



CALIFORNIA
HEALTH BENEFITS REVIEW PROGRAM

Analysis of Senate Bill 572 Mental Health Benefits

A Report to the 2005-2006 California Legislature
April 16, 2005

CHBRP 05-06



Established in 2002 to implement the provisions of Assembly Bill 1996 (*California Health and Safety Code*, Section 127660, et seq.), the California Health Benefits Review Program (CHBRP) responds to requests from the State Legislature to provide independent analysis of the medical, financial, and public health impacts of proposed health insurance benefit mandates. The statute defines a health insurance benefit mandate as a requirement that a health insurer and/or managed care health plan (1) permit covered individuals to receive health care treatment or services from a particular type of health care provider; (2) offer or provide coverage for the screening, diagnosis, or treatment of a particular disease or condition; or (3) offer or provide coverage of a particular type of health care treatment or service, or of medical equipment, medical supplies, or drugs used in connection with a health care treatment or service.

A small analytic staff in the University of California's Office of the President supports a task force of faculty from several campuses of the University of California, as well as Loma Linda University, the University of Southern California, and Stanford University, to complete each analysis within a 60-day period, usually before the Legislature begins formal consideration of a mandate bill. A certified, independent actuary helps estimate the financial impacts, and a strict conflict-of-interest policy ensures that the analyses are undertaken without financial or other interests that could bias the results. A National Advisory Council, made up of experts from outside the state of California and designed to provide balanced representation among groups with an interest in health insurance benefit mandates, reviews draft studies to ensure their quality before they are transmitted to the Legislature. Each report summarizes sound scientific evidence relevant to the proposed mandate but does not make recommendations, deferring policy decision-making to the Legislature. The State funds this work through a small annual assessment of health plans and insurers in California. All CHBRP reports and information about current requests from the California Legislature are available at CHBRP's Web site, www.chbrp.org.

A Report to the 2005-2006 California State Legislature

Analysis of Senate Bill 572 Mental Health Benefits

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PREFACE

This report provides an analysis of the medical, financial, and public health impacts of Senate Bill 572 Mental Health Benefits a bill to mandate the “coverage of the diagnosis and medically necessary treatment of mental illnesses of a person of any age and of serious emotional disturbances of a child under the same terms and conditions as applied to other medical conditions, as specified.” In response to a request from the California Senate Banking, Finance, and Insurance Committee on February 15, 2005, the California Health Benefits Review Program (CHBRP) undertook this analysis pursuant to the provisions of Assembly Bill 1996 (2002) as chaptered in Section 127600, et seq., of the California Health and Safety Code.

Patricia Franks, BA, and Edward Yelin, PhD, both of the University of California, San Francisco (UCSF), prepared the analysis of the effects of implementation of mental health parity laws and the medical effectiveness analysis. Min-Lin Fang, MLIS, of UCSF conducted the literature search. M. Audrey Burnam, PhD, Director, Center for Research in Alcohol, Drug Abuse, and Mental Health, Rand Corporation, provided technical assistance with the literature review and clinical expertise for the medical effectiveness analysis. Helen Halpin, PhD, Sara McMenamin, PhD, and Nicole Bellows, MHSA, of the University of California, Berkeley, prepared the public health impact analysis. Gerald Kominski, PhD, Miriam Laugesen, PhD, and Nadereh Pourat, PhD, all of the University of California, Los Angeles, and Patricia Franks, BA, of UCSF prepared the analysis of the cost impact. Robert Cosway, FSA, MAAA, and Chris Girod, FSA, MAAA, of Milliman, provided actuarial analysis. Patricia Franks, BA, of UCSF, Susan Philip, MPP, and Sachin Kumar, BA of CHBRP staff prepared the background section and contributed to integrating the individual sections into a single report. Other contributors include Cynthia Robinson, MPP, Robert O’Reilly, BS, of CHBRP staff, and Sarah Ordody, who provided editing services. In addition, a subcommittee of CHBRP’s National Advisory Council (see final pages of this report) reviewed the analysis for its accuracy, completeness, clarity, and responsiveness to the Legislature’s request.

Jay Ripps, FSA, MAAA of Milliman recused himself from contributing to this and all other CHBRP analyses beginning March 1, 2005. His recusal is valid through his duration as acting chief actuary at Blue Shield of California.

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 CHBRP:

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EXECUTIVE SUMMARY

California Health Benefits Review Program Analysis of Senate Bill 572

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 Senate Bill (SB) 572, Mental Health Benefits, a bill that would mandate “coverage for the diagnosis and medically necessary treatment of mental illnesses of a person of any age, and of serious emotional disturbances of a child...under the same terms and conditions applied to other medical conditions.” SB 572 would amend Section 1374.72 of California’s Health and Safety Code and Section 10144.5 of the Insurance Code relating to health care coverage.

The intent of SB 572 is to expand health insurance coverage of mental health conditions from a limited number of conditions to comprehensive coverage for all mental disorders defined in the *Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV)*.¹

Current law, also known as Assembly Bill (AB) 88, Health Care Coverage: Mental Illness, was signed into law in September 1999 and added Section 1374.72 to California’s Health and Safety Code and Section 10144.5 to the Insurance Code. The law was implemented in July 2000. AB 88 requires that health plans and insurers cover nine specific conditions known as “severe mental illnesses” (SMIs) of persons of any age, under the same terms and conditions as other medical conditions. AB 88 also requires coverage for “serious emotional disturbances” (SEDs) among children.

Under current law and under the proposed mandate, SB 572, “parity” means that the same terms and conditions applied to hospital, medical, and surgical coverage for other health conditions would be applied to coverage for the diagnosis of and medically necessary treatment for mental health conditions. The terms and conditions that would apply equally include, but are not limited to, maximum lifetime benefits; copayments and coinsurance; and individual and family deductibles.

Services that would be mandated at parity levels include outpatient services, inpatient hospital services, partial hospital services, as well as prescription drug coverage for those plans and policies that include prescription drug coverage.

SB 572 would apply to health care service plans licensed by Knox-Keene² and to health insurance policies regulated under the California Insurance Code. It would not apply to contracts between the State Department of Health Services and a health care service plan for enrolled Medi-Cal beneficiaries.

¹ Mental disorders included in subsequent editions of the DSM-IV would be covered. The exceptions are those codes defining substance abuse disorders (291.0 to 292.9, inclusive, and 303.0 to 305.9, inclusive) and the “V” codes.

² Health maintenance organizations in California are licensed under the Knox-Keene Health Care Services Plan Act, which is part of the California Health and Safety Code.

CHBRP's analysis of SB 572 is designed to:

- Provide background information on policies and legislation in California, other states, and at the federal level affecting health insurance coverage for mental health conditions.
- Assess evidence on the effects of implementation of state and federal mental health parity policies as a means to improve access to mental health services, quality of services, and health outcomes of adults and children with mental health conditions.
- Review evidence from the medical effectiveness literature on outcomes of treatment of mental health conditions at parity levels.
- Analyze utilization, cost, and coverage impacts of mental health parity provisions under SB 572.
- Evaluate the potential public health impacts of SB 572.

I. Effects of Implementation of Mental Health Parity Laws

- General characteristics of state and federal mental health parity laws are:
 - Federal and state mental health parity laws have created a multi-tiered system of benefits and benefit limitations based on different definitions of parity and of mental health conditions to be covered under parity.
 - The federal government and several states use the expanded definition of mental health conditions proposed in SB 572 in mental health parity laws.
 - Some states have moved to a comprehensive definition of mental health conditions to be covered under parity; other states, including California, are considering such legislation.
- There are still relatively few comprehensive evaluations of implementation of mental health parity laws at the federal level or among states.
- Most implementation studies have focused on:
 - The effects on, and responses of, employers, health plans, and Managed Behavioral Healthcare Organizations (MBHOs)
 - The costs to these stakeholders, pre- and post-parity
 - The utilization of services over the short term.
- Key findings of the implementation studies are:
 - Implementation of mental health parity laws affects many stakeholders, including federal, state, and local government agencies; employers providing health insurance benefits; individuals purchasing health insurance for themselves; insurers and plans (HMOs, PPOs, POS, FFS³); MBHOs; providers; and consumers) both over the long and short term.
 - Some studies report that parity laws have increased access for both adults and children.

³ FFS = fee for service; HMO = health maintenance organization; POS = point of service; PPO = preferred provider organization

- Other evaluation studies indicate that evidence of increased access is mixed. Employers, health plans, and MBHOs may be exercising options through benefit design, benefit limitations, and utilization management that are affecting access as well as controlling utilization and costs.
- One evaluation study in California reported in early 2002 on the implementation of AB 88 in the first year:
 - This study found the following positive impacts of AB 88:
 - most aspects of implementation had gone smoothly
 - health insurance benefits for mental health services had been expanded
 - adverse consequences in the health insurance market did not occur
 - health insurance premiums did not increase substantially, and
 - employers did not drop health coverage for their employees or become self insured to avoid the state's parity mandate.
 - The study found the following negative impacts of AB 88:
 - implementation of parity for selected conditions (SMI) and serious emotional disturbances (SED) of a child, rather than all mental health diagnoses, created administrative challenges and confusion
 - several large health insurers changed coverage to MBHOs from integrated physician services, disrupting care for some consumers, and
 - consumers were not well informed about changes and providers often had to act as intermediaries for their patients.
- Within California, several evaluations of the implementation of AB 88 are currently being conducted and will be available within the next three to six months. These studies are:
 - An in-depth follow-up to the “snapshot” study discussed previously.
 - A survey of health plans and MBHOs by the Department of Managed Care to assess major issues of concern in implementation of AB 88.
 - A report on mental health parity required under SB 1103, which was passed in 2004, from the Department of Mental Health in collaboration with the Department of Managed Care and the Department of Insurance.

A comprehensive evaluation of the implementation of mental health parity in the Federal Employee Health Benefit Program will also become available within the next few months.

II. Medical Effectiveness

- No studies in the peer-reviewed scientific literature specifically address health outcomes (e.g., reduction in risk of suicide, suicide attempts, suicides; reduction in mental and emotional distress; increased well-being; improved function; decreased school and work absences; increases in productivity) related to the implementation of mental health parity

laws, comparisons of health outcomes in parity versus non-parity states, or comparisons in health outcomes before and after parity.

- The medical effectiveness of mental health parity policies, such as covering a certain set of mental health conditions (e.g., SMI versus other mental health conditions), a certain “package” of treatment interventions, or a certain number of outpatient visits or inpatient days (e.g., 10 versus 20 outpatient visits/year or 30 inpatient days/year versus unlimited inpatient days/year), in ameliorating certain mental health conditions, is not addressed in the mental health parity literature reviewed in this analysis.
- Health effects and outcomes are the last in a chain of events that begins with health insurance coverage of mental health benefits (i.e., diagnoses covered; services covered; and terms, rates, and conditions of service coverage, including copayments, coinsurance, and deductibles), access to mental health treatments and services, consumers seeking treatment and services, and consumers obtaining appropriate and effective treatment and services. In the published literature reviewed in this analysis, no studies were found that investigated how implementation of mental health parity laws has affected this chain of events for individuals, vulnerable populations, health plan groups, or national and state population samples.
- Several public policy makers and researchers have called for studies of health outcomes under mental health parity, including studies of effectiveness, efficiency, and equity of mental health services, and the use of health plan performance measures for mental health services by all health plans and MBHOs.

III. Utilization, Cost, and Coverage Impacts

- Coverage for some level of non-SMI mental health care currently approaches 91% in California among the insured population. However, only 2% of the insured population has full parity coverage for services for all conditions falling within the broad scope of SB 572.
- CHBRP estimates that 17,168,000 people in specified health plans and insurance policies would be subject to the mandate and that the number of individuals who would receive new coverage as a result of the mandate is 16,798,000 people.
- CHBRP has estimated that modest utilization changes would occur as a result of the mandate. Increased utilization would result from an elimination of benefit limits (e.g., limits on number of annual hospital days and outpatient visits) and reduced cost-sharing levels (e.g. copayments that may be higher than for other health care services). Increased utilization would also result for people who previously had no coverage at all of mental health treatment for conditions other than those defined in AB 88 as SMIs. However, increased utilization would be somewhat mitigated as health plans react by strengthening their utilization management (e.g., shifting consumers from inpatient to outpatient settings).

- It is estimated that SB 572 will increase total health care costs by \$118,596,000 per year for the population in plans subject to the mandate. This is an increase of approximately 0.2115%.
- Total premiums paid by all private employers in California would increase by an estimated \$111,423,000 per year, or 0.3151%. The impact on per member per month premiums varies by market segment. Large group FFS plans would experience the largest increase of \$2.24. Large group HMOs would experience the smallest increase of \$0.17.
- Out-of-pocket expenditures are estimated to decrease by \$40,288,000, a decline of 0.9888%.

Table 1. Summary of Utilization, Cost, and Coverage Effects of SB 572

	Before Mandate	After Mandate	Increase/ Decrease	Change
Total insured population = 17,168,000				
<u>Coverage</u>				
Percentage of insured individuals with full coverage for mandated benefit	2%	100%	98%	98%
Number of insured individuals in California with full coverage for the benefit	370,000	17,168,000	16,798,000	4540%
Number of insured individuals with limited coverage for the benefit	15,102,000	0	-15,102,000	-100%
Number of insured individuals in California without coverage for the benefit	1,696,000	0	-1,696,000	-100%
<u>Utilization</u>				
Annual inpatient days per 1,000 members	3.37	3.29	-0.08	-2.3739%
Annual outpatient visits per 1,000 members	228.27	247.75	19.48	8.5338%
<u>Annual Expenditures</u>				
Premium expenditures by private employers for group insurance	\$35,360,055,000	\$35,471,478,000	\$111,423,000	0.3151%
Premium expenditures by individuals with group insurance, CalPERS, or Healthy Families	\$10,261,105,000	\$10,290,592,000	\$29,487,000	0.2874%
Premium expenditures for individually purchased insurance	\$3,818,726,000	\$3,834,730,000	\$16,004,000	0.4191%
CalPERS employer expenditures	\$2,212,881,000	\$2,214,511,000	\$1,630,000	0.0737%
Medi-Cal state expenditures	\$0	\$0	\$0	0.0000%
Healthy Families state expenditures	\$347,858,000	\$348,198,000	\$340,000	0.0977%
Out-of-pocket expenditures and other expenditures for noncovered services	\$4,074,535,000	\$4,034,247,000	-\$40,288,000	-0.9888%
Total annual expenditures	\$56,075,160,000	\$56,193,756,000	\$118,596,000	0.2115%

Source: California Health Benefits Review Program, 2005.

Notes: The population includes individuals and dependents in California who have private insurance (group and individual), or are enrolled in public plans subject to the Health and Safety Code, including CalPERS, and Healthy Families.

Employees and their dependents that receive their coverage from self-insured firms are excluded because these plans are not subject to mandates. SB 572 would not apply for Medi-Cal beneficiaries.

Key: CalPERS = California Public Employees' Retirement System.

IV. Public Health Impacts

- It is not possible to quantify the anticipated impact of the mandate on the public health of California because 1) the numerous approaches for treating mental disorders, and the multiple disorders on which they may be applied renders a medical effectiveness analysis of mental health care *treatment* outside the scope of this analysis; and 2) the literature review found no studies in the peer-reviewed scientific literature that specifically address health outcomes related to the implementation of mental health parity laws.
- Approximately 20% of the United States population is estimated to have a mental disorder each year, amounting to more than 4 million privately insured Californians. The state's current mental health parity law (AB 88) already specifies a subset of the population with mental disorders for which parity is explicitly required—roughly estimated at 20% of those 4 million Californians estimated to have a mental disorder. SB 572 would require parity for the more than 3.2 million remaining Californians estimated to have a mental disorder estimated each year. It important to recognize that this estimate reflects the difference between what health plans are *required by law* to cover under AB 88 and SB 572.
- In 2001, 14.4% of surveyed privately insured Californians reported needing help for emotional/mental health problems and 8.1% reported having seen a health professional for mental or emotional problems in the past 12 months. Of those who reported needing help for emotional/mental health problems, 33.6% reported having taken prescription medication for emotional/mental health problems.
- Mental health treatment includes inpatient and outpatient services. Various forms of psychotherapy and pharmacologic therapies are used to treat mental disorders. Although the health impacts of SB 572 cannot be quantified, the scope of potential outcomes includes reduced suicides, reduced inpatient psychiatric care, reduced symptomatic distress, improved quality of life, health improvements for co-morbid conditions, and other social outcomes. Any improvements in outcomes resulting from SB 572 are dependent on changes in access to care, utilization of care, and the appropriateness and effectiveness of treatment. While an increase in utilization of outpatient mental health treatment is anticipated in the Utilization, Cost, and Coverage analysis, the impact of SB 572 on health outcomes could not be estimated, due to the lack of information on the appropriateness and effectiveness of various mental health treatments.
- 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. 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 mental disorders. In general, minority groups are less likely than Whites to receive treatment for mental disorders. SB 572 has the potential to reduce racial disparities in *coverage* for mental health treatment. It would not, however, necessarily translate into a significant reduction of disparities in those receiving mental health treatment.

