CALIFORNIA
HEALTH BENEFITS REVIEW PROGRAM

EXECUTIVE SUMMARY:
Analysis of Assembly Bill 1887
Health Care Coverage:
Mental Health Services

A Report to the 2007–2008 California Legislature
April 8, 2008

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California Health Benefits Review Program Analysis of Assembly Bill 1887
Health Care Coverage: Mental Health Services

The California Legislature has asked the California Health Benefits Review Program (CHBRP) to conduct an evidence-based assessment of the medical, financial, and public health impacts of Assembly Bill (AB) 1887, as introduced by Assemblymember Jim Beall on February 8, 2008, Health Care Coverage: Mental Health Services. This bill would expand the mandated coverage for mental health services from the current covered conditions—severe mental illness and serious emotional disturbances in children—to a broader range of conditions. The bill would also extend the "parity" requirement for mental health services from the limited conditions covered under current law to a broader range of conditions. The "parity" requirement mandates that coverage for mental health services be no more restrictive or limited than coverage for other medical conditions.

Under current law, health plans and insurers are required to cover the diagnosis and medically necessary treatment of severe mental illnesses (SMI) of a person of any age, and of serious emotional disturbances (SED) of a child. Coverage is required to be at "parity," that is, under the same terms and conditions applied to other medical conditions. Terms and conditions include, but are not limited to, maximum lifetime benefits, copayments, and individual and family deductibles.

Under the proposed mandate, health plans and insurers would be required to cover all mental health benefits at parity for persons with all disorders identified in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV).

Health insurance products regulated by the Department of Managed Care and Department of Insurance would be subject to this proposed mandate. Medi-Cal Managed Care plans and California Public Employees' Retirement System (CalPERS) plans would not be subject to this proposed mandate.

Medical Effectiveness

Mental illness and substance abuse are among the leading causes of death and disability in the United States and California. There are effective treatments for many of the mental health and substance abuse (MH/SA) conditions to which AB 1887 applies. However, the literature on all treatments for MH/SA conditions covered by AB 1887—more than 400 diagnoses—could not be reviewed during the 60 days allotted for completion of CHBRP reports. Instead, the effectiveness review for this report summarizes the literature on the effects of parity in coverage for MH/SA services on utilization, cost, access, process of care, and health status of persons with MH/SA conditions.

The impact of MH/SA parity legislation on the health status of persons with MH/SA conditions depends on a chain of events. Parity reduces consumers' out-of-pocket costs for MH/SA services. Lower cost sharing is expected to lead to greater utilization of these services. If consumers obtain more appropriate and effective MH/SA services, their mental health may improve and they may recover from chemical dependency. Improvement in mental health and recovery from chemical dependency may lead to improvements in productivity and quality of life and reduction in illegal activity.

The effects of parity in MH/SA coverage are difficult to separate from the effects of more intensive management of MH/SA services. Many employers that have implemented parity in MH/SA coverage have simultaneously increased the management of MH/SA services. Some employers have contracted with managed behavioral health organizations (MBHOs) to administer MH/SA benefits. In addition, some persons in states that have parity laws are enrolled in health maintenance organizations (HMOs) that tightly manage utilization of both medical and MH/SA services.

The generalizability of studies of MH/SA parity to AB 1887 is limited. None of the studies published to date have examined the effects of parity in coverage for treatment of non-severe mental illnesses separately from treatment for severe mental illnesses. In addition, only a few studies have assessed use and/or cost of substance abuse services separately from use and/or cost of mental health services. Moreover, in most studies the subjects had some level of coverage for MH/SA services prior to the implementation of parity. *Thus, findings from these studies may not generalize to Californians who are enrolled in private health plans that currently do not cover services for non-severe mental illness or substance abuse.*

- Findings from studies of parity in coverage for MH/SA services suggest that when parity is implemented in combination with intensive management of MH/SA services and provided to persons who already have some level of coverage for these services:
    - Consumers' out-of-pocket costs for MH/SA services decrease.
    - There is a small decrease in health plans' expenditures *per user* of MH/SA services.
    - Rates of growth in the use and cost of MH/SA services decrease.
    - Utilization of MH/SA increases slightly among persons with substance abuse disorders and persons with moderate levels of symptoms of mood and anxiety disorders.
    - Inpatient admissions for MH/SA conditions per 1,000 members decrease.
- The effect on outpatient visits for MH/SA conditions depends on whether persons were enrolled in a fee-for-service (FFS) plan or an HMO prior to the implementation of parity.
- Parents of children with chronic mental illnesses who reside in states with MH/SA parity laws are less likely to report that paying for health care services for their children creates financial hardship.
- Persons with mental health needs who reside in states with MH/SA parity laws are more likely to perceive that their health insurance and access to care have improved.
- Very little research has been conducted on the effects of MH/SA parity on the provision of recommended treatment regimens or on mental health status and recovery from chemical dependency. The literature search identified only two studies on these topics.
    - One study reported that MH/SA parity is associated with modest improvements in receipt of a recommended amount and duration of treatment for depression.

