Key Findings

Analysis of California Assembly Bill 2242 Mental Health Services

Summary to the 2019–2020 California State Legislature, April 10, 2020

CALIFORNIA HEALTH BENEFITS REVIEW PROGRAM

AT A GLANCE

The version of California Assembly Bill 2242 analyzed by CHBRP would require Department of Managed Health Care (DMHC)–regulated plans and California Department of Insurance (CDI)–regulated policies to schedule an initial outpatient appointment with a licensed mental health professional on a date that is within 48 hours of a person's release from an involuntary, 72-hour psychiatric hold. The bill also has requirements regarding geographic proximity to mental health services, and it limits cost sharing for the outpatient mental health follow-up visit to in-network amounts, even if the patient sees an out-of-network provider.

1. CHBRP estimates that, in 2021, of the 21.7 million Californians enrolled in state-regulated health insurance subject to benefit mandates, 13,363,000 enrollees in commercial and CalPERS DMHC-regulated plans and CDI-regulated policies will have coverage subject to AB 2242.
2. **Benefit coverage.** CHBRP estimates that 100% of enrollees have coverage for 72-hour treatment and evaluation holds and 100% have coverage for follow-up visits after the 72-hour hold at baseline and postmandate. CHBRP estimates there are 59,200 enrollees who are subject to AB 2242 and detained for 72-hour treatment and evaluation holds at baseline, as well as postmandate (no change). Mental health services are one of the ten essential health benefits (EHBs), and AB 2242 appears not to exceed the definition of EHBs in California.
3. **Utilization.** At baseline, CHBRP estimates 14,300 enrollees (24% the 59,200 enrollees who had a 72-hour hold) have a follow-up visit scheduled within 48 hours of discharge; 23,100 (39%) have a visit between 3 and 90 days; and 21,800 (37%) have no follow-up visit within 90 days. CHBRP estimates that postmandate 23,100 enrollees will shift to having a visit earlier (within 48 hours of discharge rather than in the 3- to 90-day timeframe), and that an additional 3,700 enrollees will have a follow-up visit postmandate.
4. **Expenditures.** CHBRP estimates that AB 2242 would increase total net annual expenditures by $1,559,000 or about 0.001% for enrollees with DMHC-regulated plans and CDI-regulated policies. This is due to an increase of $1,840,000 in total health insurance premiums paid by employers and enrollees, adjusted by a $281,000 decrease in enrollee expenses for covered benefits.
5. **Medical effectiveness.** The medical effectiveness review for this report summarizes the literature on the impacts of receiving follow-up outpatient mental health services after discharge from inpatient mental health care in general; the literature is not specific to involuntary holds, which may take place in an emergency department (ED), an outpatient mental health crisis center, or an inpatient psychiatric facility.
    a. There is *inconclusive evidence* that receiving follow-up outpatient mental health services is associated with a reduction in hospital readmissions.
    b. There is *insufficient evidence* that timely follow-up care with a mental health provider reduces ED visits or improves medication adherence.
    c. There is *insufficient evidence* to determine whether receiving timely follow-up outpatient mental health services, after discharge from inpatient mental care, improves mental health outcomes.
    d. There is *inconclusive evidence* that scheduling visits for follow-up outpatient mental health services after discharge from inpatient mental care affects use of mental health services, including hospital readmissions.
    e. There is *insufficient evidence* to determine whether access to outpatient mental health providers in close proximity to a patient's business or residence increases receipt of follow-up outpatient mental health services following discharge from inpatient mental care or improves mental health outcomes.

f. There is *limited evidence* that reducing cost sharing for follow-up outpatient mental health services increases use of these services.

g. There is *insufficient evidence* to determine if reducing cost sharing for follow-up outpatient mental health services improves mental health outcomes.

6. **Public health.** CHBRP estimates that 26,800 persons with commercial insurance would receive outpatient appointments within 48 hours of discharge after a 72-hour hold in the first year postmandate; however, CHBRP is unable to project a change in: (1) ED visits/emergency medical services use; (2) hospital readmissions; or (3) suicide and attempted suicide, due to insufficient or inconclusive evidence that the provisions mandated in AB 2242 would reduce emergency and inpatient mental health services use or improve mental health outcomes.

