



CALIFORNIA
HEALTH BENEFITS REVIEW PROGRAM

EXECUTIVE SUMMARY
Analysis of Assembly Bill 244:
Health Care Coverage: Mental Health
Services

A Report to the 2009-2010 California Legislature
April 17, 2009

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California Health Benefits Review Program Analysis of Assembly Bill 244: 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) 244 Health Care Coverage: Mental Health Services, as introduced by Assembly Member Jim Beall on February 13, 2009. This bill would expand the mandated coverage for mental health benefits from the limited conditions currently covered—severe mental illness for individuals of all ages and serious emotional disturbances in children—to a broader range of conditions. The bill would also extend the “parity” requirement for mental health benefits from the limited conditions covered in current law to a broader range of conditions. The parity requirement mandates that coverage for mental health benefits be no more limited than coverage for other medical conditions. The effective date of AB 244 is January 1, 2010.

Under the proposed mandate, health plans and insurers would be required to cover all mental health benefits at parity for persons with all disorders defined in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV). By virtue of their inclusion in the DSM-IV, diagnosis and treatment of substance use disorders would be included and covered at parity levels.

Health insurance products regulated by the Department of Managed Health 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.

Under current state 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. The state law requires parity with respect to enrollee cost-sharing for covered benefits; however, the state law does not require parity with respect to treatment limitations.

Under the recently enacted federal law—The Mental Health Parity and Addiction Equity Act (MHPA)—health plans and insurers that *offer* mental health coverage to groups must provide coverage that is no more restrictive than coverage for other medical/surgical benefits. This parity provision applies to financial requirements (e.g., deductibles and copayments) and treatment limitations (e.g., number of visits or days of coverage). The law applies to all group health plans for plan years beginning after October 3, 2009. Small employers of 50 or fewer employees are exempt. State parity laws will continue to apply to these employers, as well as to individual plans. Although AB 244 defines mental illness as those disorders defined in the DSM-IV, the MHPA does not specify a definition for mental health and substance use disorders.

In this analysis, the impacts described are based on the changes in coverage attributable to AB 244 *after* the implementation of the federal MHPA. In Table 1, for example, the “adjusted” baseline reflects the expected costs and coverage post-MHPA. Tables presenting the change in coverage between existing state law and the federal MHPA are included in Appendix D. Use of this “adjusted” baseline in the main tables in the *Utilization, Cost, and Coverage Impacts* section was adopted because the MHPA will have been enacted before the effective date of AB 244.

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 244 applies. However, the literature on all treatments for MH/SA conditions covered by AB 244—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 the 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 may 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 greater productivity and quality of life and reduction in illegal activity.

- When assessing the studies' implications of parity in coverage for MH/SA services, several important caveats should be kept in mind:
 - The generalizability of studies of MH/SA parity to AB 244 is limited because
 - No studies have examined the effects of parity in coverage for nonsevere mental illnesses separately from severe mental illnesses, which health plans and health insurers in California are already required to cover at parity.
 - Only a few studies have assessed the impact of parity in coverage for substance abuse services separately from mental health services.
 - In most studies, the subjects had some level of coverage for MH/SA services prior to the implementation of parity and, thus, may have responded differently than Californians enrolled in health plans or health insurance policies that do not cover nonsevere mental illness or substance abuse services.
 - The effects of parity in MH/SA coverage are difficult to separate from the effects of more intensive management of MH/SA services, because many employers that have implemented parity in MH/SA coverage have simultaneously intensified the management of MH/SA services.
- 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 is 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.
- Inpatient admissions for MH/SA conditions per 1,000 members decrease.
- Utilization of MH/SA services increases slightly among
 - Persons with substance abuse disorders
 - Persons with moderate levels of symptoms of mood and anxiety disorders
 - Persons employed by moderately small firms (50-100 employees) who have poor mental health or low-incomes.
- 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.
- 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. MH/SA parity is associated with a decrease in outpatient visits among persons enrolled in FFS plans and an increase among persons enrolled in HMOs.
- 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 or 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.
 - No studies were located that assessed the impact of MH/SA parity laws on recovery from chemical dependency.

Utilization, Cost, and Coverage Impacts

All estimates in the Executive Summary and the body of this report use adjusted (post-MHPA) baseline figures, because MHPA would take effect prior to AB 244. For estimates of current (pre-MHPA) coverage and costs, please refer to Appendix D.

Coverage

- In California, SMI services are already covered under AB 88, so AB 244 focuses on the incremental effect of extending parity to non-SMI and substance use disorders.

- CHBRP estimates that 18,009,000 insured individuals would be subject to the mandate. However, services for non-SMI and substance use disorders services would already be covered at parity for large employers (>50 employees) under MHPA at the time AB 244 would take effect, so the impact of AB 244 would be limited to the small-group and individual markets.
- Pre-mandate, about 64% of individuals in policies subject to AB 244 would have parity coverage for non-SMI disorders, 35% would have less than full parity coverage and 1% would have no coverage. About 64% would have parity coverage for substance use disorders, 30% would have less than full parity coverage and 6% would have no coverage. Post-mandate, 100% of these individuals would have coverage for both non-SMI and substance use disorders.

