California Health Benefits Review Program

Analysis of California Assembly Bill 2242
Mental Health Services

A Report to the 2019–2020 California State Legislature

April 10, 2020

CALIFORNIA
HEALTH BENEFITS REVIEW PROGRAM

Key Findings

Analysis of California Assembly Bill 2242 Mental Health Services

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

CALIFORNIA HEALTH BENEFITS REVIEW PROGRAM

AT A GLANCE

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

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

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

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

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

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

CONTEXT

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

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

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

BILL SUMMARY

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

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

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

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

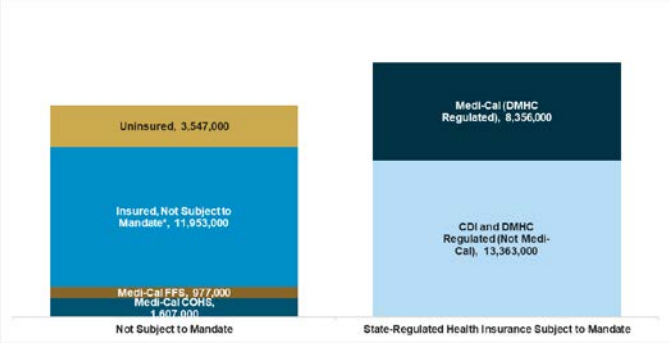
[1] Refer to CHBRP’s full report for full citations and references.

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

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

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

Figure A. Health Insurance in California



Source: California Health Benefits Review Program, 2020.

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

IMPACTS

Benefit Coverage, Utilization, and Cost

Benefit Coverage

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

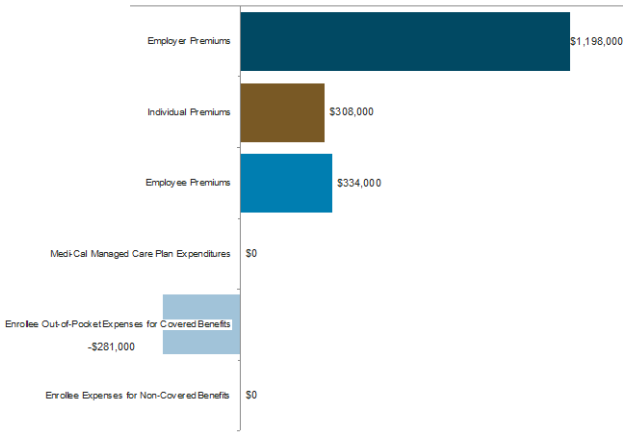
Utilization

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

Expenditures

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

Figure B. Expenditure Impacts of AB 2242



Source: California Health Benefits Review Program, 2020.

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

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

Medi-Cal

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

CalPERS

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

Number of Uninsured in California

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

Medical Effectiveness

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

The medical effectiveness review finds:

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

Public Health

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

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

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

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

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

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

Long-Term Impacts

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

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

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

Essential Health Benefits and the Affordable Care Act

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

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

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Mental Health Services

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The California Health Benefits Review Program (CHBRP) was established in 2002. As per its authorizing statute, CHBRP provides the California Legislature with independent analysis of the medical, financial, and public health impacts of proposed health insurance benefit-related legislation. The state funds CHBRP through an annual assessment on health plans and insurers in California.

An analytic staff based at the University of California, Berkeley, supports a task force of faculty and research staff from multiple University of California campuses to complete each CHBRP analysis. A strict conflict-of-interest policy ensures that the analyses are undertaken without bias. A certified, independent actuary helps to estimate the financial impact. Content experts with comprehensive subject-matter expertise are consulted to provide essential background and input on the analytic approach for each report.

More detailed information on CHBRP's analysis methodology, authorizing statute, as well as all CHBRP reports and other publications, are available at www.chbrp.org.

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Table 1. AB 2242 Impacts on Benefit Coverage, Utilization, and Cost, 2021

	Baseline (2021)	Postmandate Year 1 (2021)	Increase/ Decrease	Change Postmandate
Benefit Coverage				
Total enrollees with health insurance subject to state-level benefit mandates (a)	21,719,000	21,719,000	0	0%
Total enrollees with health insurance subject to AB 2242	13,363,000	13,363,000	0	0%
Total percentage of enrollees with coverage for 72-hour treatment and evaluation	100%	100%	0%	0%
Total percentage of enrollees with coverage for follow-up outpatient visit	100%	100%	0%	0%
Utilization and Cost				
Number of enrollees subject to AB 2242 detained for 72-hour treatment and evaluation	59,200	59,200	0	0%
… who attend a mental health outpatient visit within 48 hours of discharge	14,300	41,100	26,800	187.00%
… who attend a mental health outpatient visit after 48 hours of discharge (b)	23,100	0	-23,100	-100%
… who do not attend a mental health outpatient visit following discharge (b)	21,800	18,100	-3,700	-16.97%
Average cost per unit				
Follow-up mental health outpatient visit with in-network provider	$140	$140	$0	0%
Follow-up mental health outpatient visit with out-of-network provider	$197	$197	$0	0%
Administration cost per scheduled outpatient visit	$0	$14	$14	N/A
Expenditures				
Premium (expenditures) by Payer				
Private Employers for group insurance	$54,037,059,000	$54,038,198,000	$1,139,000	0.002%
CalPERS HMO employer expenditures (c) (d)	$3,264,098,000	$3,264,157,000	$59,000	0.002%
Medi-Cal Managed Care Plan expenditures	$29,218,820,000	$29,218,820,000	$0	0%
Enrollee Premiums (expenditures)				
Enrollees for individually purchased insurance	$15,689,758,000	$15,690,066,000	$308,000	0.002%
Enrollees with group insurance, CalPERS HMOs, Covered California, and Medi-Cal Managed Care (d)	$15,867,227,000	$15,867,561,000	$334,000	0.002%
Enrollee out-of-pocket expenses				
For covered benefits (deductibles, copayments, etc.)	$12,776,801,000	$12,776,520,000	-$281,000	-0.002%
For noncovered benefits (e)	$0	$0	$0	0%
Total Expenditures	$130,853,763,000	$130,855,322,000	$1,599,000	-0.001%

Source: California Health Benefits Review Program, 2020.

