Key Findings:

Analysis of California Assembly Bill 2193
Maternal Mental Health

Summary to the 2017–2018 California State Legislature, April 17, 2018

CALIFORNIA HEALTH BENEFITS REVIEW PROGRAM

AT A GLANCE

The version of California Assembly Bill 2193 analyzed by CHBRP would require OB-GYNs to screen mothers for maternal mental health conditions at least once during pregnancy and once postpartum. It would also require that plans and policies develop a case management program for maternal mental health conditions.

1. CHBRP estimates that, in 2019, all 23.4 million Californians enrolled in state-regulated health insurance will have insurance subject to AB 2193.
2. **Benefit coverage.** 100% of enrollees with health insurance subject to AB 2193 have coverage for mental health screenings during the prenatal and postpartum periods. No enrollees currently have coverage for follow-up case management that would be fully compliant with AB 2193. The benefits for which AB 2193 requires coverage do not appear to exceed the essential health benefits (EHBs).
3. **Utilization.** Postmandate, CHBRP estimates that the overall number of pregnant women enrolled in DMHC-plans or CDI-policies would remain 407,000. The mental health screening rate would increase to 90%, which would increase the number of women screened by 43,000 women. This increase would result in an additional 10,000 women receiving needed mental health treatment after screening positive for a mental health condition.
4. **Expenditures.** AB 2193 would increase total net annual expenditures by $4,519,000 or 0.0029% for enrollees in DMHC-regulated plans and CDI-regulated policies. This is due to a $3,952,000 increase in total health insurance premiums paid by employers and enrollees for covered benefits, plus an increase of $567,000 for enrollee out-of-pocket costs.
5. **Medical effectiveness.** There is clear and convincing evidence that screening programs for postpartum women can reduce the risk of depression 3 to 5 months postpartum and increase the likelihood of depression remission or response at 6 to 14 months postpartum. There is insufficient evidence to conclude whether screening for anxiety disorders, bipolar disorders, or postpartum psychosis during pregnancy or postpartum leads to changes in relevant health outcomes. For case management to treat anxiety disorders, bipolar disorder, or postpartum depression, CHBRP finds insufficient evidence to conclude whether there is an associated change in health outcomes. However, CHBRP finds a preponderance of evidence that case management interventions are effective in promoting timely, frequent engagement with mental health treatment for perinatal depression.
6. **Public health.** In the first year postmandate, CHBRP estimates that due to AB 2193, 43,000 more women will be screened for maternal mental health disorders, which will result in increased linkages to treatment and symptom reduction.
7. **Long-term impacts.** The long-term public health impacts include a consistent improvement in access to maternal mental health treatment and related reduction in symptoms among those who are identified and screened.

CONTEXT

Maternal mental health (MMH) disorders comprise a range of distinct disorders, including depression, anxiety disorders, bipolar disorder, and postpartum psychosis.[1] To be characterized as an MMH disorder, women must demonstrate relevant symptoms for at least one of the following periods:

1. **Prenatal period** (i.e., during pregnancy, also called “antenatal”);
2. **Postpartum period** (i.e., within 1 year of giving birth, also called “postnatal”); or
3. **Perinatal period** (i.e., both during pregnancy and post-pregnancy — up to 1 year after giving birth, also called “peripartum”)**.**

Terminology and definitions for these periods may vary somewhat across sources. While also prevalent among new mothers, “baby blues,” which is characterized as emotional sensitivity, low mood, and/or feeling overwhelmed and occurring up 2 weeks postpartum, is not considered a MMH disorder

BILL SUMMARY

AB 2193 would require obstetrician-gynecologists (OB-GYNs) to screen mothers for maternal mental health conditions at least once during pregnancy and once postpartum. It would also require that health care service plans and health insurance policies develop a case management program for enrollees or insureds who may have a maternal mental health condition. The case management program shall include:

- Direct access to a clinician assigned to the provider and the patient;

