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Earmarked Taxes as a Policy Strategy to Increase Funding for Behavioral Health Services

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Abstract

Earmarked taxes for behavioral health services are a policy strategy that many jurisdictions have implemented to increase funding for behavioral health systems. However, little has been written about these taxes and limited guidance exists for policymakers who are pursing or implementing such taxes. This article summarizes approaches to designing earmarked behavioral health taxes, evidence of their impacts, strategies to enhance implementation, and future directions for research. The article focuses on two jurisdictions: California, which imposes an additional 1% tax on all household income exceeding $1 million, and Washington, which provides counties the option of increasing sales tax by .01%.

Public concern about mental health and substance use disorders (i.e., behavioral health) is perhaps greater than it has ever been in the United States. Increasing rates of suicide, opioid overdose death, and mental health problems among youth have galvanized public support, and demand, for policymakers to increase access to behavioral health services. In fact, many Americans are willing to pay higher taxes to fund behavioral health services. Surveys conducted in 2017 revealed that 42% of U.S. adults were willing to pay an additional $50 annually to improve the mental health service system (1) and 58% were willing to pay this for more social services for people with serious mental illness (e.g., supportive housing and employment) (2). Concurrent with these increases in public support is a growing body of knowledge about evidence-based behavioral health treatments. More is known about what treatments work, and for whom, than ever before. However, inadequate funding is a persistent barrier to the availability of evidence-based treatments and the fidelity with which they are implemented (3).

The current sociopolitical context provides an opportunity for legislators to successfully introduce tax proposals that increase funding for behavioral health services. Earmarked taxes —defined as taxes for which revenue can only be spent on specific activities—are one approach that might be politically feasible and effective at increasing access to behavioral health services. Legislation authorizing earmarked taxes for behavioral health services has

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passed in jurisdictions such as California, Washington, Missouri, Illinois, and Colorado. However, little has been written about these taxes and limited guidance exists to inform questions that policymakers, behavioral health advocates, researchers, and other behavioral health stakeholders (e.g., consumers, direct service providers, behavioral health organizations) might have about earmarked taxes. Such questions include:

1. What are different approaches to designing such taxes?
2. What is the evidence for their impacts?
3. What implementation strategies can be used to ensure that they promote access to evidence-based treatments? and
4. What are priority areas for research?

In this article, we begin to shed light on these questions by synthesizing information about earmarked behavioral health taxes that were implemented in two states: California and Washington. We focus on these states because of similarities in the timeline and scope of their taxes but significant differences in their design and implementation.

What are different approaches to designing earmarked taxes for behavioral health services?

Using publicly available information, we compiled details regarding the authorizing legislation, timeline, design, revenue, and fiscal oversight of the earmarked behavioral health tax laws in California and Washington. As shown in Table 1, the taxes share only two broad features. First, they were both signed into law in 2005. Second, they both were passed with the overarching purpose of increasing funding for behavioral health services.

The two states differ in the design, spending, and oversight of these earmarked taxes. Specifically, the state of California imposes an additional 1% income tax on the taxable portion of annual household incomes exceeding $1 million to furnish revenue in the state Mental Health Services Fund. In contrast, Washington permits each county (and city with a population >30,000 in a county with a population >800,000) to opt-in to the tax, which imposes a 0.1% sales tax increase to furnish revenue to county governments for behavioral health services. As of 2017, 28 of the 40 counties in Washington state, and the City of Tacoma, had opted to implement the tax. The differences in tax structure are apparent in the per capita revenue generated, with California generating more than double the per capita revenue than Washington ($56.50 versus $22.17).

