the waiver program implementation are higher than they had expected. With this in mind, mental health advocates must exercise continued vigilance in monitoring waiver processes, contributing to public comment about Medicaid reform proposals and communicating with Medicaid officials about the importance and cost-effectiveness of including mental health services in even the most basic benefits packages. This chart will be updated periodically and available on the NMHA Web site at http://www.nmha.org/shcr/community_based/waiverwatch.cfm.

State	Expansion Population	Basic Structure	Impact on Mental Health Benefits
Arizona HIFA Waiver Phase I Implemented; Phase II 10/1/02	50,000 adults ≤200 percent of the federal poverty level (FPL) in two phases: Phase I: Childless adults up to 100 percent of FPL. Phase II: Parents of SCHIP and Medicaid children, 100 percent to-200 percent of FPL.	Benefits and cost-sharing requirements are identical to those stipulated in state's acute care and SCHIP program benefit packages.	No change to current benefits.
California HIFA Waiver Implemented 7/1/02	275,000 Parents, relative caretakers and guardians with incomes ≤ 200 percent of FPL.	Newly eligible beneficiaries' benefits package is similar to SCHIP program (based on state employees package).	No change to current benefits.
Utah Non-HIFA 1115 Waiver Implemented 7/1/02	25,000 uninsured residents.	Restructures Medicaid into three plans: • Traditional Medicaid. • Public Employee Health Plan-based package for TANF eligible, Medically Needy, SCHIP children. • Primary Care Network for adults with incomes below 200 percent of the FPL, including childless adults who earn below 53 percent of the FPL.	Reductions include cap on visits to psychiatrists, elimination of transportation services except in emergencies. Individuals with chronic mental illness, children, seniors, and individuals with physical disabilities are exempt from benefit reductions. Under Primary Care Network no mental health or substance abuse benefits are offered. Under Public Employee Health Plan, state imposes a $100 per day co-payment for psychiatric inpatient stays; increases the co-payment from $2 to $3 per visit for outpatient visits. Prescription drug co-payments imposed: PEHP: $2 per prescription PCN: $5 per prescription (generic or preapproved brand); 25% coinsurance for non-formulary Rx.
Maine HIFA Waiver Approved 9/13/02	Uninsured adults earning < 125 percent of FPL.	State plans to implement this waiver and maintain the current Medicaid benefits package; however the state has reserved the right to adjust benefits to levels consistent with the state employees health plan based on cost estimates.	No change to current benefits.