- Mental disorders are a substantial cause of disability in the United States, resulting in economic losses associated with productivity. The annual indirect cost for mental disorders was estimated at \$94 billion for 1992. Any changes in premature death and indirect costs resulting from SB 572 are dependent on changes in access to care, utilization of care, and the appropriateness and effectiveness of treatment. While an increase in utilization of outpatient mental health treatment is anticipated in the Utilization, Cost and Coverage analysis, the impact of SB 572 on premature death and indirect costs could not be estimated due to the lack of information on the appropriateness and effectiveness of various mental health treatments.

INTRODUCTION

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 Senate Bill (SB) 572 Mental Health Benefits, a bill that would mandate “coverage for the diagnosis and medically necessary treatment of mental illnesses of a person of any age, and of serious emotional disturbances of a child...under the same terms and conditions applied to other medical conditions.” SB 572 would amend Section 1374.72 of California’s Health and Safety Code and Section 10144.5 of the Insurance Code relating to health care coverage.

The intent of SB 572 is to expand coverage of mental health conditions from a limited number of conditions to comprehensive coverage for all mental disorders defined in the Diagnostic and Statistical Manual IV (DSM-IV).⁴

Current law, also known as Assembly Bill (AB) 88, Health Care Coverage: Mental Illness, was signed into law in September 1999 and added Section 1374.72 to California’s Health and Safety Code and Section 10144.5 to the Insurance Code. The law was implemented in July 2000. AB 88 requires that health plans and insurers cover nine specific conditions known as “severe mental illnesses” (SMIs), of persons of any age under the same terms and conditions as other medical conditions. AB 88 also requires coverage for “serious emotional disturbances” (SEDs) among children.

Under current law and under the proposed mandate, SB 572, “parity” means that the same terms and conditions applied to hospital, medical, and surgical coverage for other health conditions would be applied to coverage for the diagnosis of and medically necessary treatment for mental health conditions. The terms and conditions that apply equally include, but are not limited to:

- Maximum lifetime benefits
- Copayments and coinsurance
- Individual and family deductibles

Services that would be mandated at parity levels include outpatient services, inpatient hospital services, partial hospital services, as well as prescription drug coverage for those plans and policies that include prescription drug coverage.

SB 572 would apply to health care services plans licensed by Knox-Keene⁵ and to health insurance policies regulated under the California Insurance code. It would not apply to contracts between the State Department of Health Services and a health care service plan for enrolled Medi-Cal beneficiaries.

The bill includes several additional provisions for health plans, which indicate that the mandate would not prohibit plans from engaging in its regular utilization and case management functions. Specifically, plans and insurers would not be prohibited from:

- 1) Providing coverage for all or part of mental health services required through a separate specialized health care service plan or mental health plan without obtaining an additional license for the purpose.

⁴ Mental disorders included in subsequent editions of the DSM-IV would be covered. The exceptions are those codes defining substance abuse disorders (291.0 to 292.9, inclusive, and 303.0 to 305.9, inclusive) and the “V” codes.

⁵ Health maintenance organizations in California are licensed under the Knox-Keene Health Care Services Plan Act, which is part of the California Health and Safety Code.

- 2) Providing coverage in an entire service area or in emergency situations as may be required by applicable laws and regulations.
- 3) Requiring enrollees who reside or work in geographic areas served by specialized health care service plans or mental health plans to secure all or part of their services within the geographic areas served by the plans.
- 4) Utilizing case management, network providers, utilization review techniques, prior authorization, copayments, or other cost-sharing.

CHBRP's analysis of SB 572 is designed to:

- Provide background information on policies and legislation in California, other states, and at the federal level affecting health insurance coverage for mental health conditions.
- Assess evidence on the effects of implementation of state and federal mental health parity policies as a means to improve access to mental health services, quality of services, and health outcomes of adults and children with mental health conditions.
- Review evidence from the medical effectiveness literature on outcomes of treatment of mental health conditions at parity levels.
- Analyze utilization, cost, and coverage impacts of mental health parity provisions under SB 572.
- Evaluate the potential public health impacts of SB 572.

CHBRP took this approach to the analysis of SB 572 for four reasons:

- 1) The DSM-IV includes more than 400 distinct diagnoses. The subset not including severe mental illnesses and serious emotional disturbances among children would be subject to the mandate of SB 572. Traditional analysis of evaluating the medical effectiveness of every type of potential intervention for each mental health condition is not feasible within a 60-day time frame for CHBRP analysis.
- 2) Many mental health conditions are treated by identical or similar types of therapy, and an analysis of which therapies cross-cut conditions and their medical effectiveness for each condition would be complex.
- 3) There is a lack of treatment protocols or guidelines for many mental health conditions, as well as a lack of consensus among providers about appropriate and effective courses of treatment for some mental health conditions, as there is for other health conditions.
- 4) As mental health policies have been implemented at the federal level and within several states, including California, since the early to mid-1990s, more information on the effects of parity laws on costs, utilization, and access have become available, or are becoming available, through evaluation studies of implementation. These data include effects of mental health parity policies on different stakeholders (e.g., federal, state, and local government, employers providing health benefits, individuals purchasing their own health insurance, health plans, managed behavioral health organizations, providers, and consumers). In discussions with legislative staff, it was decided that this body of evidence is most relevant to policy makers' consideration of SB 572.

Mental Health Parity Legislative Activity in California

In California and in other states, as well as on a federal level, mandating mental health benefits has been an ongoing policy process (Bao and Sturm, 2004). California has mandated that health insurers and employee benefit plans offer coverage for health services since 1983 (Peck, 2003). There were early attempts to require mental health parity in the mid-1980s. In 1989, California legislators developed a bill

for the first time that addressed mental disorders by diagnosis (Peck, 2003). In 1997, AB 1100, a predecessor bill to AB 88, included seven SMI diagnostic disorders and SEDs of children. In December 1998, AB 88 was introduced in the legislature. In February 1999, SB 468, a predecessor bill to SB 572, was introduced proposing to mandate comprehensive coverage of mental health conditions. SB 468 was amended several times in 1999 and was left without action in the Assembly in November 2000. AB 88 was passed by the Senate and Assembly in August 1999 and signed into law in September 1999. SB 572 was introduced on February 18, 2005 and amended on March 29, 2005.

Table 2 compares AB 88 and SB 572 in terms of covered diagnoses. The additional mental health conditions that would be covered under SB 572 can be grouped into four areas.

Table 2: Mental health condition diagnoses covered under AB 88 and SB 572

<p>Mental health condition diagnoses covered under AB 88</p> <ul style="list-style-type: none"> • Anorexia Nervosa • Autism • Bipolar Disorder • Bulimia Nervosa • Major Depression • Panic Disorder • Schizoaffective Disorder • Obsessive-Compulsive Disorder • Schizophrenia 	<p><i>Additional</i> Mental health condition diagnoses proposed under SB 572</p> <ul style="list-style-type: none"> • Psychoses and Neuroses • Personality Disorders • Sexual Disorders • Other Conditions
<p>SED for Children</p>	

Mental Health Parity Legislative Activity among Other States

Mental health legislation been an important point of discussion in health care policy for more than 40 years, and mental health parity legislation continues to remain on the agenda in many state legislatures and in the Congress.

Types of Mental Health Laws

Three terms commonly used to describe mental health laws are 1) mental health “parity” or equal coverage laws, 2) minimum mandated mental health benefit laws, and 3) mandated mental health “offering” laws.⁶

Mental health “parity” or equal coverage laws: Parity laws require that insurers provide the same level of benefits for mental disorders (and sometimes for substance abuse problems) as for other health conditions and diseases. Parity also requires that benefit limitations for mental health conditions be the same as benefit limitations for other health conditions. Parity laws differ across states and among federal

⁶ National Conference of State Legislatures (2005). *State Laws Mandating or Regulating Mental Health Benefits* <http://www.ncsl.org/programs/health/Mentalben.htm>.(accessed April 7, 2005).

laws in terms of insurance policies affected by the laws, types of benefit, types of benefit limitations, and types of mental health conditions covered.

Parity laws generally do not apply to federal/state funded programs, such as Medicaid, or federally funded programs, such as Medicare and the Veterans Benefits Administration. Employer self-funded or self-insured health insurance plans, often sponsored by large employers, are also exempt from state parity laws through the federal Employee Retirement Income Security Act (ERISA) of 1974.

Minimum mandated mental health benefits laws: Mandated benefit laws require that some level of mental health coverage be provided, but discrepancies are permitted between the level of mental health benefits provided and those for other health conditions. Also, benefit limitations do not have to be equal.

Mandated mental health “offering” laws: Offering laws do not require that any benefits be provided. However, the laws may require that an option of coverage for mental health conditions be offered to insured persons, or that offered mental health benefits must be equal to offered health benefits.

Prior to 1991, 23 states had passed laws mandating some level of coverage for the treatment of mental illness; however, no state at the time required coverage for mental illness on the same level as treatment of other illnesses.¹

In 1991, North Carolina and Texas enacted legislation that provided equal coverage for mental illness and other illnesses. Although these laws applied only to their respective state employee health plans, and thus affected only state and local government employee populations, these statutes were the first of their kind in the nation. The Texas law applied only to serious mental illness until it was amended in 2001, switching coverage levels from full parity to providing a minimum mandated benefit for serious mental illness.¹

Forty-six states and the District of Columbia have now passed some type of legislation related to mental health benefits. Thirty-four states have passed laws on mental health parity. These laws have taken many different forms; statutes have ranged from requiring parity coverage for all mental health conditions listed in the DSM-IV to coverage at parity levels for a certain set of illnesses. Between three and thirteen of these conditions are commonly referred to as either SMI or biologically based mental illness (BBMI). Other states have elected to implement benefit “floors”, or minimum mandated benefit laws. These laws generally indicate a certain number of inpatient hospitalization days and outpatient visits related to mental illness that a health plan must provide.¹

The remaining four states do not have any specific mental health parity laws in place.

- Nine states (Arkansas, Connecticut, Maryland, Minnesota, North Carolina², Rhode Island, South Carolina², Vermont, and Washington) have *mental health parity laws* that mandate parity coverage for all mental disorders as defined by the latest revision of the DSM-IV. Some states also mandate coverage of substance abuse disorders. These states are described as having comprehensive or broad-based definitions of mental health conditions to be covered.

¹State Laws Mandating or Regulating Mental Health Benefits, National Conference of State Legislatures. Downloaded April 8, 2005 from McKinley NCSL’s Health Policy Tracking Service: Parity and other Insurance Mandates for the Treatment of Mental Illness and Substance Abuse. April 2004

- Other states (Louisiana, Nebraska, Nevada, Tennessee, and Rhode Island) have passed *minimum mandated benefit laws*. Some of these states have extended benefits to all mental illnesses in the DSM-IV, while others extend benefits only to BBMI. In addition, some states noted set minimum inpatient/outpatient coverage requirements or have specified that coinsurance rates must be the same as those provided for other illnesses.
- Arizona, Missouri, Georgia, Indiana, Kentucky, and Utah have chosen to require parity or benefit floors if mental health benefits are offered (*mandated offering laws*).
- A large number of states, including California, have extended parity level benefits to a specific set of diagnoses—those illnesses considered to be SMI or BBMI. In addition to California, these states include Colorado, Delaware, Hawaii, Illinois, Maine, Massachusetts, Montana, New Hampshire, New Jersey, New Mexico, Oklahoma, South Dakota, Virginia, and West Virginia. These states are described as having narrow, limited, or restricted definitions of mental health conditions to be covered in their parity laws.
- As summarized in Table 2, in California, nine conditions are considered SMI—schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, panic disorder, obsessive compulsive disorder, pervasive developmental disorders or autism, anorexia nervosa, and bulimia nervosa.

Of the states that currently require full parity for all mental illness, two states have amended laws to expand coverage from BBMI to all mental health conditions. Connecticut previously provided coverage for BBMI (1997) but in 2000 changed its law to expand coverage parity to all mental health illness (Connecticut General Statutes, Section 38a-488a). Rhode Island’s 1995 law was restricted to “full parity” coverage of “serious mental illness” for individual, group, self-insured, and HMO policies. Legislation in 2000 expanded “full parity” coverage to all mental illnesses and substance abuse disorders (Chapter 27-38.2, Rhode Island General Laws). New Hampshire in 2002 extended policies covered under mental health parity to any policy or group or blanket accident or health insurance, with parity for biologically based mental illnesses and mandated benefits for other mental health conditions and substance abuse disorders

Federal Legislative and Administrative Activity on Mental Health Parity

Federal legislative activity includes:

- The Mental Health Parity Act of 1996 (42 USCS Section 300gg-5). Signed into law by President Clinton, the MHPA lifted annual and lifetime dollar limits on mental illness benefits, if these limits differed from limits placed on coverage for other illnesses and conditions. The act, which covered all mental health conditions listed in the DSM-IV but did not require that mental health benefits be offered by insurers, took effect in 1998 and has been extended four times. The MHPA’s current extension is through December 31, 2005. Small employers (<50 employees) as well as health plans that would see an increase in cost of coverage of at least 1% six months after implementation, are exempt from the MHPA.⁷
- The Senator Paul Wellstone Mental Health Equitable Treatment Act of 2003 would have required parity for all mental conditions listed in the DSM-IV. However, MHETA like MHPA would not have required that health plans provide mental health treatment benefits. Benefit

⁷ McKinley, Andrew. Issue Brief: NCSL’s Health Policy Tracking Service: Parity and other Insurance Mandates for the Treatment of Mental Illness and Substance Abuse. April 2004

limitations, such as limits on the frequency of treatment, would also be prohibited. The MHETA did not pass Congress.⁸

- Mental health parity in the Federal Employees Health Benefits Program (FEHBP) was implemented by the federal Office of Personnel Management in 2001 after President Clinton's Executive Order 13124 called for full parity for both mental health and substance abuse benefits. The FEHBP has been described as the largest employer-sponsored health benefits system in the United States.⁹ The program offers health insurance coverage to 8.7 million beneficiaries through more than 200 distinct health plans.

I. EFFECTS OF IMPLEMENTATION OF MENTAL HEALTH PARITY LAWS

A search of the literature on the effects of implementation of state and federal mental health parity laws was conducted to attempt to answer three questions:

- 1) What evidence exists on the implementation effects of AB 88 in California?
- 2) What evidence exists on the implementation effects of federal mental health parity laws and such laws in other states?
- 3) What are the implications of California's implementation experience with AB 88, as well as the implications of the federal and state experience with mental health parity laws, for the proposed mandate, SB 572, particularly as a means to improve access to mental health care, use of appropriate care, quality of care, and health outcomes for populations in need of care?

Appendix A: Literature Review Methods and Other Methods of Analysis describes in detail search terms, databases searched, and search results for the analysis of implementation effects and medical effectiveness.

Key findings focus on the importance of definitions of parity and mental health conditions to be covered under parity laws; effects of implementation on stakeholders and their responses to implementation; other factors influencing effects of implementation of mental health parity; and additional and ongoing mental health parity implementation studies.

Definitions of Parity and Mental Health Conditions

In California, other states, and at the federal level, the effects of implementation of mental health laws, including parity laws, are shaped by the definitions of parity and the definitions of mental health conditions to be covered under parity laws.

⁸ Fact Sheet, US Department of Labor, Employee Benefits Security Administration, December 2004: Mental Health Parity Act

⁹ US Department of Health and Human Services, (2002). *Mental Health United States 2002*. Edited by R.W. Manderscheid and Marilyn Henderson. Section IV. Insurance for Mental Health Care. Chapter 14: Parity in the Federal Employees Health Benefits Program: An Overview. K.D. Hennessy and C.L. Barry., DHHS Publication No. SMA04-3938, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Mental Health Information Center. <http://www.mentalhealth.samhsa.gov/publications/allpubs/SMA04-3938/default.asp> accessed April 2, 2005..

Definitions of parity

“‘Parity’ refers to the effort to treat mental health financing on the same basis as financing for general health services” (U.S. Department of Health and Human Services, 1999).