Another striking difference between the taxes in California and Washington is the flexibility related to behavioral health tax spending and fiscal oversight. In California, revenue from the tax is allocated to five mental health service components: community services and support, prevention and early intervention, capital facilities and technological needs, workforce education and training, and innovation. The spending is overseen by a statewide Mental Health Oversight and Accountability Commission to which each county is required to regularly submit reports. Counties in California have some flexibility and autonomy to make decisions about the specific mental health interventions across the five components. For

example, the Los Angeles County Department of Mental Health used tax revenue in the areas of prevention and early intervention to offer county mental health centers funding and implementation support to have their providers trained to deliver specified evidence-based treatments (4). All counties in California are required to ensure that their decisions about tax spending are consumer-engaged and reflect representation of diverse stakeholders (e.g., consumers of behavioral health services, caregivers, families).

Washington, in contrast, offers each county/city that opts-in to the tax tremendous tax spending discretion as long as the revenue is dedicated to "treatment services, case management, transportation, and housing that are a component of a coordinated chemical dependency or mental health treatment program or services." The only service mandate is that implementing jurisdictions must establish and operate a therapeutic court for substance use disorder proceedings. Tax dollars can also only be used to *expand* and *implement new* services, with the exception that funding can be used to support services for which federal funding has ceased. As a result of the discretion permitted by the authorizing legislation, the specific services funded through the tax appear to vary widely between counties. There is no requirement for implementing counties to report how they spend tax dollars or fiscal oversight at the state-level. However, some counties that have implemented the tax—such as King and Thurston—require, and make publicly available, detailed reports about tax spending.

What is the evidence for the impacts of earmarked taxes for behavioral health services?

Indicators of the impact of earmarked taxes can be assessed at multiple levels. These include the amount of revenue generated by the tax (policy-level), the number of providers billing for services funded by the tax (system-level), the number of providers offering evidence-based treatments through revenue from the tax (system-level), or improvements in clinical outcomes and client or provider satisfaction based on services funded by the tax (client and provider-level). Although these indicators of tax impact are likely to be of great interest to policymakers and their constituents, it should be noted that they are more accurately characterized as *outputs* than *outcomes*. Determining the outcomes of earmarked taxes for behavioral health services requires comparison of *what happens* after the tax is implemented and the counterfactual of what *would have happened* if the tax was not implemented. This can be achieved through quasi-experimental difference-in-difference designs that, for example, compare the magnitude of pre-post tax changes between similar behavioral health service settings that did and did not receive tax revenue in the same county (as could be assessed in California) or between similar counties that did and not implement the tax (as could be assessed in Washington).

In California, a small number of studies have assessed the impact of the tax in Los Angeles County. A mixed method, quasi-experimental study assessed impacts of the tax in the county by comparing public mental health clinics with tax-funded "full service partnerships" to clinics without these tax-funded services (5). The study found that the tax-funded services were associated with higher rates of service utilization, greater provision of recovery-

oriented services, and improved client-provider working alliances. However, the tax-funded services were associated with higher levels of provider stress because they were required to change practices to offer more coordinated and patient-centered care. A RAND analysis of claims data assessed the reach of tax-funded services in Los Angeles (6). Among the main findings, tax-funded prevention and early intervention services were provided to 130,000 children and transition aged youth between 2012–2016, nearly 65% of whom were new clients—suggesting that the reach of these services might be attributable to the tax. A study of the reach of six tax-funded, evidence-based mental health treatments for children in Los Angeles receiving prevention and early intervention services sought to understand factors that affected the sustainment of these services within the context of the tax initiative (7). Results indicated that the reach of the services varied by the unit of analysis (e.g., system-level versus provider-level), highlighting the complexity of measuring tax impacts.

In Washington state, few evaluations have explicitly focused on the tax. However, quasi-experimental studies have assessed the impacts of services that were exclusively funded by the tax. By extension, the impacts of these services are attributable to the tax. For example, a quasi-experimental evaluation of a tax-funded family treatment drug court in King County—which used propensity score matching to create a control group—found that the program improved outcomes for both parents and children (8). Some tax-implementing counties track indicators of the reach and impact of tax-funded programs and include these data in spending reports. Thurston County, for example, reports the number of people served by each tax-funded program (e.g., outpatient services provided to 303 youth in 2018) as well as the percentage of program participants who met the program goal (e.g., graduated from chemical dependency court). King County reports this information in addition to pre-post changes in mental illness symptoms among tax-funded program participants.