State	Expansion Population	Basic Structure	Impact on Mental Health Benefits
Michigan HIFA Waiver (MIFamily) Pending	220,000 low-income adults: • Parents/ guardians of MIChild enrollees earning up to 100 percent of FPL. • Disabled adults earning up to $31,188 per year. • Pregnant women earning $21,182-$23,980.	MIFamily would cover outpatient care, prescription drugs, mental health and substance abuse services, and "limited" inpatient care.	The Engler administration vows that services for mental health will not be changed, and advocates note that upon initial review, optional mental health benefits appear to be intact. However, the proposal outlines a process to review the benefit and cost-sharing requirements annually, and preserves the state's ability to cap enrollment for new participants.
Oregon Amendment to existing 1115; HIFA Waiver Pending	Approximately 42,000 working poor earning up to 185 percent of FPL.	• OHP Plus. Current OHP benefit package is available to people eligible for Medicaid (w/o a waiver), General Assistance recipients, and pregnant women and children (both Medicaid and SCHIP) up to 185 percent FPL. • OHP Standard. Benefit package is similar to commercial insurance coverage for adults who are not otherwise eligible for Medicaid (including parents, singles and couples) w/ incomes up to 185 percent FPL. Enrollment is capped. • Family Health Insurance Assistance Program (FHIAP). Premium subsidies program for uninsured earning up to 185 percent of FPL. Enrollment capped.	Under OHP Standard program, mental health and chemical dependency services are covered with $5 co-payment. Under FHIAP, state has included inpatient and outpatient services for mental health and chemical dependency in the insurance benchmark; however, there is no specification about durational limits or cost-sharing. Pregnant women, children, and individuals with disabilities, however, would be exempt from the benefit cuts, and state officials say they intend to preserve coverage of mental health services and drug treatment.
Washington HIFA Waiver Pending.	20,000 residents earning < 200 percent of FPL: • Parents of Medicaid and Basic Health (BH) children. • Childless adults.	Newly eligible enrollees receive coverage through Washington's Basic Health Plan. Beginning July 1, 2003, waiver will permit cost-sharing, benefit reduction and enrollment caps.	Mental health services, alcohol/substance abuse services and long-term care services are not affected by proposed benefit reductions. Note: Current Basic Health plan covers up to 10 inpatient days and 12 outpatient visits per year. General Medicaid clients have no inpatient limits but a 12-visit outpatient limit per year.
New Mexico HIFA Waiver Pending	Phase I: 40,000 adults < 200 FPL. Phase II: 40,000 adults.	Under Phase II, state would submit a waiver amendment to scale back Medicaid benefits package for certain enrollees. Modifications will be based on recommendations from a statutory committee.	Mental health benefits are limited to 25 inpatient/partial hospitalizations and 20 outpatient visits per year. Substance abuse benefits are limited annually to the following: 10 days of outpatient detox, 12 days of general substance abuse outpatient services or 30 days of intensive outpatient services. All MH/SA benefits have tiered co-payments of $5-$20 depending on income.
Colorado HIFA Waiver Pending	16,000 pregnant women earning 133 percent to 185 percent of FPL.		No limits on benefits for treatment of biologically based mental illnesses (defined as schizophrenia, schizoaffective disorder, bipolar affective disorder, major depression, specific obsessive-compulsive disorder and panic disorder. All other mental health treatment services are limited to 45 inpatient days (can be converted to 90 days of day treatment) or 20 outpatient visits. Substance abuse services are limited to 20 outpatient visits and inpatient detox services (5 days per episode).

Advocacy Resources

NMHA is committed to providing mental health advocates and stakeholders with quality information that helps promote positive policy changes in states and communities. Below is a list of resources advocates can use to help support their advocacy efforts. Most of these materials are available on the Internet. If you have problems accessing any of the following items online, contact the Advocacy Resource Center at 800-969-6642 and select option 6, or e-mail shcrinfo@nmha.org.

Children

- From the General Accounting Office—*Mental Health Services: Effectiveness of Insurance Coverage and Federal Programs for Children Who Have Experienced Trauma Largely Unknown*, available at http://www.gao.gov/new.items/ d02813.pdf.

Criminal Justice

- From The Council of State Governments Eastern Regional Conference—*Criminal Justice/Mental Health Consensus Project*, available at http://www.consensusproject.org.

Health Insurance

- From The Henry J. Kaiser Family Foundation—*Sicker and Poorer: The Consequences of Being Uninsured*, available at http://www.kff.org/content/2002/20020510/4004.pdf. You must have Adobe Acrobat to view.
- From the National Health Law Program—HealthCareCoach.com, which "features hundreds of articles with information about everything from keeping health care costs down and coping with emergencies to dealing with denied claims and what people can do when they lose coverage."

Health Insurance Flexibility and Accountability (HIFA)

- From The Centers for Medicare & Medicaid Services—The Health Insurance Flexibility and Accountability Demonstration Initiative, available at http://www.hcfa.gov/medicaid/hifa/default.htm.

Medicaid

- From The United States General Accounting Office—*Medicaid Financial Management: Better Oversight of State Claims for Federal Reimbursement Needed*, available free of charge from Open Minds at http://www.openminds.com/IndustryResources/financial.htm.
- From The Commonwealth Fund—*Partnering with Parents to Promote the Health Development of Young Children Enrolled in Medicaid,* available free of charge at http://www.cmwf.org/programs/child/bethell_partnering_570.pdf.

The President's New Freedom Commission on Mental Health

- The President's New Freedom Commission on Mental Health's Web site, available at http://www.mentalhealthcommission.gov.

SCHIP

- From the Urban Institute—*Five Things Everyone Should Know About SCHIP*, available at http://www.urban.org.

NMHA State Advocacy Update

The *State Advocacy Update* is a quarterly publication of the National Mental Health Association's Healthcare Reform program.

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