“‘Parity,’ as it relates to mental health, prohibits insurers or health care service plans from discriminating between coverage offered for mental illnesses and other physical disorders and diseases. NCSL (National Conference of Legislatures) defines parity as insurance coverage that makes no distinction between mental and physical illnesses covered by the plan” (Dixon, 2002).

“The term ‘parity’ or ‘mental health parity’ refers generally to insurance coverage for mental health services that is subject to the same benefits and restrictions as coverage for other health services (U. S. Department of Health and Human Services, 2000).

Types of parity: Several evaluators, organizations, and agencies have described and classified types of parity (e.g., full versus partial, broad versus narrow, comprehensive versus limited, strong versus weak). The purpose of these classifications is to distinguish characteristics of parity laws in terms of insurance policies affected by the laws, “terms, rates, and conditions” of the laws, and other benefit conditions (National Conference of State Legislatures, 2005; Dixon, 2002; National Conference of State Legislatures, 2000; National Mental Health Association, 2005; American Psychological Association 2004; Kaiser Family Foundation, 2004; National Association of Health Underwriters, undated; U.S Department of Health and Human Services, 2001; Gitterman et al., 2001, GAO, 2000; Kjorstad, 2003; Peck and Scheffler, 2002; Bao and Sturm, 2004). The significant variations in parity that occur among states are noted in the GAO reports, (GAO, 2000a), GAO 2000b).

Although there is sometimes a lack of agreement about their interpretation, the terms “full,” “broad,” “comprehensive,” and “strong” parity generally refer to states that cover both individual and group insurance plans and employers of all sizes. States with broad or more comprehensive approaches to parity also require insurance policies or employers to cover parity regardless of cost increases and they require the same “rates, terms, and conditions” (or “terms and conditions”) for mental health coverage as for coverage of other health conditions (e.g., they prohibit benefit limitations on coverage of mental health conditions that are not benefit limitations for other health conditions).

Definitions of mental health conditions

Definitions of mental health conditions covered in state and federal parity laws vary significantly. “Definitions of mental illness in state parity laws have important implications for access, cost, and reimbursement; they determine which populations receive a higher level of mental health services.... To be considered for parity coverage, a person must qualify for a diagnosis included in the parity law included in his or her state.” (Peck and Scheffler, 2002). In their analysis of definitions among states, these authors categorized definitions as: 1) broad-based mental illness, 2) serious mental illness, and 3) biologically based mental illness.

The authors describe two main classification systems in the clinical literature: The first system, widely accepted and used by clinicians, is described in the American Psychiatric Association’s DSM.¹⁰ DSM

¹⁰ The DSM defines a mental disorder as “a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual,...is associated with present distress...or disability...or with a significant increased risk of suffering” (Quoted in Peck and Scheffler, 2002). “The DSM groups disorders by symptom clusters and differentiates between normality and psychopathology on the basis of the duration and severity of symptoms.” (Peck and Scheffler, 2002)

diagnoses are included in the International Classification of Diseases and Related Health Problems (ICD); ICD codes are used for reimbursement. The second system, developed by biological psychiatrists, describes mental illnesses as brain disorders and classifies them on the basis of genetic, biochemical, and anatomic markers. It is considered too limiting by most clinicians (Peck and Scheffler, 2002).

In federal legislation, the term “mental illness” has been interpreted to include all disorders in the DSM (Peck and Scheffler, 2002).

Definitions of mental health conditions at the present time use “a combination of criteria that address diagnosis, functional disability, and duration of illness” (Peck and Scheffler, 2002).

When Peck and Scheffler (2002) compared clinical definitions and those used in federal legislation with those used in state mental health parity laws, the only agreement that they found was with the seven states that then included all disorders in the DSM. They noted that states that use “serious mental illness” as the definition are not using the accepted combination of criteria addressing diagnosis, duration, and disability. States that use “biologically based mental illness” as the definition are charting new territory because this term has never been used in federal legislation and has no accepted clinical definition.

These authors also note that “states rarely, if ever, considered disease prevalence, needs-based studies, and clinical judgment” in developing statutory definitions in their parity laws.

State and federal mental health parity laws have created a multi-tiered system of benefits and benefit limitations based on different definitions of parity and of mental health conditions to be covered under parity.

Stakeholders and the Implementation of Mental Health Parity Laws: Effects and Responses

Implementation of mental health parity laws produces a great number of interactive effects and responses, both short term and longer term, involving many stakeholders including federal, state, and local government agencies; employers providing health insurance benefits; individuals purchasing health insurance for themselves; health insurers and plans (HMOs, PPOs, POS, FFS); MBHOs; providers; and consumers.

Figure 1 shows major stakeholders and their roles in implementation of state parity laws, including the proposed mandate, SB 572, some effects of implementation, and some potential responses.

State agencies: The California Department of Managed Health Care and the California Department of Insurance would have primarily regulatory responsibility to ensure that plans and insurers are in compliance with SB 572.

Employer groups: Employer groups of all sizes would be required to purchase plans or policies that include coverage for all mental health conditions at the same levels as for other health conditions, if they offered health insurance benefits to their employees. Benefit design and benefit limitations (e.g., establishing levels of employee cost-sharing), including developing different plan options for employees, could be used by employers to deal with any impacts of the implementation of SB 572. Employers could also decide to “carve out” mental health services and contract directly with an MBHO

for these services. (This option is usually pursued only by large employers that self-insure. Self-insured employers would be exempt from SB 572 and are exempt from AB 88.)

Individual purchasers: Individual policies or plans would include coverage for mental health care at the same levels as coverage for health conditions, and purchasers would have a choice to determine what benefit package to purchase at what cost.

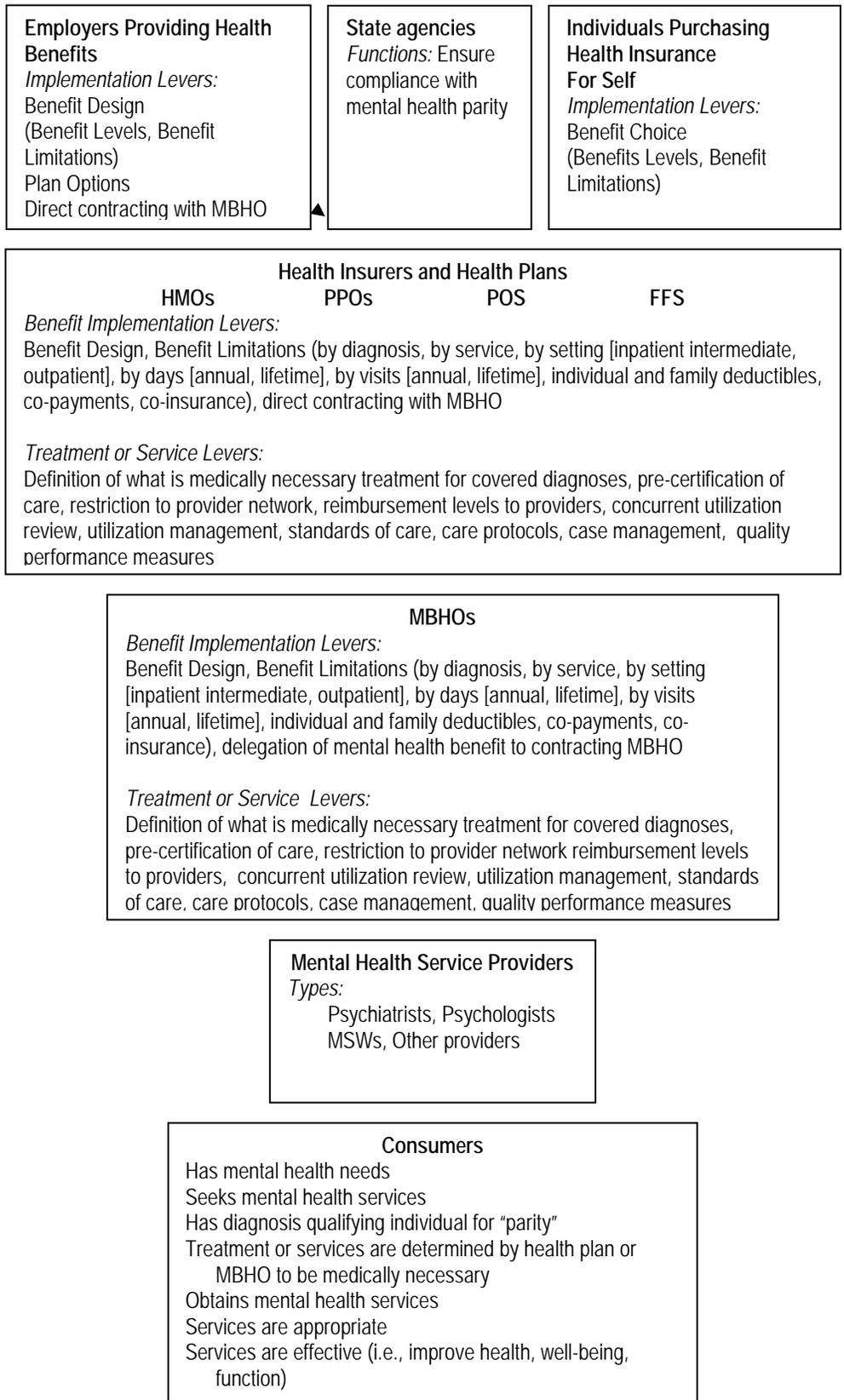
Health insurers and plans (HMOs, PPOs, POS, and FFS): Health plans would have many options for implementing mental health benefits under SB 572, including benefit design, benefit limitations, and contracts with an MBHO for mental health services. Health plans also could use any one or any combination of treatment or service levers (e.g., defining what is medically necessary treatment for diagnoses covered, pre-certification of care, restriction of services provided to a provider network, reimbursement levels to providers, concurrent utilization review, utilization management, standards of care, care protocols, case management, and quality performance measures).

Managed behavioral health organizations: MBHOs would have the same benefit implementation and treatment or service levers as health plans in implementing parity laws, such as SB 572.

Mental health service providers: Psychiatrists, psychologists, social workers, and others may work as individuals providing services, as individuals providing services through a health plan, or as part of a network of providers for a health plan or an MBHO. The arrangements that service providers have with health plans, patients and/or clients could change with the implementation of SB 572, if employers, health plans, or MBHOs changed arrangements for providing mental health benefits under SB 572.

Consumers: Of people who need treatments for mental health conditions that are among the diagnoses covered under SB 572, some will newly seek treatment due to new coverage. For these consumers access will be improved. Some will already have insurance for mental health conditions covered under SB 572. If consumers seek a treatment or service, that treatment or service may or may not be judged as being medically necessary by their health plan or MBHO. If it is judged medically necessary and consumers obtain the treatment or service, that treatment may or may not be appropriate and effective. If the service or treatment is appropriate and effective, it may or may not result in improved health outcomes (e.g., increased well-being, improved function, decreases in school or work absences, increased work productivity).

Figure 1: Major Stakeholders and Their Roles in Implementing State Parity Laws



Most studies of implementation have focused on the effects on, and responses of, employers, health plans, and MBHOs. Costs to these stakeholders, pre- and post-parity, as well utilization of services over the short term have been the major areas of emphasis in these studies (Branstrom and Sturm, 2002; The Lewin Group, Inc., 1997; Zukevas et al., 2001; Salkever and Shinogle, 2000; Frank and McGuire, 1998; Murray and Henriques, 2004; Robert Wood Johnson Foundation, 2001; Feldman et al., 2002; Bachman, 1997; Goldman et al., 1999; Sturm and McCulloch, 1998; Jensen et al., 1998; Levin et al., 2001; Sturm and Pacula, 2000; Zukevas et al., 2002; Melek, 2005; Hodgkins et al., 2003; Peele et al., 1999; U.S. Department of Health and Human Services, 2001; Praeger, 2001; Goldman et al., 1998; Sturm, 1999; Sturm, 2000; Pacula and Sturm, 2000; Sturm and Pacula, 1999; Branstrom et al., 2004; Sturm et al., 1998; Cuffel et al., 1999; Zukevas, 2000; U. S. Department of Health and Human Services, 1998).

For the most part, implementation studies of federal and state mental health parity laws indicate that increases in costs and utilization overall have been minimal after the implementation of mental health parity laws, particularly in comprehensive managed health care plans, health plans with MBHO “carve-outs”^{11, 12} before parity, and health plans that moved to MBHO carve-outs simultaneously with the implementation of parity. Costs to employers, however, appear to vary depending on employer size (small, medium, and large), benefit design, and employer arrangements with health plans and MBHOs to manage mental health benefits. Some studies report declining total costs to health plans and MBHOs. Out-of-pocket costs to consumers also are reported to have declined. Data on costs are difficult, however, to compare across studies.

Some studies report that parity laws have increased access for both adults and children (Zukevas et al., 2000). Some studies report mixed evidence in terms of improvements in access under parity (Ma and McGuire, 1998; Pacula and Sturm, 2000; Sturm et al., 1998; Goldman et al., 1999). One study (Zukevas et al., 2000), which was requested by the National Mental Health Advisory Council (NMHAC), examined the effects of a state mental health parity mandate combined with carve-out managed care on costs, utilization, and access for a large employer group (over 100,000 employees) subject to parity. About 75,000 continuously enrolled members under age 55 were studied using proprietary enrollment and claims data.

The study, which extended over a four-year period (one year before parity to three years after parity) found that the proportion of the population receiving some mental health services (overall treated prevalence rate) increased from 5.0% to 7.3%. The overall increase in employee, spouse, and dependent use of outpatient services (i.e., hospital outpatient departments, emergency rooms, providers’ offices, and clinics) over the four-year period was 50%. The mean number of visits for those with any outpatient use remained about the same over this period. There was a total 50% increase in outpatient visits over the study period. Costs for outpatient visits increased by 85% over the four years, with three-quarters of these costs resulting from more people getting outpatient treatment and another quarter resulting from increases in cost per visit. Inpatient costs accounted for 80% of all costs in the first year, but only 40% by the fourth year. More than 97% of the overall cost decline was accounted for by dependents; 91% was accounted for by children aged 6-12 years (accounting for 27%) and adolescents aged 13-17 years (accounting for 64%). These groups had high inpatient utilization before parity: Children aged 6-12 years had a mean length of stay of 33.7 days in year one and 7.1 days in year four, and adolescents aged 13-17 years had mean stays of 42.1 days in year one and 12.7 days in year four. Outpatient use for both

¹¹ “Carve-outs” are defined by the American Managed Behavioral Health Association as “a management approach where a defined category of health benefits are placed under the supervision of experts who understand that category of services and are better prepared to manage the associated costs.”

¹² Another definition is “the use of administrative or legally separate organizations to provide health care services for particular conditions, procedures, diseases, or groups of patients.”(Salkever and Shinogle, 2000).

children and adolescents increased over the study period, in terms of the proportion of children and adolescents with any use. For children, the percentage with any use increased from 4.4 % in year one to 7.2 % in year four; for adolescents, from 4.1% to 6.5%. The mean number of outpatient visits for children declined from 6.2 in year one to 5.6 in year four; the mean number of visits for adolescents increased, from 6.8 in year one to 7.3 in year four.

Both inpatient admissions and length of stay decreased over the four-year period, offsetting the increase in outpatient use and costs. Plan costs declined by 39% after simultaneous implementation of a parity benefit and a carve-out for benefit management.

Some evaluation studies indicate that the effects of mental health parity laws in terms of increasing access are counterbalanced by employer, health plan, and MBHO management mechanisms to control utilization and costs (e.g., benefit design, benefit limitations by diagnosis, service, setting, day, and visits; and administrative requirements, such as pre-certification of care, restriction to network providers, intensive utilization review, and quality management measures), and that the effects of most mental health parity laws are minimal in terms of cost, utilization, and access because of these countervailing forces.

Others point out that a managed care approach has allowed mental health benefits to be expanded and costs to be managed. Before implementing mental health parity in the Federal Employees Health Benefit Program in 2001, the federal Office of Personnel Management requested that the Washington Business Group on Health, a member organization representing nearly 150 large employers, assist in an assessment of members' experiences and best practices in providing mental health care (Nelson, 2001). Based on the outcome of this assessment, the OPM stated that "(t)he overriding goal of parity is to expand the range of benefits offered while managing costs effectively." OPM "encouraged health plans to manage mental health... care...in order to (meet these ends)." Nelson (2001) notes: "The key to the approach chosen by OPM was that parity "can be introduced, using appropriate care management...delivered in a fully coordinated managed health care environment that incorporates techniques such as case management, authorized treatment plans, gatekeepers and referral mechanisms, contracting networks, pre-certification of inpatient services, concurrent review, discharge planning, (and) retrospective review and disease management."