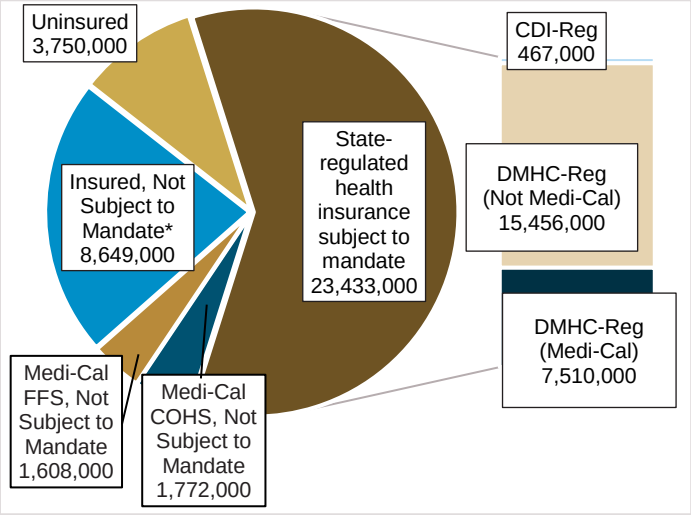
[1] Refer to CHBRP’s full report for full citations and references.

- Direct access for the enrollee to a therapist trained in maternal mental health;
- Direct access for the provider and enrollee to psychiatric consultation with a psychiatrist familiar with research related to pregnant and lactating women;
- When a treatment plan is available, clinical case managers to follow the enrollee's treatment and symptoms, and to document the enrollee's status to the enrollee's provider at least once every 8 months.

At the request of the California Assembly Committee on Health, CHBRP's analysis of AB 2193 incorporates one amendment in draft form and not yet published that would limit the scope of the bill to OB-GYNs instead of any provider treating a mother or a child.

Figure 1 notes how many Californians have health insurance that would be subject to AB 2193.

Figure 1. Health Insurance in CA and AB 2193



Source: California Health Benefits Review Program, 2018.

Notes: * Medicare beneficiaries, enrollees in self-insured products, etc.

Key: CDI = California Department of Insurance; COHS = County Organized Health System; DMHC = California Department of Managed Health Care; FFS = Fee-for-Service.

IMPACTS

Benefit Coverage, Utilization, and Cost

Benefit Coverage

At baseline, 100% of enrollees with health insurance subject to AB 2193 have coverage for mental health screenings during the prenatal and postpartum periods. No enrollees currently have coverage for follow-up case management that would be fully compliant with AB 2193. There are existing case management programs, but they do not appear to include all components of case management the bill outlines: direct access for the enrollee to a therapist trained in maternal mental health, direct access for the provider and enrollee to psychiatric consultation with a psychiatrist familiar with research related to pregnant and lactating women; and clinical case managers to follow the enrollee's treatment and symptoms, and to document the enrollee's status to the enrollee's provider at least once every 8 months.

Utilization

On the basis of existing literature, CHBRP assumes different rates of screening and reporting of depressive symptoms between women with private insurance coverage and women who are enrolled in Medi-Cal managed care plans.

Of an estimated total of 226,000 pregnant enrollees with commercial or CalPERS insurance subject to AB 2193, an additional 40,000 women with will receive some MMH screening, a 24% increase in overall screening rate. As a result of screening, an additional 5,000 women will be identified as having symptoms (22% increase), and an additional 2,000 women will be diagnosed with a MMH disorder (29% increase). This brings the total number of women who may be enrolled in case management as a result of AB 2193 to 9,000 women; of these, an additional 5,000 women will receive mental health services (250% increase).