- One study found that MH/SA parity laws are not associated with a change in suicide rates for adults.

Utilization, Cost, and Coverage Impacts

Coverage

- In California, SMI services are already covered under AB 88, so the scope of AB 1887 is narrower, focusing on the incremental effect of extending parity to non-SMI and substance use disorders.

- CHBRP estimates that 18,859,000 insured individuals would be affected by the mandate. None of these individuals currently have coverage at levels achieving full MH/SA parity with medical care, as would be mandated under AB 1887. Therefore, all of them would experience an increase in coverage as a result of the mandate.

- Approximately 92% of insured Californians affected by AB 1887 currently have some coverage for non-SMI disorders and 8% have none; 82% of insured Californians have some coverage for substance use disorders and 18% have none.

Utilization

- CHBRP estimates that utilization would increase by 23.9 outpatient mental health visits (12.03%) and 9.0 outpatient substance abuse visits (27.41%) per 1,000 members per year as a result of AB 1887. Annual inpatient days per 1,000 members would increase by 0.1 (4.36%) for mental health and by 1.1 (17.05%) for substance abuse.

- Increased utilization would result from an elimination of benefit limits (e.g., annual limits on the number of hospital days and outpatient visits) and a reduction in cost sharing, because coinsurance rates are currently often higher for MH/SA or behavioral health services than for other health care. Utilization would also increase among insured individuals who previously had no coverage for conditions other than the SMI diagnoses covered under AB 88.

- The estimated increases in utilization would be mitigated by two factors. First, direct management of MH/SA services is already substantial (e.g., due to the use of managed behavioral health care organizations or other utilization management processes), attenuating the influence of visit limits and cost-sharing requirements on utilization. Second, prior experience with parity legislation suggests that health plans are likely to respond to the mandate by further increasing utilization management (e.g., shifting patient care from inpatient to outpatient settings). More stringent management of care would partly offset increases due to more generous coverage.

Costs

- CHRBP estimates that AB 1887 would increase total health care expenditures by $104.43 million per year for the population in plans subject to the mandate. This is an increase of approximately 0.14%.

- The mandate is estimated to increase premiums by about $123.8 million. The distribution of the impact on premiums is as follows:

    - Premiums for private employers are estimated to increase by $81.59 million per year, or 0.17%.
    - Enrollee contributions toward premiums for group insurance are estimated to increase by $42.10 million per year, or 0.228%.
    - The projected impact on PMPM total premiums (including both the employer and enrollee shares) varies by market segment. For DMHC-regulated plans, total premiums would range from $0.34 in the small group market to $0.48 in the large group. For CDI-regulated plans, total premiums would range of $1.64 in the large group to $1.66 in the individual market.

- Total premiums for individually purchased insurance would increase by about $21.96 million, or 0.36%. The share of premiums paid by individuals for group or public insurance would increase by $20.15 million, or 0.16%.

- The increase in individual premium costs would be partly offset by a decline in individual out-of-pocket expenditures (e.g., deductibles, copayments) of $19.39 million (–0.36%).

- CHBRP estimates that approximately 900 of the 812,000 individuals who currently purchase insurance products regulated by the California Department of Insurance (CDI) in the individual market would drop coverage due to the premium increases resulting from the mandate. This may be an overestimate if individuals value the new benefits more than the premium increase.

Public Health Impacts

- It is not possible to quantify the anticipated impact of the mandate on the public health of Californians because (1) the numerous approaches for treating MH/SA disorders and the multiple disorders (covered under AB 1887) on which these approaches may be applied renders a medical effectiveness analysis of mental health care treatment outside of the scope of this analysis; and (2) the literature review found an insufficient number of studies in the peer-reviewed scientific literature that specifically address physical, mental health, and social outcomes related to the implementation of mental health parity laws to evaluate whether mental health parity has an impact on health outcomes.

- Approximately 12% of the population have a MH/SA disorder that would make them eligible for coverage under the current mental health parity law (AB 88). A larger percentage of children with MH/SA disorders have mental illness diagnoses that qualify for parity coverage compared to adults (37% versus 5%). AB 1887 would expand coverage to a broader range of conditions so that over 4 million insured individuals with an MH/SA disorder diagnosis would be eligible for coverage.