Some investigators note that mental health parity laws cannot be expected to solve all of the problems of equal access to mental health services, and that inequity of access to mental health services remains a problem for several reasons (Burnam and Escarce, 1999; Peck and Scheffler, 2002; Jensen et al., 1998; Mechanic, 2003; Frank et al, 2001; Hennessy and Goldman, 2001; Zukevas et al., 1998; Sharfstein, 2002; Mechanic and McAlpine, 1999; Frank et al., 1997). Burnam and Escarce (1999) point out that "...in important ways mental disorders continue to be considered separately in health care policy and practice, a historical evolution shaped at least in part by social stigma and misconceptions surrounding mental illness." But these authors cite another reason that contributes to inequity.

There is a public system of mental health care, which specializes in the treatment of severely mentally ill, and there is private insurance, which usually provides restricted mental health benefits "designed to pay for time-limited mental health problems." When problems become "prolonged and severe," responsibilities shift from private insurance coverage to public funding. Since public funding is limited, only the most needy are served, leaving gaps in care for the mentally ill in the public system. Benefit design and limitations in private insurance coverage for mental health services also "limit medically necessary care... and restrict access to acute care and medication management for persons with severe mental illness." (Burnam and Escarce, 1999).

An evaluation study in California, providing a snapshot of implementation of AB 88 during the first year and conducted by a team of evaluator at Mathematica Policy Research, Inc. for the California HealthCare Foundation, reported several key findings: “1) Most aspects of implementation went smoothly in the first year; 2) Health insurance benefits for mental health services were expanded; 3) Implementation did not appear to have any adverse consequences on the health insurance market; 4) Health insurance premiums did not increase substantially during the year after implementation; 5) Employers did not drop health coverage for their employees or become self insured to avoid the state’s parity mandate; 6) Implementation of parity for selected mental health conditions (SMI) and serious emotional disturbances (SED) of a child, rather than all mental health diagnoses, created administrative challenges and confusion.7) Several large health insurers changed coverage to MBHOs from integrated physician services, disrupting care for some consumers; and 8) Consumers were not well informed about changes, and providers often had to act as intermediaries for their patients” (Lake et al., 2002).

This same study identified remaining challenges to implementation of AB 88 as: “1) Continued efforts to improve coordination among health providers, and employers in implementing or responding to system changes; 2) Stakeholder discussions about the role of the private and public sectors in delivering services to children with SED and autism; 3) Stakeholder development of appropriate strategies for improving consumer awareness about benefit expansion and facilitating their access to mental health services; and 4) Stakeholder identification of strategies for addressing shortages in certain provider specialties (i.e., psychiatrists, child psychiatrists, eating disorder specialists)” (Lake et al., 2002).

Other Factors Influencing Effects of Implementation of Mental Health Parity

Some investigators note that effects of parity are difficult to separate from other changes in the organization and financing of health care and rapid changes in the health care marketplace that often differ from state to state. They note that a large number of factors, some unrelated to parity, may have affected health insurance coverage and access in both parity and non-parity states. These factors include state economic conditions, changing employer generosity in private insurance benefits, the small number of people reached by mandates in some states, lack of consumer awareness of the availability of improved mental health coverage, increased use of psychotherapeutic drugs, and outpatient mental health services (Zukevas, 2000). A number of studies find no significant or consistent effect of mental health parity legislation (Bao and Sturm, 2004; Gitterman, et al., 2001; Zukevas et al., 2001; Zukevas, 2000).

Additional and Ongoing Mental Health Parity Implementation Studies and Related Studies

There are still relatively few comprehensive evaluations of implementation of mental health parity laws at the federal level or among states. The most informative studies for California’s policy makers may well be in states that have moved from SMI-based definitions of mental health conditions to broad-based definitions including all DSM-IV diagnoses. Connecticut has moved in this direction and New Jersey may be moving to more comprehensive coverage of mental health conditions, if proposed legislation passes.

For mental health parity laws that have been relatively recently implemented in California, other states, and at the federal level, evaluation studies of their implementation are just being initiated, are ongoing, or their results not yet been made public or published in peer-reviewed medical literature.

The first study, which is ongoing in California, is an in-depth update to the snapshot implementation study by Mathematica Policy Research Inc. of mental health parity in California initiated after the passage of AB 88. The snapshot study was conducted for the California HealthCare Foundation during the first year of implementation of AB 88 (Lake, 2002). The update study is sponsored by the Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. The purpose of the study is determine which implementation issues and effects from the snapshot study were temporary or short term, and which ones continue to be persistent. In addition, over time, the study seeks to answer the questions: what new intended or unintended consequences of the parity legislation have occurred? Are these consequences market issues, secular trends, or issues that are truly effects of the parity legislation? After the transitional issues have subsided, which issues still persist? The study will examine impacts on access, utilization, and process and administrative effects.

A second study is being conducted by California's Department of Managed Care. This study will survey health plans and MBHOs to assess major issues of concern in implementation of AB 88.

The third is an evaluation required under the California Budget Act of 2004. "The bill would require the State Department of Mental Health, in collaboration with the Department of Managed Health Care, the Department of Insurance, and applicable representatives from the California public and private mental health systems, to identify the core reasons that mental health parity in California is not being achieved, the barriers to achieving that parity, and what approaches over the short term and long term can be done to effectuate a more comprehensive mental health system in California, both public and private. The bill would require the State Department of Mental Health to submit a report of this information to the Legislature on or before March 1, 2005" (SB 1103 (2004)). The report has been completed and is presently undergoing administrative review.

A fourth study is an evaluation of mental health parity in the 8.7-million-member Federal Employee Health Benefit Program initiated by the federal Office of Personnel Management in 2001. The evaluation began in fall of 2001 and concluded in December 2004. The evaluation study was conducted by a consortium of investigators (U. S. Department of Health and Human Services, Mental Health, United States, 2002, Hennessy and Barry, Chapter 14. Parity in the Federal Employees Health Benefits Program: An Overview) and was jointly commissioned by the Office of the Assistant Secretary for Planning and Evaluation with the Office of the Secretary, U.S. Department of Health and Human Services and the Office of Personnel Management. A report on the study has not yet been made public by the funding agencies and results of the study have not yet been published in a peer-reviewed journal.

The objectives, methods, and findings of these studies vary significantly, and findings are often difficult to compare. Study findings related to the implementation of mental health parity laws in one state often are peculiar to the demographics, health care marketplace, and other features of the study state, and findings are not applicable to other states.

II. MEDICAL EFFECTIVENESS

The search of the literature on the effects of implementation of mental health parity laws included a search of the peer-reviewed scientific literature on health effects, health outcomes, and medical effectiveness related to mental health parity laws. Appendix A: Literature Review Methods and Other Methods of Analysis describes search terms used, databases searched, and results of the search.

No relevant studies were found in the scientific peer-reviewed literature that specifically address health outcomes (e.g., reduction in risk of suicide, attempted suicide, suicide; reduction in mental and emotional distress; increased well-being, improved function; decreased school and work absences; increases in productivity) related to the implementation of mental health parity laws, comparing health outcomes in parity and non-parity states, or comparing health outcomes before and after parity.

The medical effectiveness of mental health parity policies, such as covering a certain set of mental health conditions (e.g., SMI versus other mental health conditions), a certain “package” of treatment interventions, or a certain number of outpatient visits or inpatient days (e.g., 10 versus 20 visits/year or 30 days versus unlimited inpatient days/year) in ameliorating certain mental health conditions, is not addressed in the mental health parity literature reviewed in this analysis.

Health effects and outcomes are the last in a chain of events that begins with insurance coverage of mental health benefits (i.e., diagnoses covered; services covered; and terms, rates, and conditions of service coverage, including copayments, coinsurance, and deductibles), access to mental health treatments and services, consumers seeking treatment and services, and consumers obtaining appropriate and effective treatment and services. In the review of the literature in this analysis, no studies were found that have investigated how implementation of mental health parity laws has affected this chain of events for individuals, vulnerable populations, health plan groups, or national and state population samples. Such studies would include investigations of access of different populations of consumers (i.e., children, adolescents, elders, seriously mentally ill) to services, targeting of services to populations at high risk, use of services, availability and choice of providers, relationships with providers, patient satisfaction, coordination and integration of services in the private and public sectors and between medical care and mental health care sectors, the use of treatment protocols and guidelines in providing services patients, access to appropriate care, quality of care, and health outcomes.

Two mental health parity related studies include some information about consumers’ views on access, quality of insurance coverage, and use of care.

The first study followed Maryland’s passage of a mental health parity law in 1994. When focus groups were convened by investigators in late 1997 (more than two years after the law had gone into effect), investigators found that focus group participants indicated that mental health parity laws were a partial way to improve access problems for people with mental illness and that there were ways to improve policies that did not appear to improve access (Castellblanch and Abrahamson, 2003).

Three problem areas were noted by participants in the focus groups: 1) internal review systems upset treatment plans by requiring repeated calls for managed care authorizations and reauthorizations; 2) review processes can tie up mental health professionals; 3) review processes could increase the emphasis of promoting medications to suppress a client’s symptoms.

Focus group participants also reported that the use of professional panels could make access to professional services difficult, specifically: 1) managed care clerks could lack information about specialties of mental health professionals; 2) managed care clerks could delay treatment by acting as “double gatekeeper” requiring both a primary care physician and psychiatrist visit before patients could see a therapist. 3) mental health professionals could be “red flagged” for providing too much service and removed from the panel. (Castellblanch and Abrahamson, 2003.)

Broad exemptions for managed care and medically necessary restrictions were discussed as some of the ways that impede access (Castellblanch and Abramhamson, 2003). Others have suggested that

definitions of “medically necessary” be could broadened to include: 1) desired goals of services (e.g., to improve functioning so as to enable clients to live at home and have success at work), and 2) the range of services that are to be considered medically necessary (Koyanagi, et.al, 1998).

A second study (Bao and Sturm, 2004) looked at effects of state mental health parity legislation on perceived quality of insurance coverage, perceived access to care, and the use of mental health specialty care. Data analyzed in the study came from two waves (Wave 1 1997/1998 and Wave 2 2000/2001) of the Health Care Communities (HCC) household survey, a component of the Robert Wood Johnson Foundation’s Tracking Initiative that follows participants in the Community Tracking Study (CTS). The HCC survey has independent measures of mental health status. In Wave 1, investigators reinterviewed 9,585 CTS tracking participants (64% response rate). The first component of Wave 2 reinterviewed 6,659 participants (70% response rate) from a new cross-sectional sample of CTS (59% response rate.) The combined waves included a sample size of 21,743 interviews with individuals living in 48 states and the District of Columbia. (There were no respondents from Vermont and Hawaii.)

Results of the study showed that in general that the population described as “mentally ill” was slightly more likely to perceive a positive change, but also much more likely to perceive a negative change, in the quality of their insurance coverage and their access to care. This population also had much higher utilization rate of mental health specialty care when compared to people with “probable mental disorders” (Bao and Sturm, 2004).

The investigators found that comparisons between respondents in parity states and non-parity states indicate “no clear pattern” in terms of the two outcomes (perceived quality of insurance coverage and perceived access to care). However, respondents in parity states had a higher rate of specialty care use than did those in non-parity states before and after parity. Mental health specialty visits were defined as “visits to a mental health provider, such as a psychiatrist, psychologist, social worker, psychiatric nurse, or counselor for emotional or mental health problems.” Inpatient mental health care was not studied by these authors (Bao and Sturm, 2004).

As the Final Report to Congress of the National Advisory Mental Health Council notes, “...it is still unclear what impact parity has on the quality of mental health services and the well-being of people with mental illnesses” (U.S. Department of Health and Human Services, 2000).

The NAMHC indicates that knowledge gaps related to the impact of mental health parity legislation include:

1. What is the long-term effect on continued access to appropriate mental health services?
2. What is the impact on particularly vulnerable populations, such as children and adolescents, the elderly, the severely mentally ill, and traditionally underserved populations?
3. What is the effect on disability and work productivity in insured populations?
4. How is the quality of treatment affected?
5. What is the long-term impact on public mental health?
6. How do health care systems respond to parity?
7. What is the impact on types of co-morbid conditions seen in the general health care sector?

Others, including policy makers, have also called for studies of the health outcomes of parity (Meyer, 2001; Aday et al.,1999; Otten, 1998; U.S. Department of Health and Human Services, 2004). Meyer 2001 notes that: “...in the arguments for and against parity legislation, there have been surprisingly few data on health outcomes...Unfortunately, it has been virtually impossible to obtain outcomes data in the

geographically distributed networks of (managed behavioral health care) firms. No federal agency or corporate purchaser has proposed that the collection of such data is at least as important as collecting data on the incremental costs associated with parity. None has proposed to cover the costs for collection of the data; with purchasers focus on costs, no managed behavioral health plan has the resources to commit to studying health outcomes. Some...leaders in the industry would welcome support for studies of health outcomes as a tool for quality improvement.”

Otten (1998) asserts that “states have large gaps in their information about numbers of people covered, costs, and other elements of mental health care. Their task is further complicated by constant and rapid changes in the health field—new benefit designs, the accelerating growth of managed care, the creation and expansion of new provider groups, hospital consolidation, health plan profitability, intricate information systems—that make it difficult to isolate and measure factors that affect access and costs of health care.”

Woodward (U.S. Department of Health and Human Services, 2004) describes determinants of mental health services as: demographics, health status and functional limitations, severity of condition, socioeconomic status and employment, patient view of mental illness, acculturation, ethnicity, community support, church participation, provider sensitivity, structural and operating aspects of providers, and a variety of economic and financial barriers. (U.S. Department of Health and Human Services, 2004).

Aday and colleagues propose a framework for assessing the effectiveness, efficiency, and equity of behavioral healthcare (Aday et al, 1999). They note: “Current policy and practice in behavioral healthcare reveal the absence of a comprehensive, coordinated continuum of care; substantial variation in policy and financial incentives to encourage such development; and poorly defined or articulated outcome goals and objectives. The current state of the art of research in this area reflects considerable imprecision in conceptualizing and measuring the effectiveness, efficiency, and equity criteria. These 3 criteria have not been examined together in evaluating system performance.”

These same investigators conclude that there have been three eras of behavioral healthcare. The first era focused on cost savings in managed care alternatives. The second is focusing on quality and outcomes. The third era must “consider issues of equity and access to behavioral health care, especially for the most seriously ill and vulnerable, in an increasingly managed cared-dominated public and private policy environment” (Aday et al.,1999).

More than 75% of Fortune 500 companies surveyed from April 1997 to May 1998 reported using at least one performance standard (Merrick et al, 1999). However, investigators note that there is some evidence that employers tend to consider quality information, such as “clinical outcomes,” NCQA (National Center for Quality Assurance) accreditation, and HEDIS (Health Plan Employer Data and Information Set) measures less important than other factors such as cost or claims processing in general medical plans” (Hibbard et al.,1997).

One study examined mental health care performance on the HEDIS report card during 1999. Three hundred and eighty four plans covering 73 million enrollees (90% of all individuals enrolled in the U.S. and nearly 68% of all U.S. HMOs) submitted data to the NCQA (Druss, et al.,2002). The investigators assessed five mental health quality measures: 1) percentage of members hospitalized for a mental disorder who had an ambulatory visit with a mental health care provider within 7 days; 2) a visit within 30 days, of hospital discharge; 3) effective treatment in the acute phase (ongoing medication treatment in the three-month period after a new depressive episode); 4) effective continuation therapy (ongoing

medication treatment in the six months after a new depressive episode); and 5) optimal practitioner contacts (at least three mental health care visits in the three months after a new depressive episode. The mean rate of mental health care performance was 48%, substantially lower than the 69% mean rate for general medical care. Of the 384 plans surveyed, 101 chose not to release their data; these plans performed substantially worse on the mental health care data indicators.

The Surgeon General's Report on Mental Health (U.S. Department of Health and Human Services, 1999) notes that there are ongoing efforts to develop quality reporting systems in managed behavioral health systems using existing administrative claims data to measure the process of care, as well as some clinical outcomes. The report also notes that clinical outcome data systems have greater potential for evaluating how programs and practices affect patient outcomes.

Norquist and Hyman (1999) note that there are three major questions faced by policy makers in terms of mental health:

- 1) Who should receive treatment?
- 2) What treatment interventions should be provided?
- 3) How can one ensure that appropriate care is delivered?

One of the problems in assessing the impact of mental health treatment, they note, is that there have not been public health indicators. New methods of measuring functional status should make it possible to develop indicators to monitor mental health in a nationally representative population sample, similar to the way that other illnesses, such as cancer and heart disease, are monitored.