Utilization

- CHBRP estimates that among individuals in policies subject to AB 244, utilization would increase by 9.1 outpatient mental health visits (4.10%) and 1.8 outpatient substance abuse visits (8.70%) per 1,000 members per year as a result of the mandate. Annual inpatient days per 1,000 members would increase by 0.00 (0.06%) for mental health and by 0.4 (4.97%) 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.
- Although utilization of behavioral healthcare is also limited by factors other than limited insurance coverage (e.g., stigma, limited availability of specialty providers), the CHBRP estimates, which are based on empirical utilization data, implicitly take these barriers into account.

Costs

- Total net annual expenditures among insured individuals subject to state regulation are estimated to increase by about \$34.6 million, or 0.04%.

- AB 244 is estimated to increase premiums by about \$46.4 million. The distribution of the impact on premiums is as follows:
 - Total premiums for private employers are estimated to increase by \$21.1 million per year, or 0.04%.
 - Total premiums for individually purchased insurance would increase by about \$22.5 million, or 0.38%. The increase in individual premium costs would be partly offset by a decline in individual out-of-pocket expenditures (e.g., deductibles, copayments) of about \$12 million (−0.19%).
 - Enrollee contributions toward premiums for group or public insurance are estimated to increase by \$4.7 million per year, or 0.04%.
 - The projected impact varies by market segment. For DMHC-regulated plans, total PMPM premiums would increase by \$0.28 in the small-group market and by \$0.29 in the individual market. For CDI-regulated plans, total PMPM premiums would increase by \$1.44 in the small-group market and \$1.54 in the individual market.

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 244) 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.
- 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, reduced employment absenteeism, reduced cessation of employment, and improved social outcomes, such as a decrease in criminal activity.
- There is insufficient evidence to evaluate the effect of parity in private insurance coverage for non-SMI and substance-use disorders on incarceration.
- AB 244 will alleviate a financial burden for some users of MH/SA treatment. Although it is likely that AB 244 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 244 on outcomes are unknown. The exception is for tobacco use disorders, where the increased utilization of tobacco cessation pharmaceuticals is expected to result in 649 persons quitting tobacco use, which is estimated to yield California approximately 4,400 years of life gained per year.

- 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 244 has the potential to reduce racial disparities in coverage for mental health treatment. There is no evidence, however, that AB 244 would increase utilization of MH/SA treatment among minorities or that AB 244 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 244 result in a reduction of premature death. Again, the exception is for the 649 persons expected to quit tobacco use, which is estimated to reduce mortality and disability.
- There are sizeable economic costs associated with mental and substance abuse disorders; however, the total impact of AB 244 on economic costs cannot be estimated.
- Another potential benefit of AB 244 is that it would eliminate an insurance coverage disparity in the individual and small-group insurance market between psychological and physical health conditions and could therefore help to destigmatize MH/SA treatment.

Table 1. Summary of Coverage, Utilization, and Cost Impacts of AB 244

	Before Mandate (e)	After Mandate	Increase/ Decrease	Change After Mandate
Coverage				
Total population in plans subject to state regulation (a)	21,340,000	21,340,000	0.00%	0%
Total population in plans subject to AB 244	18,009,000	18,009,000	0.00%	0%
<i>Mental health other than serious mental illness</i>				
Percentage of individuals with:				
Full-parity coverage	63.86%	100.00%	36.14%	57%
Less than full parity coverage	34.82%	0.00%	-34.82%	-100%
No coverage	1.33%	0.00%	-1.33%	-100%
Number of individuals with:				
Full parity coverage	11,500,000	18,009,000	6,509,000	57%
Less than full parity coverage	6,267,000	0	-6,270,000	-100%
No coverage	239,000	0	-239,000	-100%
<i>Substance use disorders</i>				
Percentage of insured individuals with:				
Full parity coverage	63.86%	100.00%	36.14%	57%
Less than full parity coverage	30.20%	0.00%	-30.20%	-100%
No coverage	5.94%	0.00%	-5.94%	-100%
Number of insured individuals with:				
Full parity coverage	11,500,000	18,009,000	6,509,000	57%
Less than full parity coverage	5,439,000	0	-5,439,000	-100%
No coverage	1,070,000	0	-1,070,000	-100%
Utilization and Cost				
<i>Mental health other than serious mental illness</i>				
Annual inpatient days per 1,000 members	3.2	3.2	0.0	0.06%
Annual outpatient visits per 1,000 members	222.3	231.4	9.1	4.10%
Average cost per inpatient day	\$857.71	\$858.15	\$0.44	0.05%
Average cost per outpatient visit	\$87.25	\$87.27	\$0.02	0.03%
<i>Substance use disorders</i>				
Annual inpatient days per 1,000 members	7.1	7.4	0.4	4.97%
Annual outpatient visits per 1,000 members	21.1	22.9	1.8	8.70%
Average cost per inpatient day	\$760.73	\$761.87	\$1.14	0.15%
Average cost per outpatient visit	\$78.03	\$78.07	\$0.05	0.06%