7. **Long-term impacts**. CHBRP estimates that after the initial 12 months from the enactment of AB 2242, utilization of follow-up visits after release from 72-hour holds will likely be similar to utilization estimates during the first 12 months postmandate, and that annual costs will likely be similar to the costs during the first 12 months postmandate. It is possible that mental health providers and plans/policies may prioritize patients with recent 5150s due to their high-risk status; however, given the projected diminishing supply of providers relative to demand, the ability of mental health providers to meet the 48-hour appointment standard for persons with a 5150 discharge, as mandated by AB 2242, will likely decrease over time along with potential improvements in health outcomes attributable to increased and earlier outpatient appointment access.

CONTEXT

In California, the Lanterman-Petris-Short Act authorizes peace officers and mental health professionals to place an involuntary hold on persons — adults or children — who, for reasons related to mental health, are a danger to others, or themselves, or gravely disabled. During involuntary holds, commonly known as "5150s" in reference to the relevant California code number, patients are taken into custody for up to 72 hours, stabilized, and evaluated for additional treatment needs. Patients with 5150s must be evaluated at facilities designated to receive persons with involuntary mental health holds; these facilities include most emergency departments, psychiatric hospitals, VA hospitals, and some outpatient mental health crisis centers. Although there is no mandated standard of care after a 5150 discharge, it is generally accepted that prompt follow-up with outpatient mental health providers after discharge from a psychiatric hospitalization is critical for maintaining continuity of treatment and preventing repeat hospitalizations.[1]

There were 157,795 72-hour involuntary detentions in California in fiscal year 2016-2017, of which 136,116 were for adults aged 18 years and older and 21,679 for children aged 17 years or younger. California's Office of the Patient Advocate (OPA) reported that in 2018, 37% to 75% of persons aged 6 years and older with commercial insurance had access to an outpatient mental health appointment within 7 days after discharge for a psychiatric hospitalization and 57% to 84% had access to this type of appointment within 30 days of discharge.

Mental health provider supply is a significant barrier to outpatient appointment access. In California, the mental health workforce is distributed unevenly throughout the state and it is projected that, by 2028, California will have 50% fewer psychiatrists and 28% fewer nonphysician mental health professionals than will be needed to meet current patterns of behavioral health demand and unmet demand.

BILL SUMMARY

AB 2242 would require a health care service plan contract or a health insurance policy that is issued, amended, or renewed on or after January 1, 2021, that includes coverage for mental health services to:

1. Approve the provision of mental health services for enrollees/insureds who are detained for 72-hour treatment and evaluation (5150).

2. Schedule an initial outpatient appointment for the enrollee/insured with a licensed mental health professional on a date that is within 48 hours of the person's release from detention.

3. Ensure the location of the facilities providing the covered mental health services (references #1 above) be within reasonable proximity of the business or personal residences of the enrollee/insured.

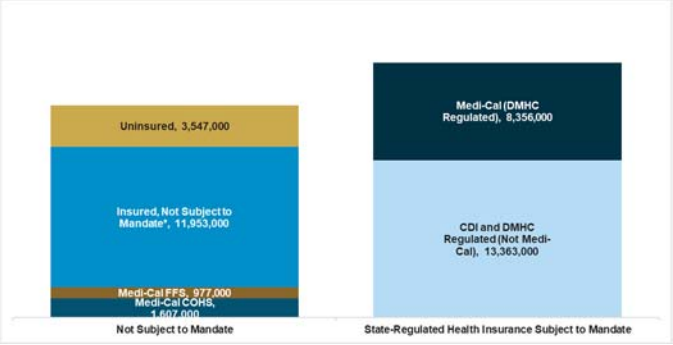
[1] Refer to CHBRP's full report for full citations and references.

4. Provide that an enrollee/insured who receives covered mental health services from a noncontracting provider shall pay no more than the same cost-sharing amount as if the services were received from a contracting provider.

5. Pay the noncontracting provider and inform them of the cost-sharing amount owed by the enrollee/insured.

Figure A shows the number of Californians who have health insurance; these are shown in two groups – those not subject to state mandates and those that may be subject to mandates. AB 2242 does not apply to Medi-Cal (Managed Care, Fee for Service, and County Organized Health Systems/COHS) or Medicare.

Figure A. Health Insurance in California



Source: California Health Benefits Review Program, 2020.