- The scope of potential outcomes related to MH/SA treatment includes reduced suicides, reduced symptomatic distress, improved quality of life, reduced pregnancy-related complications, reduced injuries, improved medical outcomes, and improved social outcomes, such as a decrease in criminal activity.

- AB 1887 will alleviate a financial burden for some users of MH/SA treatment. While it is likely that AB 1887 will also have positive health outcomes for some people, to estimate these benefits at the population level, it is necessary to examine research on the relationship between mental health parity laws and health and social outcomes. At present, the literature is lacking in these areas, and therefore the impacts of AB 1887 on outcomes are unknown.

- Although the lifetime prevalence for mental disorders is similar for males and females, gender differences exist with regard to specific mental disorder diagnoses, with some having a much higher frequency in males and others in females. Overall, adult women are more likely to use mental health services than adult men.

- Race and poverty influence the risk of developing a mental disorder and the chance that treatment will be sought. There is substantial variation both across and within racial groups with respect to the prevalence of and treatment for MH/SA disorders. AB 1887 has the potential to reduce racial disparities in coverage for mental health treatment. There is no evidence, however, that AB 1887 would increase utilization of MH/SA treatment among minorities or that AB 1887 would decrease disparities with regard to health outcomes.

- Mental and substance abuse disorders are a substantial cause of mortality and disability in the United States. Substance abuse, in particular, often results in premature death. At present, there is no evidence that parity laws like AB 1887 result in a reduction of premature death.

- There are sizeable economic costs associated with mental and substance abuse disorders; however, the impact of AB 1887 on economic costs cannot be estimated.

- Another potential benefit of AB 1887 is that it would eliminate an insurance coverage disparity between psychological and medical conditions and could therefore help to destigmatize MH/SA treatment.

Table 1. Summary of Coverage, Utilization, and Cost Impacts of AB 1887

	Before Mandate	After Mandate	Increase/ Decrease	Change After Mandate
Coverage				
Mental health other than serious mental illness (SMI)				
Percentage of insured individuals with:				
Full parity coverage	0.00%	100.00%	100.00%	N/A
Non-parity coverage	91.78%	0.00%	–91.78%	–100%
No coverage	8.22%	0.00%	–8.22%	–100%
Number of insured individuals with:				
Full parity coverage	0	18,859,000	18,859,000	N/A
Non-parity coverage	17,309,000	0	–17,309,000	–100%
No coverage	1,550,000	0	–1,550,000	–100%
Substance use disorders				
Percentage of insured individuals with:				
Full parity coverage	0.00%	100.00%	100.00%	N/A
Non-parity coverage	81.85%	0.00%	-81.85%	-100%
No coverage	18.15%	0.00%	-18.15%	-100%
Number of insured individuals with:				
Full parity coverage	0	18,859,000	18,859,000	N/A
Non-parity coverage	15,436,000	0	–15,436,000	–100%
No coverage	3,423,000	0	–3,423,000	–100%
Utilization				
Mental health other than serious mental illness (SMI)				
Annual inpatient days per 1,000 members	2.8	2.9	0.1	4.36%
Annual outpatient visits per 1,000 members	198.5	222.4	23.9	12.03%
Substance use disorders				
Annual inpatient days per 1,000 members	6.4	7.5	1.1	17.05%
Annual outpatient visits per 1,000 members	32.7	41.7	9.0	27.41%
Average cost per service				
Mental health other than serious mental illness (SMI)				
Inpatient day	$970.08	$970.99	$0.91	0.09%
Outpatient visit	$90.31	$90.28	–$0.03	–0.03%
Substance use disorders				
Inpatient day	$843.72	$842.37	–$1.34	–0.16%
Outpatient visit	$67.46	$67.44	–$0.02	–0.03%

Table 1. Summary of Coverage, Utilization, and Cost Impacts of AB 1887 (Cont'd)