III. UTILIZATION, COST, AND COVERAGE IMPACTS

SB 572 would affect all people who are enrolled in plans subject to the Health and Safety Code, and those with private health insurance subject to the Insurance Code in California. This includes 17,168,000 enrollees. Since SB 572 does not apply to Medi-Cal, this analysis excludes Medi-Cal beneficiaries. Other insured individual covered by public payers, including people enrolled in managed care plans that contract with the California Public Employees' Retirement System (CalPERS) and the Healthy Families' Program, would be affected by the mandate¹³.

Present Baseline Cost and Coverage

In 2003, around half of all people with mental illness did not receive needed mental health treatment (SAMHSA, 2003). People do not always receive treatment when symptoms occur. The average delay between onset and first treatment has been shown to be 5 years for more serious disorders, and 10 years for other disorders (Wang et al., 2004).

There are many reasons why under-treatment occurs, many of which relate to the nature of mental illness itself and the lack of awareness of the symptoms of mental illness. Some of the most common reasons for under-treatment of mental illness include:

¹³ State benefit mandates do not typically apply to self-insured plans, therefore this analysis excludes this population.

- Cost
- Lack of coverage for enough mental health treatment or counseling; however, one study showed that depressed patients reported better mental health benefits than they actually had (Meredith et al., 2002)
- Stigma associated with seeking mental health care or having a mental illness diagnosis
- Feeling treatment was not needed
- Lack of time
- Lack of knowledge about where to find services
- Fear of being committed or having to take medicine (Substance Abuse and Mental Health Service Administration, 2003).

Current coverage of the mandated benefit (3(i))

As mentioned earlier, coverage for illnesses specified by AB 88 is mandatory for health plans and insurers that are regulated by the Health & Safety Code and the Insurance Code in California (see Table 6).

The level of coverage among different people in California's insured population (excluding the employees and dependents of self-insured firms, and Medi-Cal) is shown for the privately insured in Figure 3 and for the public and private population in Table 7.

Based on CHBRP's survey of the seven largest health plans and insurers in California, the level of coverage for the mental illnesses included in SB 572 is as follows:

- 88% of the insured population has limited coverage for these services.
- 10% of the insured population has no coverage for these services.
- 2% of the insured population has full coverage for the services.

Limited coverage means that these benefits are covered but have higher copayments or benefit limits that do not apply to other medical services. For example, for services not mandated in AB 88, users may be limited to 20 outpatient visits per year, or 30 hospital days.

The level of coverage among different types of public and private plans is shown in Table 7. Coverage varies by size of employer and the type of policy:

- 5% of the enrollees of large group HMOs have full parity coverage of non-mandated mental health services, 90% have limited coverage, and 5% have no coverage.
- 80% of employees and dependents in other group plans and all individually-purchased insurance have limited coverage; 20% have no current coverage.
- In the public sector, Table 7 shows that 100% of managed care enrollees of CalPERS and Healthy Families public programs have limited coverage for non-mandated mental health services. Most CalPERS plans cover non-mandated mental illnesses but most plans limit inpatient care either to a 30-day limit or cover outpatient care for 20 visits only. Healthy Families limits utilization to 20 outpatient visits and 30 inpatient hospital days.

Current utilization levels and costs of the mandated benefit (Section 3(h))

Services for most diagnoses covered by SB 572 are widely available in California. Outpatient treatment typically involves medication management and/or counseling. Patients are typically treated in any of a number of settings and types of providers: by primary physicians, psychiatrists, social workers, psychologists in outpatient settings or in hospitals. Pharmaceuticals, such as antidepressants and anti-psychotics, are also used to treat the services listed in the DSM-IV.

Inpatient hospital treatment for mental disorders is less common today. Since the development of more effective medications in the 1960s, long-term hospitalization of persons with mental illnesses has declined substantially.

Table 8 provides information about baseline utilization of hospital and outpatient services for large and small group plans. The table reflects utilization and costs only for the treatment of mental health conditions other than those considered SMI (as defined by AB 88). To understand utilization of services by the privately insured population, diagnosis-specific claims data that matched the diagnoses mandated by SB 572 were analyzed to determine average utilization and costs of treatment for hospital and outpatient treatment.

Pharmaceuticals were excluded from this analysis, because health plans and insurers generally do not restrict coverage of pharmaceuticals to specific diagnoses. The methods used in this analysis are explained further below.

Some highlights from Table 8 are as follows:

Inpatient treatment:

- The average annual rate of hospital admission is 0.55 per 1,000 insured members, with an average length of stay of 6.12 days.
- The average annual number of hospital days utilized per 1,000 insured members is 3.37 (the average hospital days utilized can reflect multiple admissions per person).
- The total cost of hospital admissions is \$0.37 per member per month.
- The average proportion of total costs that is out-of-pocket expenses is 5%, or \$0.02 per member per month, although this understates the true cost to users, since this figure averages the cost across the entire insured population.

Outpatient treatment:

- The average annual rate of outpatient treatment (including services from physicians and other providers) is 228.27 per 1,000 members. This means that for every 1,000 members, there are 228.27 outpatient visits per year.
- The total cost of outpatient treatment is equivalent to \$2.22 per member per month.
- The average level of cost-sharing is approximately 21% of the total cost, or \$0.47 per member per month, although this understates the true cost to users, since this figure averages the cost across the entire insured population.

These estimates are drawn from a large dataset of national commercial claims data that includes the inpatient and outpatient utilization and expenditures of 7 million people. Mental health claims were identified using the International Classification of Disease (ICD) Version 9.

In accordance with the requirements of SB 572, the diagnoses analyzed are only those that are allowed within the scope of the legislation, summarized in Table 6. All claims with diagnoses coded between ICD 290 and 319.99 were extracted. Using those classifications, the diagnoses were split between categories under AB 88 and SB 572, with analysis focusing on the specific services mandated by SB 572.

As stated, national data were used because national data sets have larger samples than California data, thus allowing for statistical estimates with greater confidence. In order to use national data, an assumption is that utilization rates in California do not differ with other regions of the country. However, because underlying rates of prevalence (which are a key factor in predicting utilization rates) do tend to differ from region to region, comparison tests were conducted between California and other regions, in order to determine whether the assumption was valid. These test showed a similarity in utilization rates, thus supporting the assumption.

The extent to which costs resulting from lack of coverage are shifted to other payers, including both public and private entities. (Section 3(f))

Two types of cost transfer to public programs could arise as a result of the present limitations on coverage: people choosing public coverage instead of taking up employer-based insurance, and second, the implications of employer-based or individually purchased health care service plans or insurers coverage polices resulting in under-treatment of mental illness.

Because most state programs also place some limits on mental health treatment, it is not likely that people would forgo private insurance in order to access state programs. However, because mental illness typically reduces people's income earning potential, individuals may be unable to purchase private insurance.

There is a possibility that under-treatment of individuals with private insurance may occur as a result of limits on mental health care coverage. Unfortunately, it is not possible to make estimates about how limits on treatment may impact the public sector through reduced income or labor-force participation.

Public demand for coverage (Section 3(j))

Based on criteria specified under AB 1996 (2002), CHBRP is to report on the extent to which collective bargaining agents negotiate for and the extent to which self-insured plans currently have coverage for the benefits specified under the proposed mandate. Currently, the largest public self-insured plan, California Public Employees' Retirement System (CalPERS) preferred provider organization (PPO) plan covers medically necessary inpatient and outpatient care to "to stabilize an acute psychiatric condition" for up to 30 days per calendar year or up to 30 precertified visits per calendar year. These limits do not apply to those SMI or SED conditions provided for by AB 88. Copayments for all mental health and medical services are at parity levels. Based on conversations with the largest collective bargaining agents in California, there is no evidence that unions currently include such detailed provisions during the negotiations of their health insurance policies. In order to determine whether any local unions engage in negotiations at such detail, they would need to be surveyed individually, an undertaking beyond the scope of CHBRP's 60-day analysis.¹⁴

¹⁴ Conversations with SEIU and California Labor Federation on February 8, 2005

Impacts of Mandated Coverage

As discussed in the “Effects of Implementation of Mental Health Parity Laws ” section of this analysis, for the most part, implementation studies of federal and state mental health parity laws indicate that increases in costs and utilization overall have been minimal after the implementation of mental health parity laws, particularly in comprehensive managed health care plans, health plans with MBHO “carve-outs”^{15, 16} before parity, and health plans that moved to MBHO carve-outs simultaneously with the implementation of parity. Costs to employers, however, appear to vary depending on employer size (small, medium, and large), benefit design, and employer arrangements with health plans and MBHOs to manage mental health benefits. Some studies report declining total costs to health plans and MBHOs. Out-of-pocket costs to consumers also are reported to have declined. Data on costs are difficult, however, to compare across studies.

One study of the effects of parity (Zuvekas et al., 2000), cited by the National Mental Health Advisory Council (NMHAC), found that the proportion of the population receiving some mental health services (overall treated prevalence rate) increased from 5.0% to 7.3%. More than 97% of overall cost decline were accounted for by children and adolescents (aged 6-17 years) who had had high inpatient utilization before parity. Employee, spouse, and dependent use of outpatient services (i.e., hospital outpatient departments, emergency rooms, providers’ offices, and clinics) increased over the four-year period. However, inpatient utilization, both admissions and length of stay decreased over a four-year period. Both inpatient admissions and length of stay decreased over the four-year period, offsetting the increase in outpatient use and costs. Plan costs declined by 39% after simultaneous implementation of a parity benefit and a carve-out for benefit management.

To contain costs, health plans and insurers typically move to MBHO management mechanisms, also known as carve-outs, to control utilization and costs (e.g., benefit design, benefit limitations by diagnosis, service, setting, day, visits; and administrative requirements such as pre-certification of care, restriction to network providers, intensive utilization review, quality management measures). These mechanisms may increase access and utilization of mental health care services by shifting the mix of services provided, and tend to lower patient co-payments. Under carve-outs, utilization for mental health outpatient care may increase because more people are using services, but the mean number of outpatient visits may not increase, or increase only marginally, due to tight utilization controls. Also while inpatient utilization and costs decrease, offsetting increases in outpatient use and cost. (Grazier, 1999, Zuvekas, 2002).

SB 572 differs from the legislation studied by researchers in other states. However, the cost impact analysis drew on this research in developing some general assumptions that typically result as a result of parity:

1. Health plans and insurers will use mechanisms to manage mental health care utilization and costs.
2. Therefore, effects of most mental health parity laws are minimal in terms of cost, utilization, and access because of these countervailing forces.
3. Greater management of care has the following effects:

¹⁵ “Carve-outs” are defined by the American Managed Behavioral Health Association as “a management approach where a defined category of health benefits are placed under the supervision of experts who understand that category of services and are better prepared to manage the associated costs.”

¹⁶ Another definition is “the use of administrative or legally separate organizations to provide health care services for particular conditions, procedures, diseases, or groups of patients.”(Salkever and Shinogle, 2000).

- There will be fewer inpatient admissions
- Users of inpatient care will have shorter lengths of stay in hospital.
- Outpatient visits are likely to increase due to and increased number of people using these services
- Cost-sharing for users will fall

How will changes in coverage related to the mandate affect the benefit of the newly covered service and the per-unit cost? (Section 3(a))

The clinical benefit of treatment for the average patient

The average clinical benefit of treatment will likely increase for those people who did not previously have coverage for the services affected by the mandate. For other people, the average clinical benefit will be similar to premandate levels.

Unit costs (average cost per service) of inpatient hospital stays and outpatient visits are assumed to stay the same as a result of the mandate.

How will utilization change as a result of the mandate? (Section 3(b))

Estimates of changes in utilization as a result of parity were based on discussion with experts in the mental health field, actuarial models of changes from other states with parity legislation, and expectations from economic theory regarding how copayments and benefit limits influence utilization of services.

The impact of SB 572 on utilization would vary according to the existing levels of coverage:

- For plans that do not cover conditions included under SB 572, it was assumed that utilization would go to the current levels observed when these benefits are covered. This results in new utilization of services that were formerly uncovered. The cost of these newly covered services will be borne in part by employers and state payers through higher premiums, and by members through cost-sharing and their share of the increased premiums.
- Most plans currently cover some services included under SB 572, but with limits and higher cost-sharing than for other medical services. It is assumed that modest changes in utilization resulting from this mandate for members currently covered by these plans. However, the likely introduction of more aggressive utilization management of these benefits will offset a portion of these increases. This conclusion was based on discussions with researchers that have studied the impact of similar parity provisions, as well as on the literature. The impact of the mandate on these plans is therefore modest increases in utilization, but a reduction of the cost borne by members through copayments and a corresponding increase in the cost of premiums paid by members, employers, and state payers.

In the absence of other factors, utilization is likely to increase due to:

- Parity cost-sharing (e.g., copayments). If patients have to pay less out-of-pocket, they will be more likely to use services. Additionally, parity cost-sharing might result in new users. The effect will be greatest on those benefit plans having the greatest differences between parity and non-parity cost-sharing.

- Parity benefit limits (e.g., elimination of 20-visit annual maximum on outpatient visits). This change may result in more services being covered per patient.

It is assumed that postmandate some health plans would manage utilization of all additional conditions mandated under SB 572 more aggressively. In many cases this management would be performed by a MHBO that subcontracts with the health plan.

Estimates of changes in utilization as a result of parity were based on discussion with experts in the mental health field, actuarial models of changes from other states with parity legislation, and expectations from economic theory regarding how coverage influences utilization of services.

- The following changes in inpatient utilization are estimated as a result of the mandate: The average length of stay could decrease from 6.12 days to 5.99 days postmandate.
- Outpatient visits could increase from 228.27 visits per 1,000 members, to 247.75 visits per 1,000 members.

To what extent does the mandate affect administrative and other expenses such as out-of-pocket expenses? (Section 3I)

Administrative Costs

This mandate will likely increase the administrative expenses for health plans, but not disproportionately to the increase in health care costs. Claims administration costs may go up slightly due to an increase in mental claims. Health plans will have to modify some insurance contracts and member materials to reflect parity coverage of non-SMI mental health services. Health plans and insurers may need to decide whether to contract with MBHOs or build service reimbursement arrangements into currently existing contracts. Such arrangements could be built into contracts related to the provision of mental health care services for serious mental health conditions as currently mandated by California state law.

Health care plans and insurers include a component for administration and profit in their premiums. The estimated impact of this mandate on premiums includes the assumption that plans and insurers will apply their existing administration and profit loads to the marginal increase in health care costs produced by the mandate. Therefore, although there may be administrative costs associated with the mandate, administrative costs as a proportion of the premium would not change.

Out-of-pocket expenses

Table 8 shows that cost-sharing on the part of the enrollee, or out-of-pocket expenditures, could be unchanged for inpatient services. Because insurers would cover a greater proportion of the cost of outpatient treatment, cost-sharing may decrease as a result of the mandate for outpatient services by \$0.28 from \$0.47 per member per month to \$0.19 per member per month. Table 10 shows the impact of the change in cost-sharing by plan type, and shows the total annual reduction in cost-sharing of \$40,289,000.

Impact of the mandate on total health care costs (Section 3(d))

Table 1 shows that SB 572 is estimated to increase total health care costs by \$118,596,000 per year for the population affected by the mandate (17,168,000 people). This is an increase of approximately 0.2115%

As mentioned above, out-of-pocket expenditures are estimated to decrease by \$40,288,000, a decline of 0.9888%.

Costs or savings for each category of insurer resulting from the benefit mandate (Section 3(e))

- Total annual premiums paid by private employers are estimated to increase by approximately \$111,423,000 per year, or 0.3151%. This amount is more than the increase in total health care costs because of the reduction in patient cost-sharing.
- The impact on per member per month premiums varies by market segment. Large group FFS plans would experience the largest increase of \$2.24. Large group HMOs would experience the smallest increase of \$0.17 (Table 10).
- Total annual premiums paid by all employees of private firms and CalPERS, as well as enrollees in Healthy Families, are estimated to increase by approximately \$29,487,000 per year, or 0.2874%.
- Total annual premiums paid by all individual purchasers are estimated to increase by \$16,004,000 per year, or 0.4191%.
- Annual CalPERS state expenditures are estimated to increase by \$1,630,000, or 0.0737%.
- Annual Healthy Families state expenditures are estimated to increase by \$340,000, or 0.0977%.

The magnitude of the increase in health care costs suggests that there will be limited impact, if any, on:

- Availability of the benefit, including the types of providers offering the service postmandate
- Willingness of employers to offer higher-cost insurance (i.e., offer rate)
- Willingness of employers to pay higher premiums on behalf of their employees (i.e., employer contribution rate)
- Willingness of employees to purchase insurance if premiums and/or copayments increase (i.e., take-up rate)
- Willingness of individuals with privately purchased coverage to purchase insurance if premiums and/or copayments increase

Impact on access and health service availability (Section 3(g))

SB 572 is expected to improve access and health service availability for those insured people who currently have no coverage of services for the treatment of mental health services other than that currently covered under AB 88—SMI for all ages and SED among children. For people who currently have full or limited coverage, no significant changes in access are expected.