What implementation strategies can be used to ensure that earmarked taxes promote access to evidence-based behavioral health treatments?

The field of implementation science offers guidance to help ensure that earmarked behavioral health taxes result in expanded access to evidence-based treatments. Earmarked taxes can align with several “outer-setting” implementation strategies (i.e., techniques to enhance the adoption and sustainment of an innovation) identified in the Expert Recommendations for Implementing Change compendium. These strategies include providing access to new funding, changing incentive structures, and mandating the use of evidence-based treatments, such a through contract requirements. Through these strategies, behavioral health taxes have potential to address well-established system and provider-level barriers to the implementation of evidence-based treatments (3). However, the success of these strategies is reliant upon the successful implementation of the tax itself and there is little evidence for policy—as opposed to clinical or organizational—implementation strategies (9).

Despite the dearth of evidence on policy-focused implementation strategies, the EPIS (*Exploration*, *Preparation*, *Implementation*, *Sustainment*) framework —which is widely used in implementation science (10)—can inform the design of earmarked taxes for behavioral

health services. In the *exploration* phase, as tax proposals are considered and drafted, it is important for legislators to align tax design with the policy preferences of key stakeholders —such as constituents, consumers, mental health service providers, and behavioral health system leaders. A key question in tax design is the extent to which revenue is required to be spent on specific services, such as evidence-based treatments (like in some counties in California), as opposed to giving broad discretion about the services that can be funded by the tax (like in Washington). The former is likely to produce the greatest benefits for population behavioral health, but success is contingent upon the capacity and flexibility of local behavioral health systems and workforce to deliver these services. Thus, in the *preparation* phase, it is important to assess readiness for tax implementation and develop plans and implementation supports to capitalize on strengths (e.g., openness to system innovations) and address gaps (e.g., lack of trained service providers) to facilitate delivery of tax-funded services.

In particular, authorizing legislation for earmarked taxes should consider designating funds for continuous supports for organizational leaders and direct service providers to facilitate that which will occur in the *implementation* and *sustainment* phases. These supports could include education about tax spending and reporting requirements, ongoing training for services funded by the tax, as well as other implementation strategies (e.g., facilitation, audit-feedback, enhanced training in evidence-based treatments) that have demonstrated effectiveness at improving the reach and fidelity of evidence-based treatments. This is particularly important given the high rates of staff turnover in public behavioral health systems.

During the *implementation* phase, it is essential that there is routine monitoring of the implementation process to support needed adaptations to implementation strategies. Because taxes will be implemented in diverse and constantly changing local behavioral health system environments, it is important that authorizing legislation be broad enough to allow for adaptions to spending and service requirements for different populations and contexts. Focused attention to these outer- and inner-setting structures, processes and supports at the outset of tax design will increase the likelihood of success and potential for public health impact in the *sustainment* phase.

Priority Areas for Research

There are many important knowledge gaps related to earmarked taxes for behavioral health services. A first step is to conduct a legal mapping study to identify and describe all legislation in the U.S. that authorizes earmarked taxes for behavioral health services. Subsequent lines of inquiry include: 1) policy process research to examine what influences the passage of such taxes and which advocacy frames are most effective; 2) outcome studies that use rigorous quasi-experimental designs (e.g., difference-in-difference with propensity score matching, interrupted time series) to assess service delivery, clinical, and population behavioral health outcomes; 3) implementation studies that use experimental designs (e.g., stepped wedge, hybrid implementation-effectiveness) to determine the effects of policy implementation strategies; and 4) economic research to evaluate return on tax dollar investments.