	Before Mandate	After Mandate	Increase/ Decrease	Change After Mandate
Expenditures				
Mental health other than serious mental illness (SMI)				
Premium expenditures by private employers for group insurance	$47,088,966,000	$47,141,651,000	$52,685,000	0.11%
Premium expenditures for individually purchased insurance	$6,158,288,000	$6,172,599,000	$14,311,000	0.23%
Premium expenditures by employees with group insurance or CalPERS, Healthy Families, AIM, or MRMIP	$12,299,958,000	$12,312,900,000	$12,942,000	0.11%
CalPERS employer expenditures	$2,942,984,000	$2,942,984,000	$0	0.00%
Medi-Cal state expenditures	$168,336,000	$168,328,000	–$8,000	0.00%
Healthy Families state expenditures	$644,074,000	$644,231,000	$157,000	0.02%
Individual out-of-pocket expenditures (deductibles, copayments, etc.)	$5,425,562,000	$5,405,308,000	–$20,254,000	–0.37%
Out-of-pocket expenditures for noncovered service	$0	$0	$0	N/A
Total annual expenditures	$74,728,168,000	$74,788,001,000	$59,833,000	0.08%
Substance use disorders (including nicotine)				
Premium expenditures by private employers for group insurance	$47,088,966,000	$47,117,869,000	$28,903,000	0.06%
Premium expenditures for individually purchased insurance	$6,158,288,000	$6,165,935,000	$7,647,000	0.12%
Premium expenditures by employees with group insurance or CalPERS, and by individuals with Healthy Families	$12,299,958,000	$12,307,161,000	$7,203,000	0.06%
CalPERS employer expenditures	$2,942,984,000	$2,942,984,000	$0	0.00%
Medi-Cal state expenditures	$168,336,000	$168,329,000	-$7,000	0.00%
Healthy Families state expenditures	$644,074,000	$644,061,000	-$13,000	0.00%
Individual out-of-pocket expenditures (deductibles, copayments, etc.)	$5,425,562,000	$5,426,428,000	$866,000	0.02%
Out-of-pocket expenditures for non-covered service	$0	$0	$0	N/A
Total annual expenditures	$74,728,168,000	$74,772,767,000	$44,599,000	0.06%
All services covered by mandate				
Premium expenditures by private employers for group insurance	$47,088,966,000	$47,170,554,000	$81,588,000	0.17%
Premium expenditures for individually purchased insurance	$6,158,288,000	$6,180,246,000	$21,958,000	0.36%
Premium expenditures by employees with group insurance or CalPERS, and by individuals with Healthy Families	$12,299,958,000	$12,320,103,000	$20,145,000	0.16%

Table 1. Summary of Coverage, Utilization, and Cost Impacts of AB 1887 (Cont'd)

	Before Mandate	After Mandate	Increase/ Decrease	Change After Mandate
CalPERS employer expenditures	$2,942,984,000	$2,942,984,000	$0	0.00%
Medi-Cal state expenditures[a]	$168,336,000	$168,321,000	$15,000	–0.01%
Healthy Families state expenditures	$644,074,000	$644,219,000	$145,000	0.02%
Individual out-of-pocket expenditures (deductibles, copayments, etc.)	$5,425,562,000	$5,406,173,000	–$19,389,000	–0.36%
Out-of-pocket expenditures for non-covered service	$0	$0	$0	N/A
Total annual expenditures	$74,728,168,000	$74,832,600,000	$104,432,000	0.14%

Source: California Health Benefits Review Program, 2008

Notes: The population includes employees and dependents covered by employer-sponsored insurance (including CalPERS), individually purchased insurance, and public health insurance provided by a health plan subject to the requirements of the Knox-Keene Health Care Service Plan Act of 1975. All population figures include enrollees aged 0–64 years and enrollees 65 years or older covered by employment sponsored insurance. Premium expenditures by individuals include employee contributions to employer-sponsored health insurance and member contributions to public health insurance.

[a]Medi-Cal state expenditures for members under 65 years of age include expenditures for Major Risk Medical Insurance Program (MRMIP) and Access for Infants and Mothers (AIM) program.

Key: CalPERS = California Public Employees' Retirement System

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CHBRP gratefully acknowledges all of these contributions but assumes full responsibility for all of the report and its contents. Please direct any questions concerning this report to:

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A group of faculty and staff undertakes most of the analysis that informs reports by the California Health Benefits Review Program (CHBRP). The CHBRP **Faculty Task Force** comprises rotating representatives from six University of California (UC) campuses and three private universities in California. In addition to these representatives, there are other ongoing contributors to CHBRP from UC. This larger group provides advice to the CHBRP staff on the overall administration of the program and conducts much of the analysis. The CHBRP **staff** coordinates the efforts of the Faculty Task Force, works with Task Force members in preparing parts of the analysis, and coordinates all external communications, including those with the California Legislature. The level of involvement of members of the CHBRP Faculty Task Force and staff varies on each report, with individual participants more closely involved in the preparation of some reports and less involved in others.

As required by the CHBRP authorizing legislation, UC contracts with a certified actuary, Milliman Inc. (Milliman), to assist in assessing the financial impact of each benefit mandate bill. Milliman also helped with the initial development of CHBRP methods for assessing that impact.

The **National Advisory Council** provides expert reviews of draft analyses and offers general guidance on the program to CHBRP staff and the Faculty Task Force. CHBRP is grateful for the valuable assistance and thoughtful critiques provided by the members of the National Advisory Council. However, the Council does not necessarily approve or disapprove of or endorse this report. CHBRP assumes full responsibility for the report and the accuracy of its contents.

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