Government of the District of Columbia
Office of the Chief Financial Officer

Jeffrey S. DeWitt
Chief Financial Officer

MEMORANDUM

TO:	**The Honorable Phil Mendelson** **Chairman, Council of the District of Columbia**
FROM:	**Jeffrey S. DeWitt** **Chief Financial Officer**
DATE:	**October 4, 2018**
SUBJECT:	**Fiscal Impact Statement – Behavioral Health Parity Act of 2018**
REFERENCE:	**Bill 22-597, Committee Print as shared with the Office of Revenue Analysis on September 20, 2018**

Conclusion

Funds are sufficient in the fiscal year 2019 through 2022 budget and financial plan to implement the bill.

Background

The bill requires all health benefit plans offered by health insurers in the District to comply with the requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA),[1] and any federal guidance or regulations implementing MHPAEA.[2] The bill requires the Department of Insurance, Securities and Banking (DISB) to enforce these requirements by:

- Ensuring compliance by health insurers;
- Detecting, evaluating, and responding to complaints regarding any actual or potential violations of MHPAEA;
- Developing, maintaining, and regularly reviewing a publicly available consumer complaint log recording any actual or potential violations of MHPAEA; and
- Performing market conduct examinations of health insurers' health benefits plans, including a review of any non-quantitative treatment limitations.

Beginning October 1, 2019, health insurers must submit an annual report to DISB that contains the following information:

[1] Approved October 3, 2008 (Pub. L. No. 110-343; 122 Stat. 3881).
[2] Such as 45 C.F.R §§ 146.136, 147.136, 147.160, and 156.115(a)(3).

- The frequency[3] with which the health insurer's health benefits plan required prior authorization for all prescribed procedures, services, or medications for mental health conditions, substance use disorder benefits, and medical and surgical benefits during the prior calendar year;
- A description of the process used to develop and select medical necessity criteria for mental health conditions and substance use disorder benefits;
- Identification of all non-quantitative treatment limitations that are applied to benefits provided for mental health conditions and substance use disorders;
- An analysis of the medical necessity criteria that includes:
    - An identification of the factors used to determine whether a non-quantitative treatment limitation shall apply to the provision of a benefit, including any factors that were considered but rejected;
    - An identification of the specific evidentiary standards that were relied upon and used to design any non-quantitative treatment limitations;
    - An identification and description of the methodology used to determine that the processes and strategies used to design each non-quantitative treatment limitation, as written, for mental health condition and substance use disorder benefits are comparable to and no more stringent than the processes and strategies used to design each non-quantitative treatment limitation, as written, for medical and surgical benefits;
    - An identification and description of the methodology used to determine that the processes and strategies used to apply each non-quantitative treatment limitation, in operation, for mental health condition and substance use disorder benefits are comparable to and no more stringent than the processes or strategies used to apply each non-quantitative treatment limitation, in operation, for medical and surgical benefits; and
    - A disclosure of the specific findings and conclusions reached by the health insurer to indicate that the health insurer is in compliance with the bill;
- The rates of, and reasons for, denial of claims for inpatient in-network, inpatient out-of-network, outpatient in-network, outpatient out-of-network, prescription drugs, and emergency care mental health services and substance use disorder services during the prior calendar year, compared to the rates of and reasons for denial of claims in those same classifications of benefits for medical and surgical services during the prior calendar year;
- A certification that the health insurer has completed a comprehensive review of the administrative practices of the health insurers health benefits plans for the prior calendar year to verify compliance with the bill; and
- Any other information requested by the Director of DISB.

By October 1, 2019, DISB must issue a report to the Council in non-technical, readily understandable language that must:

- Specify the methodologies used by DISB to verify compliance with the bill;
- Identify the market conduct examinations conducted by the DISB during the preceding year, including:
    - The number of market conduct examinations initiated and completed;
    - The benefit classifications assessed by each market conduct examination;

[3] Specifying the frequency for patient in-network benefits, inpatient out-of-network benefits, outpatient in-network benefits, outpatient out-of-network benefits, emergency care benefits, and prescription drug benefits.

    - The subject matter of each market conduct examination; and
    - A summary of the basis for the final decision rendered in each market conduct examination;
- A description of any educational or corrective actions DISB took to ensure health insurer compliance with the requirements of this bill; and
- A description of DISB's efforts to educate the public regarding mental health condition and substance use disorder parity protections under the MHPAEA and this bill.

The bill prohibits health insurers from imposing a non-quantitative treatment limitation with respect to mental health condition or substance use disorders. The bill requires Medicaid to cover medication prescribed for the treatment of substance use disorders; provided, that medication will not be subject to utilization control, prior authorization, step therapy, and lifetime restriction limits. The medical assistance program, including any Medicaid managed care organizations and Medicaid Alternative Benefit Plans, must also follow the requirements of the bill.

Financial Plan Impact

Funds are sufficient in the fiscal year 2019 through 2022 budget and financial plan to implement the bill.

DISB already regulates health insurance providers and can enforce the bill's insurance benefit requirements without additional resources. DISB can also produce the reports required by the bill using resources allocated in the fiscal year 2019 budget.

The District's Medicaid program already covers prescriptions for the treatment of substance use disorders. Since the bill is codifying existing practice, the Department of Health Care Finance has sufficient resources to implement the requirements of the bill.