Of an estimated total of 181,000 pregnant Medi-Cal managed care enrollees with insurance subject to AB 2193, an additional 3,000 women will receive some MMH screening, a 2% increase in the overall screening rate. As a result of screening, an additional 1,000 will be identified as having symptoms (2% increase). Although there will be no significant increase in the number of women diagnosed

due to already high screening rates for Medi-Cal, a total of 13,000 diagnosed women may be enrolled in case management as a result of AB 2193. Of these, 5,000 additional women will receive mental health services due to the more comprehensive case management required under AB 2193 (125% increase).

Expenditures

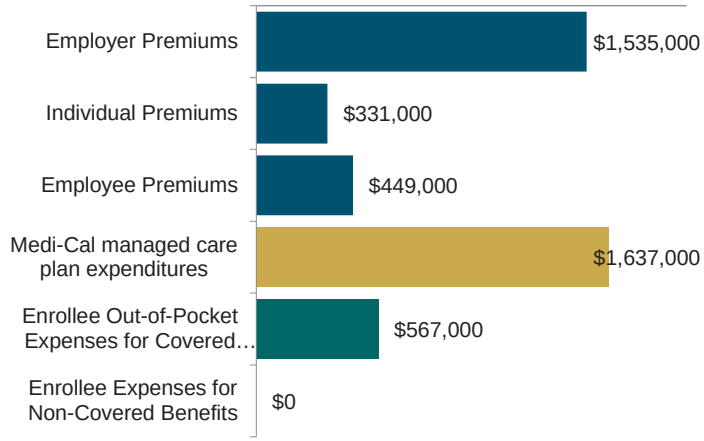
In the first year postmandate, AB 2193 would increase total net annual expenditures by $4,519,000 or 0.0029% for enrollees with DMHC-regulated plans and CDI-regulated policies.

This is due to a $3,952,000 increase in total premiums paid by employers and enrollees, plus an increase of $567,000 in enrollee expenses for covered benefits (out-of-pocket costs like deductibles and copayments).

This is equivalent to an increase of $1.54 on average per pregnant woman with coverage subject to AB 2193 who receives perinatal screening. CHBRP estimates are based on claims data and may underestimate the cost savings for enrollees due to carriers' ability to negotiate discounted rates that are unavailable to patients and their families.

Figure 2. Expenditure Impacts of AB 2193

Net Change: $4,519,000



Source: California Health Benefits Review Program, 2018.

Medi-Cal

Due to the increase in screening and connection to treatment for maternal mental health disorders, CHBRP estimates an increase in Medi-Cal managed care plan expenditures of $1,637,000 (0.0056%) in the first year postmandate.

CalPERS

CHBRP estimates an increase in CalPERS HMO employer expenditures of $108,000 (0.0020%) in the first year postmandate.

Number of Uninsured in California

AB 2193 would have no measureable impact projected on the number of uninsured in California.

Medical Effectiveness

CHBRP examined the medical effectiveness of the bill's major tenets — screening for maternal mental health disorders and case management for maternal mental health disorders. The majority of research literature is related to postpartum depression.

Postpartum depression screening: There is clear and convincing evidence that screening programs in postpartum women can reduce the risk of depression 3 to 5 months postpartum (compared to women who did not take part in the program), and increase the likelihood of depression remission or response at 6 to 14 months postpartum.

Perinatal screening for anxiety disorders, bipolar disorder, or postpartum psychosis: There is insufficient evidence to conclude whether screening for anxiety disorders, bipolar disorders, or postpartum psychosis during pregnancy or postpartum leads to changes in relevant health outcomes (condition risk, remission, treatment response).

Case management for perinatal depression: There is inconclusive evidence to determine whether case management leads to changes in health outcomes relevant to depression in pregnant and postpartum women (remission, symptom burden, functional status). However, CHBRP finds a preponderance of evidence from three primary studies and a well-conducted systematic review that case management interventions similar to the requirements proposed in AB 2193 are effective in promoting timely and frequent engagement with mental health treatment for perinatal depression.