IV. PUBLIC HEALTH IMPACTS

It is not possible to quantify the anticipated impact of the mandate on the public health of California because 1) the numerous approaches for treating mental disorders and the multiple disorders (covered under SB 572) on which they may be applied, renders a medical effectiveness analysis of mental health care *treatment* outside the scope of this analysis, and 2) the literature review found no studies in the peer-reviewed scientific literature that specifically addresses health outcomes related to the implementation of mental health parity laws. As the Final Report to Congress of the National Advisory

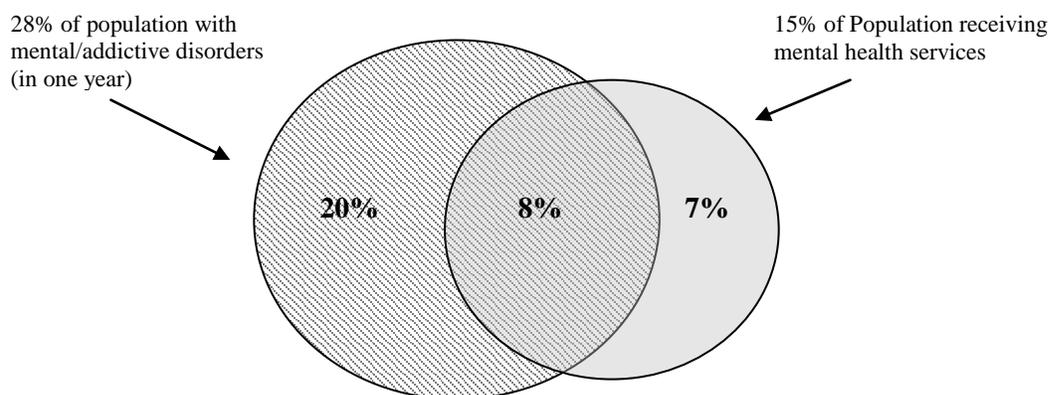
Mental Health Council notes, "...it is still unclear what impact parity has on the quality of mental health services and the well-being of people with mental illnesses" (NAMHC, 2000).

It is important, however, to identify the population within the state of California that SB 572 targets and to understand the multiple ways in which mental disorders affect the health of the community.

Present Baseline Health Outcomes

Estimating the number of Californians targeted by SB 572 is a challenge due to the different ways in which one could measure mental disorders within a population. Wakefield (1999) describes two measures of mental disorders: *clinical prevalence*, which includes the number of people being treated for mental disorders, and *true prevalence* which is the number of people with mental disorders within the population. Figure 2 details the intersection of clinical prevalence and true prevalence as described in the Surgeon General's 1999 report on mental health with 28% of the population having a mental or addictive disorder annually, 15% receiving mental health services, and 8% of the population both having a disorder and receiving treatment. In describing the population affected by SB 572, both true and clinical prevalence are examined.

Figure 2: Annual Prevalence of Mental/Addictive Disorders and Services for Adults



Source: Adapted from 1999 Mental Health: A Report of the Surgeon General. Figure 2-5a.

Population Prevalence

SB 572 requires mental health parity for all of the disorders included in DSM-IV, excluding the substance abuse disorders.¹⁷ Many of the diagnoses in the DSM are extremely rare, while other disorders, such as major depression, are more common, with an annual prevalence of approximately 6.5% (U.S. DHHS, 1999; Dickey and Blumberg, 2002). Estimates on the prevalence of mental disorders as a whole within the United States are based on two major studies: the Epidemiologic Catchment Area Study from the early to mid-1980s and the National Comorbidity Survey of the early 1990s. Based on these studies, the commonly cited estimate is that approximately 20% of the non-institutionalized U.S. population is affected by a diagnosable mental disorder (excluding substance abuse disorders) during a given year (US DHHS, 1999; Jans et al, 2004).

¹⁷ SB 572 also excludes "V" codes

Approximately a quarter of the 20% (5.4% of the total population) of those estimated to have a mental disorder are considered to have a “serious mental illness” which means that they have a DSM disorder, other than a substance abuse disorder, that interferes with social functioning (US DHHS, 1999; Jans et al, 2004). About half of those designated as having “serious mental illness” (2.6% of the total population) are further classified as having “severe mental illness” which is restricted to disorders with psychotic symptoms and/or were substantially disabling in the last year (US DHHS, 1999). “Severe mental illness” disorders are limited to diagnoses of schizophrenia, schizoaffective disorder, bipolar disorder, autism, and severe forms of depression, panic disorder, and obsessive-compulsive disorder (Jans et al, 2004).

The current California mental health parity law, under AB 88, requires parity for those who have “severe mental illness” as defined above, as well as parity for children with “serious emotional disturbances.” The term “serious emotional disturbances” is not a formal DSM diagnosis but rather indicates that a child has a mental disorder that substantially disrupts their ability to function (US DHHS, 1999). In California, the Department of Mental Health estimates that in 2000, approximately 7.5% of youth under the age of 18 had a serious emotional disturbance (CDMH 2000). AB 88 also designates parity for those with diagnoses of anorexia nervosa and bulimia nervosa, which are relatively rare, even within high-risk groups, with a prevalence of anorexia nervosa approximately 0.5% for adolescent girls and the prevalence of bulimia nervosa ranging from 1% to 2% of young women (First and Tasman, 2004).

Applying the nationwide estimate that 20% of the population has a mental disorder to the more than 20 million privately insured Californians, there are over 4 million privately insured individuals in California with a mental disorder each year. A subset of the over 4 million is already explicitly covered in terms of parity under AB 88. If one takes a strict interpretation of “severe mental illness” in AB 88, one can assume that 2.6% of the adult population has a severe mental illness (US DHHS, 1999) and that 7.5% of children under 18 have a “serious emotional disturbance” (CDMH, 2000) to calculate that approximately 20% of the 4 million Californians with underlying mental disorder diagnoses are already explicitly covered under AB 88. SB 572 would require parity for the over 3.2 million remaining Californians estimated to have a mental disorder. Appendix D describes the methods used to derive these estimates. It is important to recognize that this estimate reflects the difference between what health plans are *required by law* to cover under AB 88 and SB 572 and does not account for health plans’ decisions to offer more extensive mental health coverage than required under AB88.

Utilization of Mental Health Treatment

Another way to examine the status of mental disorders in California is to look at utilization of mental health services, which includes inpatient hospital care, outpatient services, and pharmacological therapies.

Outpatient utilization can also be examined via the California Health Interview Survey (CHIS), which asks whether the respondents needed help for emotional or mental health problems and whether they saw a health professional for emotional/mental problems in the past 12 months. In 2001, 14.4% of privately insured adults under 65 reported that they needed help for emotional/mental health problems and 8.1% reported that they saw a health provider in the past year for emotional/mental health problems. Another utilization question refers to the number of people taking prescription medications for mental health problems. According to the 2001 CHIS data, of those who reported that they needed help for emotional/mental health problems, 33.6% reported that they had taken a prescription medication for a mental or emotional problem in the last 12 months. This amounts to approximately 5.3% of all surveyed privately insured Californian adults under 65.

Impact of the Proposed Mandate on Public Health

Impact on Community Health (Section 1A)

The treatments for mental disorders fall into two basic categories: psychosocial therapies (e.g., psychodynamic therapy, behavioral therapy), and pharmacologic therapies (e.g., antidepressants, antipsychotics) (U.S. DHHS, 1999). In clinical practice, these two types of treatments are often used together as a combined treatment (Jindal and Thase, 2003). As stated previously, a review of the medical effectiveness of all the available treatments for mental disorders is outside the scope of this analysis. As a result, the health impacts of SB 572 cannot be quantified; however, it is important to acknowledge the health outcomes associated with mental disorders.

The scope of potential outcomes associated with mental health treatment includes:

- *Suicide and inpatient outcomes.* The most acute outcomes measures associated with mental health treatment include reductions in suicides and suicide attempts, in psychiatric emergency room visits, and in inpatient hospitalizations.
- *Mental/emotional health and quality of life outcomes.* Mental and emotional health measures have been examined through individual surveys such as the mental health related quality of life index from the SF-36. Another important outcome in this category is the reduction in the symptomatic distress associated with specific disorders, which can be assessed either by the patient or provider.
- *Health outcomes related to other conditions.* When mental disorders accompany medical conditions they can influence medical health outcomes for patients with conditions such as diabetes and epilepsy (Gilliam et al, 2003; Lustman and Clouse, 2005). Additionally, mental health treatment has found to be positively associated with successful outcomes in substance abuse treatment (Moos et al, 2000; Moos et al, 2001).
- *Other outcomes.* Other mental health treatment outcomes include social measures such as stability in relationships, employment, and housing. Employment and productivity measures are discussed in a subsequent section on the economic cost of illness.

Any improvements in outcomes resulting from SB 572 are dependent on changes in access to care, utilization of care, and the appropriateness and effectiveness of treatment. While an increase in utilization of outpatient mental health treatment is anticipated in the Utilization, Cost and Coverage analysis, the impact of SB 572 on health outcomes cannot be estimated due to the lack of information on the appropriateness and effectiveness of various mental health treatments.

Impact on Community Health where Gender and Racial Disparities Exist (Section 1B)

Gender Disparities

While the lifetime prevalence of mental disorders for males and females is similar, certain types of disorders are more common in one gender (Jans et al, 2004). Hartung and Widiger (1998) review the literature on gender differences in diagnoses of mental disorders, finding that males tend to have higher rates of childhood disorders while adult mental disorders have a more equal distribution across genders.

Table 3 reports the DSM-IV diagnoses that have been found to be at least twice as common in one gender compared to the other. Four of the nine mental disorder diagnoses covered under AB 88 (anorexia nervosa, bulimia nervosa, major depression, and panic disorder) are at least twice as common in females as compared to males. The eating disorders, in particular, have a much higher prevalence rates in females, between 10 to 20 times that of males (First and Tasman, 2004).

Table 3: Gender Differences in Diagnosis of DSM-IV Mental Disorders

Male to Female Ratio > 2	Female to Male Ratio > 2
Attention deficit hyperactive disorder	Anorexia nervosa
Autistic disorder	Borderline personality disorder
Breathing-related sleep disorder	Bulimia nervosa
Compulsive personality disorder	Conversion disorder
Gender identity disorder	Dissociative identity disorder
Language disorders (stuttering)	Dysthymic disorder
Pathological gambling disorder	Generalized anxiety
Primary hypersomnia	Major depressive disorder
Sexual masochism	Nightmare disorder
	Panic disorder (with and without agoraphobia)
	Retts disorder

Source: Hartung and Widiger (1998)

When looking at the utilization of mental health services, females use more outpatient services compared to males (Rhodes and Goering, 1994; Rhodes et al, 2002). The CHIS data for 2001 reflects this finding. Table 4 details the percent of privately insured adult Californians who reported that they: (1) needed help for emotional/mental health problems, (2) saw a health professional for emotional or mental problems in the last 12 months, and (3) of those that needed help, took prescription medicine for an emotional or mental health problem in the last 12 months. Females were significantly more likely than males to respond that they needed help, had seen a health professional, and had taken prescription medication for emotional or mental health problems. In Table 4, the denominator for the first two columns is the total number of surveyed privately insured adult Californians, while in the third column the denominator is the individuals from column 1 responding that they needed help for emotional/mental health problems.

Table 4: Gender Differences in Adult Use of Services for Emotional/Mental Health Problems

Gender	Needed Help for Emotional/Mental Health Problems	Saw Health Professional for Emotional/Mental Problems	Respondents in Column 1 Who Took Prescription Medication
Male	10.3% (9.6 – 11.0)	6.0% (5.5 – 6.5)	29.1% (26.3 – 31.9)
Female	18.6%	10.4%	36.3%

	(17.9 – 19.4)	(9.8 – 10.9)	(34.3 – 38.3)
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Source: California Health Interview Survey (2001). Utilization of services within the last 12 months. Includes currently insured adults aged 18-64 years with employment-based or privately purchased health insurance.

Racial Disparities

The 2001 supplement to the Surgeon General’s report (U.S. Department of Health and Human Services, 2001) on mental health details the many ways in which culture and race interact with the diagnosis and treatment of mental disorders, from the influence of racism on symptoms, to the lack of minorities in clinical trials, to the effect of provider ethnicity on the utilization of services. Additionally, other factors found to have an association with race, such as poverty and education, influence the risk of developing a mental disorder and the chance that treatment will be sought. While there is substantial variation in prevalence and treatment patterns within the broad racial categories used in typical analyses, some of the summary findings from the Surgeon General’s report include:

- While Blacks appear to have overall mental distress symptoms similar to Whites, Blacks are less likely to receive treatment and more likely to be incorrectly diagnosed. Disparities in utilization of treatment have been at least partially attributed to financial barriers and the lack of culturally-appropriate providers.
- Compared to Whites, Hispanics are less likely to receive treatment according to evidence-based guidelines. Of particular concern within the Hispanic community are immigrant Hispanics who use very few mental health services and Hispanic youth who are at increased risk for mental health problems.
- Of all the racial groups, Asians have the lowest rate of mental health services utilization. The few studies that examine Asians as a group suggest that the overall prevalence for mental disorders is not significantly different from other racial groups, however, prevalence rates often differ for specific diagnoses. For immigrant communities, acculturation is an important factor in the types of mental health problems that appear where the more acculturated the individual is, the more they resemble the broader “westernized” population in terms of mental disorders.
- While there is a lack of good epidemiologic data on Native American groups, the studies that have examined this population show that Native Americans suffer a disproportionate burden of mental health problems compared to other racial groups. In particular, Native Americans have high rates of suicide and co-morbidities associated with mental and substance abuse disorders.

The 2001 CHIS data reveal racial differences in the utilization of mental health services. Table 5 details the percent of privately insured adult respondents who reported needing help with emotional/ mental health problems and the percent of those who saw a health professional for emotional/mental health problems. Additionally, among those who reported needing help, Table 5 reports the percent that used prescription medication in the last 12 months for their emotional/mental health problems. As with Table 4, the denominators in the first two columns are the total number of privately insured Californian adults, while in the third column the denominator are those from column 1 responding that they needed help for emotional/mental health problems.

Asians reported the lowest rates of needing help for an emotional/mental health problem and seeing a health professional for emotional/mental problems. Additionally, among those reporting that they

needed help, Asians reported the lowest rates of taking prescription medication for emotional or mental health problems. The low utilization rates for Asians were followed by low rates for Hispanics and Blacks, while Whites reported significantly high rates.

Table 5: Racial Differences in Adult Use of Services for Emotional/Mental Health Problems

Race Category	Needed Help for Emotional/Mental Health Problem	Saw Health Professional for Emotional/Mental Problems	Those in Column 1 Who Took Prescription Medication
All races	14.4% (13.9-14.9)	8.1% (7.8-8.5)	33.6% (32.0-35.2)
White	16.6% (15.9-17.2)	10.7% (10.1-11.2)	38.0% (36.1-40.0)
Black	13.5% (11.1-15.9)	6.2% (4.5-7.8)	23.5% (15.8-31.1)
Hispanic	12.4% (11.1-13.7)	4.0% (3.4-4.7)	23.0% (18.8-27.2)
Asian	7.6% (6.4- 8.8)	3.5% (2.7-4.3)	18.1% (12.0-24.1)
Native American	15.3% (10.3-20.3)	7.3% (3.3-11.2)	33.3% (18.0-48.6)
Other single or 2 or more races	13.4% (10.7-16.2)	6.1% (4.4-7.9)	33.7% (24.3-43.1)

Source: California Health Interview Survey (2001). Utilization of services within the last 12 months. Includes currently insured adults age 18-64 years with employment-based or privately purchased health insurance.

CHIS (2001) also asked those who are insured whether mental health treatment was covered by their insurance. Among privately insured adults under 65 that responded that they needed help for emotional/mental health problems, 13.6% reported that their insurance did not cover mental health treatment. Privately insured Asian and Hispanic adults who stated that they needed help with emotional/mental health problems, in particular, reported that their insurance did not cover mental health, with 33.4% of Asians and 24.0% of Hispanics reporting that their health insurance did not cover mental health treatment.