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

IMPACTS

Benefit Coverage, Utilization, and Cost

Benefit Coverage

CHBRP estimates that 100% of the 13,363,000 enrollees in commercial and CalPERS DMHC-regulated plans and CDI-regulated policies would be subject to AB 2242; these enrollees make up 62% of all enrollees subject to state-level benefit mandates. All enrollees (100%) have coverage for 72-hour treatment and evaluation holds as well as follow-up visits after release from a hold. CHBRP estimates there are 59,200 enrollees who are subject to AB 2242 and detained for 72-hour treatment and evaluation holds at baseline, as well as postmandate (no change).

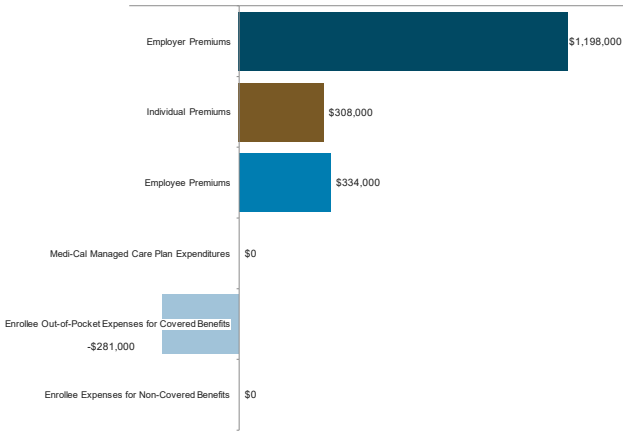
Utilization

CHBRP estimates at baseline that 14,300 enrollees (24% the 59,200 enrollees who had a 5150 hold) have a follow-up visit scheduled within 48 hours of discharge; 23,100 (39%) have a visit between 3-90 days; and 21,800 (34%) have no follow-up visit within 90 days. CHBRP finds at baseline that about 11,900 of enrollees with a follow-up visit scheduled within 48 hours of discharge have a follow-up visit with an in-network provider and 2,400 have a visit with an out-of-network provider. Under a best-case scenario model where shortages of mental health providers do not restrict the feasibility of health plans and insurers scheduling follow-up visits within 48 hours of discharge postmandate, CHBRP estimates that 23,100 enrollees will shift to having a visit earlier (within 48 hours of discharge rather than in the 3- to 90-day timeframe), and that an additional 3,700 enrollees will have a follow-up visit postmandate.

Expenditures

CHBRP estimates that AB 2242 would increase total net annual expenditures by $1,559,000 or about 0.001% for enrollees with DMHC-regulated plans and CDI-regulated policies. This is due to an increase of $1,840,000 in total health insurance premiums paid by employers and enrollees, adjusted by a $281,000 decrease in enrollee expenses for covered benefits (Figure B). CHBRP estimates that all market segments will have a similar-sized reduction in enrollee out-of-pocket expenditures due to AB 2242 of approximately $0.002 per member per month resulting from enrollees seeing out-of-network providers but paying in-network cost sharing postmandate.

Figure B. Expenditure Impacts of AB 2242



Source: California Health Benefits Review Program, 2020.

CHBRP estimated the potential increase in administration costs associated with health plans and insurers developing an information technology infrastructure to schedule outpatient mental health

appointments for enrollees released from a 5150 hold; these costs were estimated at $14 per scheduled appointment postmandate.

Medi-Cal

CHBRP estimates no impact for DMHC-regulated enrollees associated with Medi-Cal managed care, as these plans are not subject to AB 2242.

CalPERS

CHBRP estimates that total employer premium expenditures for CalPERS HMOs will increase by $59,000, or 0.002%. For CalPERS HMO enrollees, the impact on premiums is an increase of 0.002%.

Number of Uninsured in California

Because the change in average premiums does not exceed 1% for any market segment, CHBRP estimates AB 2242 would have no measurable impact on the number of uninsured persons.

Medical Effectiveness

The medical effectiveness review for this report summarizes the literature on the impacts of receiving follow-up outpatient mental health services after discharge from inpatient mental health care in general; the literature is not specific to involuntary holds, which may take place in an emergency department (ED), an outpatient mental health crisis center, or an inpatient psychiatric facility.