Case management to treat anxiety disorders, bipolar disorder, or postpartum depression: CHBRP finds insufficient evidence to conclude whether case management for anxiety disorders, bipolar disorders, or postpartum psychosis during pregnancy or postpartum leads to changes in relevant health outcomes (remission, symptom burden, functional status). Insufficient evidence is not "evidence of no effect." It is possible that an impact could result, but current evidence is insufficient to inform an estimate.

Table A summarizes the medical effectiveness findings specific to perinatal depression. For a full summary table of the medical effectiveness findings, see the Medical Effectiveness section.

Table A. Abbreviated Medical Effectiveness Summary

	Perinatal Depression
Screening alone	Insufficient evidence
Screening/Intervention Program Participation	Clear and convincing evidence, effective –postpartum women Limited evidence, effective — pregnant women
Sharing Screening Results	Insufficient evidence
Screening Tool Accuracy	Preponderance of evidence, effective — EPDS accuracy Inconclusive evidence — PHQ accuracy
Case Management	Preponderance of evidence, effective — treatment engagement Limited evidence, not effective — depression outcomes
Treatment	Clear and convincing evidence, effective — behavioral interventions Preponderance of evidence, effective – pharmacotherapy

Source: California Health Benefits Review Program, 2018.

Abbreviations: EPDS, Edinburgh Postnatal Depression Scale; PHQ, Patient Health Questionnaire.

Public Health

In the first year postmandate, CHBRP estimates that due to AB 2193, 43,000 more women will be screened for maternal mental health disorders, which will result in increased linkages to treatment and symptom reduction.

CHBRP estimates that as a result of increased screening due to AB 2193, a total of 22,000 women will be eligible for case management, and of these, 10,000 additional women will receive treatment for a maternal mental health condition. It stands to reason that women enrolled in case management will be more likely to access the care and treatments to which they are referred, which may in turn lead to improved health outcomes, but the extent to which this will occur is unknown as the structure and intensity of MMH case management programs developed as a result of AB 2193 are likely to vary across health plans.

In the first year postmandate, despite increased utilization, the public health impact of prenatal and postpartum screenings and case management due to AB 2193 for other MMH disorders besides maternal depression is unknown due to insufficient or inconclusive evidence regarding screening/case management programs. It stands to reason that if appropriate screening tools are used, more women with these disorders will be detected and receive some form of treatment, the majority of which were shown to be effective. The absence of evidence is not "evidence of no effect." It is possible that an impact could result, but current evidence is insufficient to inform an estimate.

Long-Term Impacts

Following the 1-year period modeled in the CHBRP Cost and Coverage Model, CHBRP expects that the rates of annual utilization of maternal mental health screening, diagnosis, case management, and treatment would remain consistent with the model's findings. Growth in utilization of mental health services will be tempered by a projected shortage of mental health providers, most notably psychiatrists.

Long-term, the cost impacts of AB 2193 will most likely occur in the reduction of high-cost health care associated with emergency situations or hospitalization, although there will be some increase in costs due to increases in

appropriate preventive care, in proportion to the utilization changes discussed above.

The long-term public health impacts include a consistent improvement in access to maternal mental health treatment and linked reduction in symptoms among those who are identified and screened. More accurate and potentially higher prevalence estimates for MMH disorders may become apparent as more women are identified through increased screening.

Furthermore, increased screening by health care professionals may help normalize discussions around maternal mental health and increase awareness of these issues. Case management may be particularly helpful to low income women with MMH issues as case managers may be able to help keep them connected with MMH care.

According to the research literature, the increase in identification of maternal mental health conditions and their subsequent treatment will lead to better health outcomes for both mothers and their children.

Essential Health Benefits and the Affordable Care Act

It is likely that treatment for mental health conditions during pregnancy and the postpartum period as described in AB 2193 would fall under outpatient or inpatient behavioral or mental health services which are categorized as EHB-covered benefits in the description of the state's EHB benchmark plan. Benefits required by AB 2193 do not appear to exceed the definition of EHBs in California.