SB 572 would require mental health coverage parity for all privately insured patients with a DSM-IV diagnosis. As such, SB 572 has the potential to reduce racial disparities in *coverage* for mental health treatment. While this would be an improvement, it would not necessarily translate into a significant reduction of disparities in those receiving mental health treatment. Thomas and Snowden (2001) found that minorities with private health insurance coverage use fewer outpatient mental health services than minorities with public health insurance coverage, a difference not found among Whites. The authors state that increasing private coverage for mental health services will not eliminate racial disparities in outpatient mental health services.

Reduction of Premature Death and the Economic Loss Associated with Disease (Section 1C)

Mental disorders are a substantial cause of disability in the United States, ranking as the second highest cause of activity limitation among those aged 18-44 years and third among those aged 45-64 years (Jans et al, 2004). The World Health Organization Report 2001 examines the leading causes of disability-adjusted life years (DALYs) worldwide and finds that mental disorders have a large impact on disability among people aged 15 to 44 years, with unipolar depressive disorders ranking as the second leading cause of DALYs, after HIV/AIDS. Other mental disorders in the top 20 worldwide leading causes of DALYs among 15- to 44-year-olds include alcohol disorders, schizophrenia, bipolar affective disorder, and panic disorder (WHO, 2001).

In addition to individual effects, the disability related to mental disorders has societal impacts, such as indirect costs associated with lost productivity. Indirect costs include the loss of the ability to work and reduced productivity at work, as well as the value of services from unpaid caregivers and premature mortality (US DHHS, 2000). Marcotte and Wilcox-Gok (2001) estimate that each year between 5 and 6 million workers either lose or do not obtain employment as a result of mental illness. In addition, those with mental illness that do work have lower annual incomes by \$3,500 to \$6,000 than those without mental illness.

There are various approaches to estimating the costs of illness and each approach relies on numerous assumptions, making it difficult to compare cost of illness estimates across diseases and disease categories (Bloom et al, 2001); however, numerous studies have examined the indirect costs of mental illness (Rice et al, 1992; DuPont et al, 1995; Wyatt and Henter, 1995; DuPont et al, 1996; Rice and Miller, 1998). Some studies focus on specific disorders or groups of disorders such as obsessive-compulsive disorder (DuPont et al, 1995), bipolar disorder (Wyatt and Henter, 1995), and anxiety disorders (DuPont et al, 1996), while others examine the costs of mental illness more broadly (Rice et al, 1992; Rice and Miller, 1998).

Rice and Miller (1998) report that the total economic cost of mental disorders was \$147.8 billion in 1990. A 1992 estimate reports \$94 billion in indirect costs due to mental disorders (US DHHS, 2000). While these estimates illuminate the large financial costs of mental disorders it is not possible to parse out the indirect costs associated with disorders already covered by current parity legislation and those that would be newly covered under SB 572.

Additionally, as with health outcomes, any changes in premature death and indirect costs resulting from SB 572 are dependent on changes in access to care, utilization of care, and the appropriateness and effectiveness of treatment. While an increase in utilization of outpatient mental health treatment is anticipated in the Utilization, Cost and Coverage analysis, the impact of SB 572 on premature death and indirect costs cannot be estimated due to the lack of information on the appropriateness and effectiveness of various mental health treatments.

TABLES AND FIGURES

Table 6. Comparison of California legislation AB 88, summarized from the California Department of Managed Health Care Web site and from SB 572

AB 88 Services and Illness Covered (Present law)	SB 572 Services and Illness Covered (Proposed law)
After July 1, 2000, health plans in California are required to provide coverage for the diagnosis and treatment of medically necessary treatment of severe mental illnesses and serious emotional disturbances of a child .	After January 2006, health plans in California are required to provide coverage for the diagnosis and treatment of medically necessary treatment of mental illnesses and serious emotional disturbances of a child .
The health plan benefits must include: <ul style="list-style-type: none"> • Outpatient services; • Inpatient hospital services; • Partial hospital services; and • Prescription drugs, if the plan covers prescription drugs. 	Same. The health plan benefits must include: <ul style="list-style-type: none"> • Outpatient services; • Inpatient hospital services; • Partial hospital services; and • Prescription drugs, if the plan covers prescription drugs.
Equal application of maximum lifetime benefits, copayments and coinsurance, individual and family deductibles for severe mental illness and severe emotional disturbance of a child; and other illnesses.	Same. Equal application of maximum lifetime benefits, copayments and coinsurance, individual and family deductibles for mental and other illnesses.
1. "Severe mental illness" includes: <ol style="list-style-type: none"> 1. Schizophrenia; 2. Schizoaffective disorder; 3. Bipolar disorder (manic-depressive illness); 4. Major depressive disorders; 5. Panic disorders; 6. Obsessive-compulsive disorder; 7. Pervasive developmental disorder or autism; 8. Anorexia nervosa; and 9. Bulimia nervosa. 2. Serious emotional disturbance of a child	1. Mental illness is all mental disorders: <ul style="list-style-type: none"> • defined in the American Psychiatric Association's Diagnostic and Statistical Manual IV (and subsequent editions). • Except codes defining substance abuse codes (291.0 to 292.9) inclusive, and 303.0 to 305.9 inclusive, and 'V' codes. 2. Same definition of serious emotional disturbance of a child.
A health insurer may utilize case management, managed care or utilization review.	Same. A health insurer may utilize case management, managed care or utilization review.
"Carve-outs" or specialized health care service plan or mental health plan is permitted.	Same. "Carve-outs" or specialized health care service plan or mental health plan is permitted.
The law allows plans to provide mental health parity benefits while using in-network providers.	Same. The law allows plans to provide mental health parity benefits while using in-network providers.
However, the law permits certain plans such as POS products to limit or exclude coverage of care from non-network providers.	However, the law permits certain plans such as POS products to limit or exclude coverage of care from non-network providers.

Source: Adapted from the Department of Mental Health Care (California Department of Mental Health 2005) and CHBRP analysis.

Table 7. Level of Coverage for Non-SMI Mental Illnesses in California impacted by SB 572, by Plan Type, Calendar Year 2005

Sector	People in private plans	People in public plans (1)	Total	% of all insured people affected by the mandate
Number of enrollees with full parity coverage for Non-SMI mental illnesses	370,000	-	370,000	2 %
Number of enrollees with limited coverage for Non-SMI mental illnesses	13,813,000	1,289,000	15,102,000	88%
Number of enrollees with no coverage for Non-SMI mental health illnesses	1,696,000	-	1,696,000	10%
Total	15,879,000	1,289,000	17,168,000	100%
% of all insured people affected by the mandate	92%		8%	

Source: California Health Benefits Review Program, 2005.

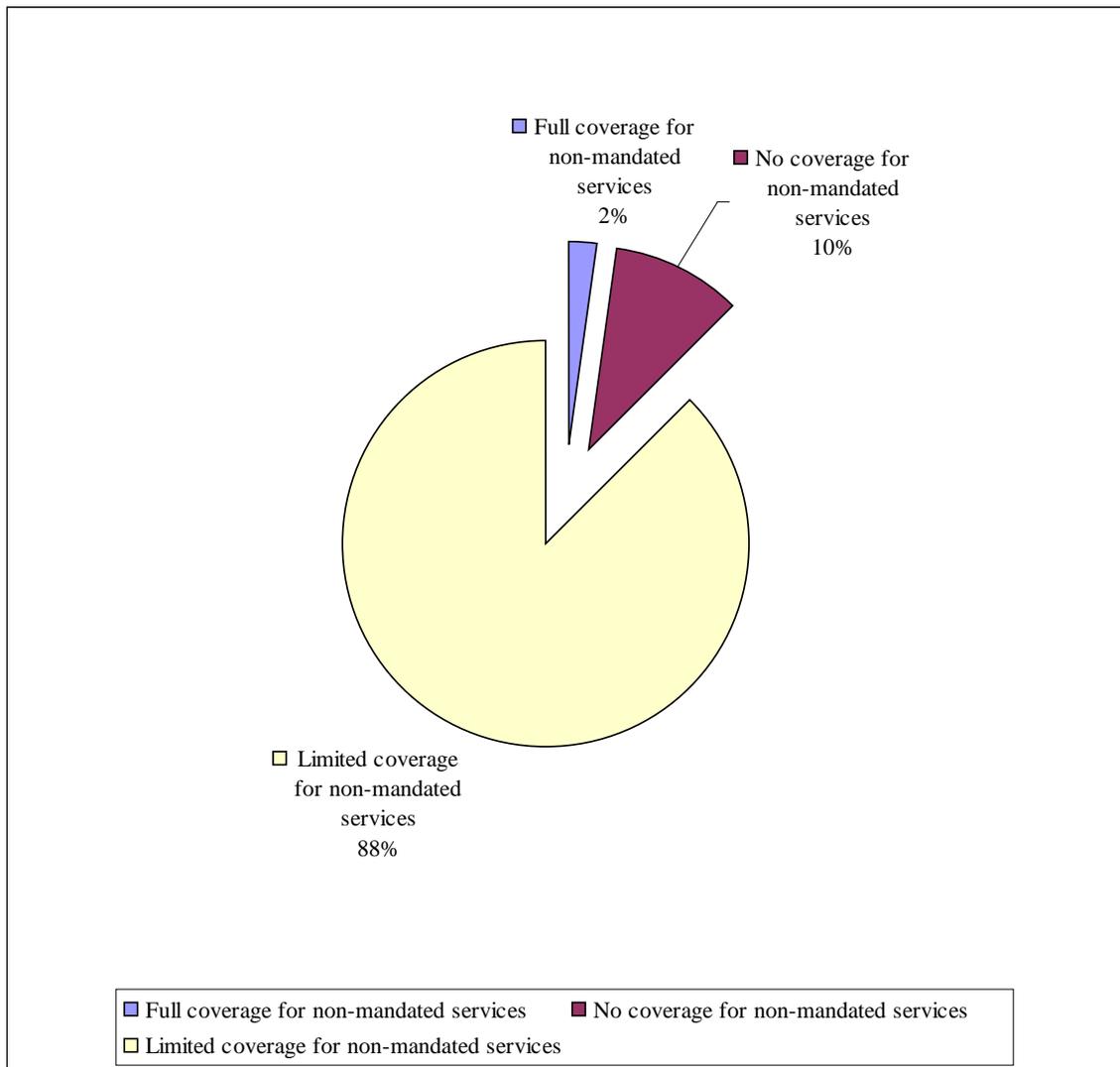
Note (1) This includes CalPERS and Healthy Families only; Medi-Cal is not affected by this legislation.

The population includes individuals and dependents in California who have private insurance (group and individual), or are enrolled in public plans subject to the Health and Safety Code, including CalPERS and Healthy Families.

All population figures include enrollees aged 0-64 years.

Employees and their dependents that receive their coverage from self-insured firms are excluded because these plans are not subject to mandates.

Figure 3. Coverage by private insurers of services listed in SB 572, excluding disorders already subject to AB 88 in California, 2005



Note: Does not include Healthy Families, or CalPERS Employees and their dependents that receive their coverage from self-insured firms are excluded because these plans are not subject to mandates.

Table 8. Baseline and Estimated Postmandate Utilization and Costs in California, 2005

	Annual hospital admissions per 1,000 members	Average length of hospital stay	Annual days or visits per 1,000 members	Per member per month claim cost	Value of cost-sharing per member per month	Net benefit cost per member per month
Hospital admissions baseline	0.55	6.12	3.37	\$0.37	\$0.02	\$0.35
Outpatient services baseline			228.27	\$2.22	\$0.47	\$1.75
Hospital services post mandate	0.55	5.99	3.29	\$0.37	\$0.02	\$0.35
Outpatient services post mandate			247.75	\$2.44	\$0.19	\$2.25
Change hospital		.13	(0.08)	\$0.00	\$0.00	\$0.00
Change outpatient			19.48	\$0.22	(\$0.28)	\$0.50

Source: California Health Benefits Review Program, 2005.

Note: Based on commercial claims. All costs are per member per month, and adjusted to 2005 dollars.

Includes services mandated in SB 572.

Based on national claims data, with some adjustments for California population and market conditions. Primary patient diagnosis only. Excludes ICD 9 codes 291 Alcoholic psychoses, and 292 Drug induced psychoses.

Table 9. Baseline (Premandate) Per Member Per Month Premium and Expenditures, California, Calendar Year 2005

Baseline PMPM Costs (1)	Large Group				Small Group				Individual		Public				Total Annual
	HMO	PPO	POS	FFS	HMO	PPO	POS	FFS	HMO	PPO	CalPERS HMO	Medi-Cal HMO Over 65	Medi-Cal HMO Other	Healthy Families HMO	
Population Currently Covered	7,400,000	3,220,000	457,000	19,000	1,498,000	875,000	454,000	4,000	887,000	1,065,000	795,000	354,000	2,846,000	494,000	20,368,000
Population Affected by Mandate	7,400,000	3,220,000	457,000	19,000	1,498,000	875,000	454,000	4,000	887,000	1,065,000	795,000	0	0	494,000	17,168,000
Average portion of premium paid by employers	\$187.97	\$283.90	\$234.95	\$240.59	\$161.28	\$234.40	\$180.93	\$181.88	\$0.00	\$0.00	\$231.96	\$235.05	\$86.12	\$58.68	\$37,920,512,000
Average portion of premium paid by employees (2)	\$50.45	\$57.87	\$51.96	\$63.25	\$83.36	\$73.27	\$94.91	\$37.09	\$214.23	\$120.38	\$44.18	\$0.00	\$0.00	\$6.32	\$14,079,753,000
Total Premium	\$238.42	\$341.77	\$286.91	\$303.84	\$244.64	\$307.67	\$275.84	\$218.97	\$214.23	\$120.38	\$276.14	\$235.05	\$86.12	\$65.00	\$52,000,265,000
Out-of-pocket payments and deductibles paid by individuals	\$8.44	\$46.18	\$18.14	\$67.04	\$12.49	\$45.71	\$21.55	\$51.02	\$13.04	\$28.09	\$9.78	\$0.00	\$0.00	\$1.71	\$4,074,187,000
Individual payments for services not covered	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0
Total Expenditures	\$246.86	\$387.95	\$305.05	\$370.88	\$257.13	\$353.38	\$297.39	\$269.99	\$227.27	\$148.47	\$285.92	\$235.05	\$86.12	\$66.71	\$56,074,452,000

Source: California Health Benefits Review, 2005.

Note The population includes individuals and dependents in California who have private insurance (group and individual), or are enrolled in public plans subject to the Health and Safety Code, including CalPERS, Medi-Cal, or Healthy Families. All population figures include enrollees aged 0-64, except the Medi-Cal population, which includes dually eligible Medicare/Medi-Cal recipients of all ages. Medi-Cal is not affected by SB 572, but baseline expenditures are shown.

Employees and their dependents that receive their coverage from self-insured firms are excluded because these plans are not subject to mandates.

(1) This represents what all individuals in a plan pay to cover the cost of this service. It represents the total expenditures per service multiplied by the quantity utilized, divided by the number of members in each plan, divided by 12 months.

All values include all healthcare benefits, except expenditures by individuals on the mandated benefit. It was assumed that members are not paying for any services which are not currently covered by their health plans.

(2) Individuals who purchase their own insurance are treated as employees in this row.

Key: FFS = fee for service; HMO = health maintenance organization; POS = point of service; PPO = preferred provider organization. CalPERS = California Public Employees' Retirement System.

Table 10. Postmandate Impacts on Per Member Per Month and Total Expenditures, California, Calendar Year 2005, by Insurance Plan Type

Postmandate Impacts on PMPM Costs (1)	Large Group				Small Group				Individual		Public				Total Annual
	HMO	PPO	POS	FFS	HMO	PPO	POS	FFS	HMO	PPO	CalPERS HMO	Medi-Cal HMO Over 65	Medi-Cal HMO Other	Healthy Families HMO	
Population Affected by Mandate	7,400,000	3,220,000	457,000	19,000	1,498,000	875,000	454,000	4,000	887,000	1,065,000	795,000	-	-	494,000	17,168,000
Average Portion of Premium Paid by Employer	\$0.1316	\$1.7244	\$0.9535	\$1.7707	\$0.4710	\$1.4237	\$0.7342	\$1.3387	\$0.0000	\$0.0000	\$0.1709	\$0.0000	\$0.0000	\$0.0573	\$113,393,000
Average Portion of Premium Paid by Employee ²	\$0.0353	\$0.3515	\$0.2109	\$0.4655	\$0.2434	\$0.4450	\$0.3852	\$0.2730	\$0.6256	\$0.7312	\$0.0325	\$0.0000	\$0.0000	\$0.0062	\$45,490,000
Total Premium	\$0.1669	\$2.0758	\$1.1643	\$2.2362	\$0.7144	\$1.8687	\$1.1194	\$1.6116	\$0.6256	\$0.7312	\$0.2034	\$0.0000	\$0.0000	\$0.0634	\$158,883,000
Covered Benefits Paid by Member (Deductibles, copayments, etc)	-\$0.0997	-\$0.5375	-\$0.0900	-\$0.1800	-\$0.0570	-\$0.4547	-\$0.0814	-\$0.1219	-\$0.0437	-\$0.1597	-\$0.1215	\$0.0000	\$0.0000	-\$0.0379	-\$40,289,000
Total Expenditures	\$0.0672	\$1.5384	\$1.0743	\$2.0563	\$0.6574	\$1.4140	\$1.0380	\$1.4897	\$0.5819	\$0.5715	\$0.0819	\$0.0000	\$0.0000	\$0.0256	\$118,594,000
Percentage Impact of Mandate															
Insured Premiums	0.070%	0.607%	0.406%	0.736%	0.292%	0.607%	0.406%	0.736%	0.292%	0.607%	0.074%	0.000%	0.000%	0.098%	0.306%
Total Expenditures	0.027%	0.397%	0.352%	0.554%	0.256%	0.400%	0.349%	0.552%	0.256%	0.385%	0.029%	0.000%	0.000%	0.038%	0.211%

Source: California Health Benefits Review, 2005.