The medical effectiveness review finds:

- There is *inconclusive evidence*[2] that receiving follow-up outpatient mental health services is associated with a reduction in hospital readmissions.
- There is *insufficient evidence*[3] that timely follow-up care with a mental health provider reduces ED visits or improves medication adherence.
- There is *insufficient evidence* to determine whether receiving timely follow-up outpatient mental health services, after discharge from inpatient mental care, improves mental health outcomes.
- There is *inconclusive evidence* that scheduling visits for follow-up outpatient mental health services after discharge from inpatient mental care affects use of mental health services, including hospital readmissions.
- There is *insufficient evidence* to determine whether access to outpatient mental health providers in close proximity to a patient's business or residence increases receipt of follow-up outpatient mental health services following discharge from inpatient mental care or improves mental health outcomes.
- There is *limited evidence*[4] that reducing cost sharing for follow-up outpatient mental health services increases use of these services.
- There is *insufficient evidence* to determine if reducing cost sharing for follow-up outpatient mental health services improves mental health outcomes.

Public Health

CHBRP estimates that 26,800 persons with commercial insurance would receive outpatient appointments within 48 hours of discharge after a 5150 hold in the first year postmandate; however, CHBRP is unable to project a change in: (1) ED visits/emergency medical services use; (2) hospital readmissions; or (3) suicide and attempted suicide, due to insufficient or inconclusive evidence that the provisions mandated in AB 2242 would reduce emergency and inpatient mental health services use or improve mental health outcomes.

Additionally, although there are known racial and ethnic disparities in the prevalence of severe mental illness (SMI) in adults and serious emotional disturbances (SED) in children, CHBRP did not identify any evidence regarding racial or ethnic disparities in who receives 5150s or in who receives follow-up outpatient mental treatment after a 5150 hold in California. Therefore, the extent to which AB 2242 would have an impact on potential disparities is also unknown.

[2] *Inconclusive evidence* indicates that although some studies included in the medical effectiveness review find that a treatment is effective, a similar number of studies of equal quality suggest the treatment is not effective.

[3] *Insufficient evidence* indicates that there is not enough evidence available to know whether or not a treatment is effective, either because there are too few studies of the treatment or because the available studies are not of high quality. It does not indicate that a treatment is not effective.

[4] *Limited evidence* indicates that the studies had limited generalizability to the population of interest and/or the studies had a fatal flaw in research design or implementation.

For the proportion of enrollees who would receive follow-up outpatient mental health care within 48 hours of a 5150 discharge as a result of AB 2242, it stands to reason that more treatment might be beneficial, but current evidence is insufficient to inform a population-level estimate of the impact of new or earlier access to outpatient mental health visits.

Long-Term Impacts

CHBRP estimates that after the initial 12 months from the enactment of AB 2242, utilization of follow-up visits after release from 5150 holds will likely be similar to utilization estimates during the first 12 months postmandate. If supply-side constraints are addressed such that there is an increase in the number of licensed mental health professionals who could meet the demand for outpatient mental health outpatient visits, utilization could improve significantly over time. However, it is unknown if and when such increases in mental health professionals are likely to occur.

As with the utilization impacts in the long term, CHBRP estimates that after the initial 12 months from the enactment of AB 2242, annual costs will likely be similar to the costs during the first 12 months postmandate. If there is an increase in mental health professionals available to see patients for outpatient visits in- and out-of-network, it is possible that costs will change significantly; however, CHBRP is unable to estimate long-term changes.

It is possible that mental health providers and plans/policies may prioritize patients with recent 5150s due to their high-risk status; however, given the projected diminishing supply of providers relative to demand, the ability of mental health providers to meet the 48-hour appointment standard for persons with a 5150 discharge, as mandated by AB 2242, will likely decrease over time along with potential improvements in health outcomes attributable to increased and earlier outpatient appointment access. Moreover, in areas with current mental health professional shortages, these diminishing health returns may be experienced sooner than for areas with more robust supplies of mental health providers.

Essential Health Benefits and the Affordable Care Act

Mental health services are one of the 10 essential health benefits (EHBs). Health plans and insurers that are required to cover EHBs must meet mental health parity requirements, which previously did not apply to the individual and small-group markets in California. Because mental health services are an EHB category, AB 2242 would not require coverage for a new state benefit mandate that appears to exceed the definition of EHBs in California.

At the time of this CHBRP analysis, there is substantial uncertainty regarding the impact of the COVID-19 pandemic on premium rates and health plan enrollment, including how the pandemic will impact healthcare costs in 2021. Because the variance of potential outcomes is significant, CHBRP does not take these effects into account as any projections at this point would be speculative, subject to federal and state decisions and guidance currently being developed and released. In addition, insurers', providers', and consumers' responses are uncertain and rapidly evolving to the public health emergency and market dynamics.