Conclusions

Earmarked taxes are a policy strategy to address growing public demand for enhancements to behavioral health service systems across the United States. California and Washington offer two contrasting examples of how such taxes have been designed, implemented, and evaluated. Future research is needed to understand how such taxes can be optimized to maximize improvements in access and outcomes for people who need behavioral health services.

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Highlights:

- Earmarked taxes—defined as taxes for which revenue can only be spent on specific activities—are a policy strategy that many state and local jurisdictions have pursued to increase funding for behavioral health services.
- California and Washington offer two contrasting examples of how such taxes have been designed, implemented, and evaluated.
- The field of implementation science offers guidance to enhance the impacts of earmarked behavioral health taxes.

Table 1.

A Tale of Two Taxes

	California	Washington
Date tax enacted	Signed into law on January 1, 2005	Signed into law on May 17, 2005
Authorizing legislation description	"Mental Health Services Act" (MHSA) (AB 488) Became law through state ballot initiative (Proposition 63)	"An act relating to the omnibus treatment of mental and substance abuse disorders act of 2005" (E2SSB-5763) Clarifications provided in Revised Code of Washington (RCW 82.14.460)
Tax design and implementation	1% tax on taxable household income exceeding $1 million Applies to the entire state	Counties have the ability to implement a 0.1% sales tax increase to expand and fund new mental health services, substance use disorder services, and therapeutic courts for substance use disorder proceedings Cities with a population >30,000 in a county with a population >800,000 can implement the tax if county does not
Tax spending	Revenue must be used to fund 5 components within every county: Community Services & Support: funds direct services primarily to consumers with severe mental illness Prevention & Early Intervention: funds services and outcomes evaluation of programs designed to prevent mental illnesses from escalating in severity and disability Capital Facilities & Technological Needs: funds physical and technological infrastructure to support the delivery of MHSA services. Workforce Education & Training: funds training for staff to provide culturally competent and relevant mental health services Innovation: funds projects that develop or test "new, unproven mental health models" to achieve a goal of increasing access to underserved groups, increasing the quality of services, promoting interagency collaboration or increasing access to services	Every county that implements the tax must establish and operate a therapeutic court for substance use disorder proceedings Mental health and substance use disorder services that can permissibly be funded by the tax include, but are not limited to, "treatment services, case management, transportation, and housing that are a component of a coordinated chemical dependency or mental health treatment program or services" Counties/cities have complete discretion regarding how tax revenue is spent within and across these, and other, categories as well as the populations who are eligible for tax-funded services Funds must be used to provide new services or expand existing services, but can be used to support services for which federal funding has ceased
Tax revenue generated	2018–2019 gross tax revenue: $2.235 billion[1] 2018–2019 per capita revenue among Californians: $56.50[3]	2016 gross tax revenue across all implementing jurisdictions: $123,685,375[2] 2016 per capita revenue among implementing jurisdictions: $22.17[4]
Oversight	Mental Health Oversight and Accountability Commission requires that each county mental health program prepare and submit a 3-year program and expenditure plan to the state and provide annual updates	Washington State Department of Revenue tracks revenue generated in implementing counties/cities No state monitoring of tax spending

1. Data from California Mental Health Services Oversight and Accountability Commission (http://mhsoac.ca.gov/document/2018-01/mental-health-services-act-revised-january-04-;2018)

2. Data from Washington State Department of Revenue (https://dor.wa.gov/about/statistics-reports/local-sales-and-use-tax-distribution)

3. Calculated by authors using data on tax revenue from the California Mental Health Services Oversight and Accountability Commission and population count data from http://transparency.mhsoac.ca.gov/Overview.

4. Calculated by authors using data on tax revenue for county from the Washington State Department of Revenue (https://dor.wa.gov/about/statistics-reports/local-sales-and-use-tax-distribution) and population count data from the Washington State Office of Financial Management (https://www.ofm.wa.gov/washington-data-research/population-demographics/population-estimates/april-1-official-population-estimates).