Table 1. Summary of Coverage, Utilization, and Cost Impacts of AB 244 (Cont'd)

	Before Mandate (e)	After Mandate	Increase/ Decrease	Change After Mandate
Expenditures				
<i>Mental health other than serious mental illness</i>				
Premium expenditures by private employers for group insurance	\$50,589,301,000	\$50,604,647,000	\$15,346,000	0.03%
Premium expenditures for individually purchased insurance	\$5,944,229,000	\$5,962,106,000	\$17,877,000	0.30%
Premium expenditures by individuals with group insurance, CalPERS, Healthy Families, AIM, or MRMIP (b)	\$13,487,348,000	\$13,490,699,000	\$3,351,000	0.02%
CalPERS employer expenditures (c)	\$3,163,264,000	\$3,163,264,000	\$0	0.00%
Medi-Cal state expenditures (d)	\$4,112,865,000	\$4,111,618,000	-\$1,247,000	-0.03%
Healthy Families state expenditures	\$643,247,000	\$643,385,000	\$138,000	0.02%
Individual out-of-pocket expenditures for covered benefits (deductibles, copayments, etc.)	\$6,371,036,000	\$6,359,787,000	-\$11,249,000	-0.18%
Out-of-pocket expenditures for noncovered benefits	\$0	\$0	\$0	N/A
Total annual expenditures	\$84,311,290,000	\$84,335,506,000	\$24,216,000	0.03%
<i>Substance use disorders (including nicotine)</i>				
Premium expenditures by private employers for group insurance	\$50,589,301,000	\$50,595,062,000	\$5,761,000	0.01%
Premium expenditures for individually purchased insurance	\$5,944,229,000	\$5,948,812,000	\$4,583,000	0.08%
Premium expenditures by individuals with group insurance, CalPERS, Healthy Families, AIM, or MRMIP (b)	\$13,487,348,000	\$13,488,729,000	\$1,381,000	0.01%
CalPERS employer expenditures (c)	\$3,163,264,000	\$3,163,264,000	\$0	0.00%
Medi-Cal state expenditures (d)	\$4,112,865,000	\$4,112,094,000	-\$771,000	-0.02%
Healthy Families state expenditures	\$643,247,000	\$643,213,000	-\$34,000	-0.01%
Individual out-of-pocket expenditures for covered benefits (deductibles, copayments, etc.)	\$6,371,036,000	\$6,370,482,000	-\$554,000	-0.01%
Out-of-pocket expenditures for noncovered benefits	\$0	\$0	\$0	N/A
Total annual expenditures	\$84,311,290,000	\$84,321,656,000	\$10,366,000	0.01%

Table 1. Summary of Coverage, Utilization, and Cost Impacts of AB 244 (Cont'd)

	Before Mandate (e)	After Mandate	Increase/ Decrease	Change After Mandate
<i>All services covered by mandate</i>				
Premium expenditures by private employers for group insurance	\$50,589,301,000	\$50,610,408,000	\$21,107,000	0.04%
Premium expenditures for individually purchased insurance	\$5,944,229,000	\$5,966,688,000	\$22,459,000	0.38%
Premium expenditures by individuals with group insurance, CalPERS, Healthy Families, AIM, or MRMIP (b)	\$13,487,348,000	\$13,492,080,000	\$4,732,000	0.04%
CalPERS employer expenditures (c)	\$3,163,264,000	\$3,163,264,000	\$0	0.00%
Medi-Cal state expenditures (d)	\$4,112,865,000	\$4,110,847,000	-\$2,018,000	-0.05%
Healthy Families state expenditures	\$643,247,000	\$643,351,000	\$104,000	0.02%
Individual out-of-pocket expenditures for covered benefits (deductibles, copayments, etc.)	\$6,371,036,000	\$6,359,235,000	-\$11,801,000	-0.19%
Out-of-pocket expenditures for noncovered benefits	\$0	\$0	\$0	N/A
Total annual expenditures	\$84,311,290,000	\$84,345,873,000	\$34,583,000	0.04%

Source: California Health Benefits Review Program, 2009.

Notes: (a) This population includes privately insured (group and individual) and publicly insured (e.g., CalPERS, Medi-Cal, Healthy Families, AIM, MRMIP) individuals enrolled in health insurance products regulated by DMHC or CDI. Population includes enrollees aged 0-64 years and enrollees 65 years or older covered by employment sponsored insurance.

(b) Premium expenditures by individuals include employee contributions to employer-sponsored health insurance and member contributions to public insurance.

(c) Of the CalPERS employer expenditures, about 59% would be state expenditures for CalPERS members who are state employees, however CHBRP estimates no impact of the mandate on CalPERS employer expenditures.

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

(e) "Before mandate" reflects the adjusted (post-MHPA) baseline. See Appendix D for current (pre-MHPA) estimates.

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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