Note: The population includes individuals and dependents in California who have private insurance (group and individual), or are enrolled in public plans subject to the Health and Safety Code, including CalPERS and Healthy Families. The total annual amount listed in “average portion of premium paid by employer” differs from the figure in the text, because this row total includes the totals from public payers.

Employees and their dependents that receive their coverage from self-insured firms are excluded because these plans are not subject to mandates

(1) This represents what all individuals in a plan pay to cover the cost of this service. It represents the total expenditures per service multiplied by the quantity utilized, divided by the number of members in each plan, divided by 12 months. All values include all healthcare benefits, except expenditures by individuals on the mandated benefit.

(2) Individuals who purchase their own insurance are treated as employees in this row.

Key: FFS = fee for service; HMO = health maintenance organization; POS = point of service; PPO = preferred provider organization. CalPERS = California Public Employees’ Retirement System

APPENDICES

Appendix A Literature Review Methods and Other Methods of Analysis

SB 572 is a bill to amend Section 1374.72 of California's Health and Safety Code, and to amend Section 10144.5 of the Insurance Code.

Literature Review Methods

Peer-reviewed journal articles sought for this analysis included evaluation studies, systematic reviews, and review articles related to the effects of implementation of state and mental health parity laws.

Searches were conducted through PubMed and PsycINFO (psychological abstracts) and ABI/INFORM (business, finance, medical economics) databases for English-only articles published during the period from 1990 through March 2005.

Below is a list of MeSH terms used in PubMed searches:

Health Services Accessibility
Insurance Coverage/legislation & jurisprudence
Mental Health Services/economics
Mental Health Services/legislation & jurisprudence
Mental Health Services/utilization
Length of Stay
Hospitalization
Health Care Quality, Access, and Evaluation
Utilization Review
Cost Control
Follow-Up Studies
Evaluation Studies

Publication Types:
Evaluation Studies
Systematic Review
Review

Keywords used for PubMed searches were as follows:

mental health parity (act, mandate* or law* or legislation), effect*, impact*, cost*,
evaluation, length of stay, hospitalization, quality care, access, utilization,
* truncation

Keywords for Psych/INFO and ABI/INFORM searches were:
search CSA PsycINFO for mental health parity.

PsycINFO Thesaurus:

Health Care Utilization
Mental Health Services
Health Care Policy
Managed Care
Government Policy Making
Health Insurance

Keywords:

mental health parity, law* or regulation*, effect*, impact*, parity law,
mental health parity act
*truncation

Below is a list of terms used to search ProQuest ABI/INFORM.

ProQuest ABI/INFORM Thesaurus:

Mental Health Care
Mental Health
Mental Disorders
Health Care Access
Impact Analysis
Health Services Utilization
Utilization Review
Parity
State Laws
Effects

Keywords in citation and abstract:

mental health parity, law* or regulation*, mental health parity act,
parity law, effect* impact*
*truncation

Peer-reviewed journal articles were also sought for health effects, health outcomes, and medical effectiveness related to the implementation of federal and state mental health parity laws.

Keywords in citation and abstract:

health effects, mental health parity, laws,

health outcomes, mental health parity, laws,
medical effectiveness, mental health parity, laws,

MeSH terms:

Health
Effects
Medical
Effectiveness
Mental Health
Mental Health
Laws
Legislation
Parity

Many documents, primarily government reports or government funded reports, were also searched for and retrieved through the Internet. Government documents included published Congressional hearing testimony, reports required by Congress of federal agencies, and regularly issued or special reports of government agencies, and special studies conducted or funded by federal and state agencies.

Web sites of federal and state agencies searched included (The Office of the Assistant Secretary for Planning and Evaluation, the National Institute of Mental Health, the Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services; the Office of Personnel Management, the Congressional Budget Office, the Government Accountability Office, formerly the General Accounting Office, the California Legislative Analyst Office)

Web sites also searched included those of professional associations, trade associations, health care organizations, consumer organizations, universities conducting health service research on mental health parity, and private and not-for-profit consulting firms conducting research under federal or state contract or grants from private foundations.

Keywords for Internet searches were:

Mental health parity, federal, state laws
Implementation
Evaluation
Effects
Employers
Health Plans
Managed Behavioral Health Care Organizations
Impact
Inpatient
Outpatient
Mental Health Providers
Psychiatrists
Psychologists
Mental Health Professions
Cost
Utilization
Access
Quality of Care
Appropriateness of Care
Stakeholders

Consumers
Health Outcomes
Health Effects
Medical Effectiveness
Mental Health Treatment Protocols and Clinical Guidelines

Eighty-three citations (nearly all with abstracts) were retrieved from the PubMed, Psych/INFO, and ABI/INFORM literature searches and reviewed.

Of the 83 citations six were determined not relevant to this analysis of evidence of the effects of implementation of mental health parity laws and implications for SB 572, and articles or documents were not retrieved.

Sixty-four citations and/or abstracts were determined to be relevant and articles were attempted to be retrieved based on information provided. (Thirteen citations had insufficient information provided to retrieve the articles or documents cited.)

In addition, 36 peer-reviewed journal articles and other documents were identified as relevant to the analysis and accessed from the Internet.

A total of 100 peer-reviewed journal articles, government reports, and other relevant documents were read and evaluated in terms of their relevance in this analysis.

Other Methods Used in the Analysis

Some mental health parity laws have been relatively recently implemented in California, other states, and at the federal level, and implementation evaluation studies are just being initiated, are ongoing, or have results not yet made public or published in peer-reviewed medical literature.

The first study is an in-depth update to the snapshot implementation study by Mathematica Policy Research, Inc. of mental health parity in California initiated after the passage of AB 88. The snapshot study was conducted for the California HealthCare Foundation during the first year of implementation of AB 88 (Lake, Sasser, Young, and Quinn, Mathematica Policy Research, Inc., 2002). The update study is sponsored by the Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. The purpose of the study is to determine which implementation issues and effects from the snapshot study were temporary and

A second study is being conducted by California's Department of Managed Care. This study will survey health plans and MBHOs to assess major issues of concern in implementation of AB 88.

The third is an evaluation required under SB 1103 passed in 2004. "The bill would require the State Department of Mental Health, in collaboration with the Department of Managed Health Care, the Department of Insurance, and applicable representatives from the California public and private mental health systems, to identify the core reasons that mental health parity in California is not being achieved, the barriers to achieving that parity, and what approaches over the short term and long term can be done to effectuate a more comprehensive mental health system in California, both public and private. The bill would require the State Department of Mental Health to submit a report of this information to the

Legislature on or before March 1, 2005.” The report has been completed and is presently undergoing administrative review.

A fourth study is an evaluation of mental health parity in the 8.7-million–member Federal Employee Health Benefit Program initiated by the federal Office of Personnel Management in 2001. The evaluation began in fall of 2001 and concluded in December 2004. The evaluation study was conducted by a consortium of investigators (U. S. Department of Health and Human Services, Mental Health, United States, 2002, Hennessy and Barry, Chapter 14. Parity in the Federal Employees Health Benefits Program: An Overview) and was jointly commissioned by the Office of the Assistant Secretary for Planning and Evaluation with the Office of the Secretary, U.S. Department of Health and Human Services and the Office of Personnel Management. A report the study has not yet been made public by the funding agencies and results of the study have not yet been published in a peer-reviewed journal.

To obtain information about these studies, structured key informant interviews were conducted with two informants to supplement the review of the peer-reviewed literature and review of government documents and to help frame the analysis of SB 572. Informants were asked the following questions about their implementation studies:

1. How did the evaluation of mental health parity come about?
 - a. What agency(ies) sponsored it?
 - b. Who is/was the program officer(s)?
 - c. Who has been involved in doing the evaluation?
2. What were the objectives of the evaluation? (e.g., impact of implementation, process of implementation)?
3. What were the methods?
4. What were the principal findings?
5. Are these findings consistent or at odds with prior literature on mental health parity implementation evaluation?
6. What are the principal limitations of the study?
7. When will results of the study be public and in what forms?

Key informants agreed to be interviewed only if the information remained confidential as it would jeopardize publications of findings and represent a breach of confidentiality with clients, funders, or study participants. Although the information provided during these key informant interviews represented important background information in developing the analysis, it will not be included in this report, as published articles or reports made available to the public are expected to be forthcoming in the next three to six months.

APPENDIX B

Cost Impact Analysis: General Caveats and Assumptions

This appendix describes general caveats and assumptions used in conducting the cost impact analysis. For additional information on the cost model and underlying methodology, please refer to the CHBRP Web site, http://www.chbrp.org/analysis_methodology/cost_impact_analysis.php

The cost analysis in this report was prepared by Milliman and the University of California, Los Angeles, with the assistance of CHBRP staff. Per the provisions of AB 1996 (California Health and Safety Code, Section 127660, et seq.), the analysis includes input and data from an independent actuarial firm, Milliman. In preparing cost estimates, Milliman and UCLA relied on a variety of external data sources. The *Milliman Health Cost Guidelines* (HCG) were used to augment the specific data gathered for this mandate. The HCGs are updated annually and are widely used in the health insurance industry to estimate the impact of plan changes on health care costs. Although this data was reviewed for reasonableness, it was used without independent audit.

The expected costs in this report are not predictions of future costs. Instead, they are estimates of the costs that would result if a certain set of assumptions were exactly realized. Actual costs will differ from these estimates for a wide variety of reasons, including:

- Prevalence of mandated benefits before and after the mandate different from our assumptions.
- Utilization of mandated services before and after the mandate different from our assumptions.
- Random fluctuations in the utilization and cost of health care services.

Additional assumptions that underlie the cost estimates presented here are:

- Cost impacts are only shown for people with insurance.
- The projections do not include people covered under self-insurance employer plans because those employee benefit plans are not subject to state-mandated minimum benefit requirements.
- Employers and employees will share proportionately (on a percentage basis) in premium rate increases resulting from the mandate. In other words, the distribution of premium paid by the subscriber (or employee) and the employer will be unaffected by the mandate.

There are other variables that may affect costs, but which Milliman did not consider in the cost projections presented in this report. Such variables include, but are not limited to:

- Population shifts by type of health insurance coverage. If a mandate increases health insurance costs, then some employer groups or individuals may elect to drop their coverage. Employers may also switch to self-funding to avoid having to comply with the mandate.
- Changes in benefit plans. To help offset the premium increase resulting from a mandate, members or insured may elect to increase their overall plan deductibles or copayments. Such changes would have a direct impact on the distribution of costs between the health plan and the insured person, and may also result in utilization reductions (i.e., high levels of patient cost-sharing result in lower utilization of health care services). Milliman did not include the effects of such potential benefit changes in its analysis.

- Adverse Selection. Theoretically, individuals or employer groups who had previously foregone insurance may now elect to enroll in an insurance plan postmandate because they perceive that it is to their economic benefit to do so.
- Health plans may react to the mandate by tightening their medical management of the mandated benefit. This would tend to dampen our cost estimates. The dampening would be more pronounced on the plan types that previously had the least restrictive medical management (i.e., FFS and PPO plans).
- Variation in existing utilization and costs, and in the impact of the mandate, by geographic area and delivery system models: Even within the plan types modeled (HMO, PPO, POS, and FFS), there are variations in utilization and costs within California. One source of difference is geographic. Utilization differs within California due to differences in the health status of the local commercial population, provider practice patterns, and the level of managed care available in each community. The average cost per service would also vary due to different underlying cost levels experienced by providers throughout California and the market dynamic in negotiations between health plans and providers. Both the baseline costs prior to the mandate and the estimated cost impact of the mandate could vary within the state due to geographic and delivery system differences. For purposes of this analysis, however, the impact on a statewide level was estimated.

APPENDIX C

Information Submitted by Outside Parties for Consideration for CHBRP Analysis

In accordance with its policy to analyze evidence submitted by outside parties during the first two weeks of each 60-day review of a proposed benefit mandate, CHBRP received the following submissions:

No information was submitted to date.

CHBRP analyzes all evidence received during the initial public submission period according to its relevance to the proposed legislation and the program's usual methodological criteria. For more information about CHBRP's methods, to learn how to submit evidence relevant to an on-going mandate review, or to request email notification of new requests CHBRP receives from the California Legislature, please visit: <http://www.chbrp.org>.

APPENDIX D:

Estimate on Number of Privately Insured Californians Not Explicitly Covered under AB 88

Table D-1 details the prevalence estimates for individuals covered under SB 572. Consistent prevalence measures for all of the mental disorders that are added by SB 572 were not identified. An alternative strategy is to take the 20% annual estimate of the population who have a non-substance abuse mental disorder and subtract those that are already explicitly covered under AB 88. According to the CHIS data, of the privately insured population under 65, 28% is under 18 and the remaining 72% is between 18 and 64 years of age (US Census, 2004). Assuming a similar population distribution among the privately insured population, one can apply the 2.6% estimate of the adult population with “severe mental illness” (US DHHS, 1999) and the 7.5% of the under 18 population with “serious emotional disturbances” (CDMH, 2000) to get a rough estimate of the number of individuals who could be potentially affected by SB 572.

An additional adjustment is required for those adults with anorexia nervosa and bulimia nervosa diagnoses. While overall and age-specific prevalence estimates were not identified, these disorders are relatively rare, with anorexia nervosa estimated as occurring in 1% of adolescent girls and a bulimia nervosa prevalence of 1% to 2% of young women (First and Tasman, 2004). Adolescents with anorexia will most likely fall under the serious emotional disturbances category. However, if one assumes that 2% of women aged 18-24 years have a diagnosis of bulimia nervosa and women aged 18-24 years make up 5.5% of the privately insured population in California (based on CHIS), one can calculate an additional 22,405 of individuals with a mental disorder already explicitly covered under AB 88.

There are a number of assumptions used in this estimate, including 1) the prevalence of mental disorders in the privately insured population is the same as in the general non-institutionalized U.S. population, and 2) the prevalence for anorexia nervosa and bulimia nervosa is largely limited to adolescents and women aged 18-24 years. Another particularly important assumption in this analysis is that AB 88 refers to a strict interpretation of “severe mental illness” where parity is only required when the specific diagnoses listed in AB 88 are accompanied by disability within the last year. It is important to recognize that the estimate in Table D-1 reflects the difference between what health plans are *required by law* to cover under AB 88 and SB 572, and does not account for a broader implementation of mental health parity under AB 88.

Table D-1: Prevalence Estimates for Individual Covered Under SB 572

(A) Estimated number of Californians with private health insurance	20,368,000
(B) Aged 0-17 years <i>(28% of A)</i>	5,703,040
(C) Aged 18-64 years <i>(72% of A)</i>	14,664,960
(D) Estimated number of privately insured Californians with a mental disorder <i>(20% of A)</i>	4,073,600
(E) Aged 0-17 years with serious emotional disturbance <i>(7.5% of B)</i>	427,728
(F) Aged 18-64 years with severe mental illness <i>(2.6% of C)</i>	381,289

(G) Adjustment for women aged 18-24 years with bulimia nervosa (2% of 18-24 females - 5.5% of A)	22,405
(H) Estimated number of privately insured Californians with a mental disorder not already explicitly covered by AB 88 ($D - (E + F + G)$)	3,242,178

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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 CHBRP's 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 CHBRP's authorizing legislation, UC contracts with a certified actuary, Milliman, to assist in assessing the financial impact of each benefit mandate bill. Milliman also helped with the initial development of CHBRP's 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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