Notes: (a) Enrollees in plans and policies regulated by DMHC or CDI aged 0 to 64 years as well as enrollees 65 years or older in employer-sponsored health insurance. This group includes commercial enrollees (including those associated with Covered California or CalPERS) and Medi-Cal beneficiaries enrolled in DMHC-regulated plans.[5]

(b) Assume that all follow-up visits occur within 90 days of release from the 72-hour hold.

(c) Of the increase in CalPERS employer expenditures, about 57.4% or $15,000 would be state expenditures for CalPERS members who are state employees or their dependents.

(d) Enrollee premium expenditures include contributions by employees to employer-sponsored health insurance, health insurance purchased through Covered California, and contributions to Medi-Cal Managed Care.

(e) Includes only expenses paid directly by enrollees (or other sources) to providers for services related to the mandated benefit that are not currently covered by insurance. This only includes those expenses that will be newly covered postmandate. Other components of expenditures in this table include all health care services covered by insurance.

Key: CalPERS = California Public Employees' Retirement System; CDI = California Department of Insurance; DMHC = Department of Managed Health Care; HMO = Health Maintenance Organization.

[5] For more detail, see *Estimates of Sources of Health Insurance in California for 2021*, available at http://chbrp.org/other_publications/index.php.

POLICY CONTEXT

The California Assembly Committee on Health has requested that the California Health Benefits Review Program (CHBRP)[6] conduct an evidence-based assessment of the medical, financial, and public health impacts of AB 2242, Mental Health Services.

Bill-Specific Analysis of AB 2242, Mental Health Services

AB 2242 addresses health plan/insurer approval of mental health services for persons who are involuntarily detained for a 72-hour treatment and evaluation hold when they, as a result of a mental health disorder, are a danger to others, or themselves, or gravely disabled. This is commonly referred to as a "5150" hold based on the relevant California code number.[7] These holds are intended to stabilize the person and reduce the risk that they will harm themselves or someone else. Although the person cannot be required to attend outpatient mental health appointments after release from a 5150 hold, prompt follow-up with outpatient mental health providers after discharge from a psychiatric hospitalization is critical for maintaining continuity of treatment and preventing repeat hospitalizations (Holt, 2018).

Bill Language

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

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

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

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

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

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

Definition

AB 2242 provides the following definition of "covered mental health services":

- Mental health services that are urgently needed to prevent serious deterioration of the enrollee's health resulting from unforeseen illness or injury for which treatment cannot be delayed until the enrollee can receive services from a contracting provider.

The full text of AB 2242 can be found in Appendix A.

[6] CHBRP's authorizing statute is available at www.chbrp.org/faqs.php.
[7] Welfare and Institutions Code (WIC) section 5150 addresses the detention of mentally disordered persons for evaluation and treatment. Available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=5150. Accessed March 24, 2020.

Relevant Populations

If enacted, AB 2242 would affect the health insurance of approximately 13.4 million enrollees (33% of all Californians). This represents 62% of the 21.7 million Californians who will have health insurance regulated by the state that may be subject to any state health benefit mandate law — health insurance regulated by the California Department of Managed Health Care (DMHC) or the California Department of Insurance (CDI). If enacted, the law would affect the health insurance of enrollees in DMHC-regulated plans and CDI-regulated policies, exempting Medi-Cal managed care plans.

CHBRP estimates that there are 59,200 enrollees who are subject to AB 2242 and detained for 72-hour treatment and evaluation hold at baseline, as well as postmandate (no change).

Interaction With Existing Requirements

Health benefit mandates may interact and align with the following state and federal mandates or provisions.

California Policy Landscape

California law and regulations

California's existing mental health parity law[8] was signed into law in 1999 and implemented in 2000. It requires coverage of the diagnosis and medically necessary treatment of severe mental illness (SMI) for enrollees of any age and of serious emotional disturbances (SED) of a child. SMI includes diagnoses of schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, and others. A child is identified as having an SED if they "(1) have one or more mental disorders identified in the most recent edition of the Diagnostic and Statistical Manual (DSM) of Mental Disorders, other than a primary substance use disorder or developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norms" and (2) meet criteria specified in current law regarding substantial impairment as a result of their mental disorder.

Another California law specifies that when specific mental health conditions are covered by either a group or individual plan or policy, certain services or locations for treatment must also be covered.[9] A comprehensive list of these requirements and other tangentially related mental health mandates in current law is included in CHBRP's resource *Health Insurance Benefit Mandates in California State and Federal Law*.[10] In most instances, the California mental health parity act supersedes these mandates with more restrictive requirements.

Additionally, DMHC-regulated plans and most small-group and individual market CDI-regulated policies[11] are required to cover Basic Health Care Services, which include inpatient care, physician services, and emergency care, and must be covered regardless of a patient's diagnosis.[12]

AB 2179 (Cohn), Chapter 797, Statutes of 2002, directed DMHC and CDI to adopt regulations to ensure enrollee access to necessary health care services in a timely manner. These timely access standards and network adequacy requirements are addressed in the California Health and Safety Code and the

[8] Health and Safety Code 1374.72; Insurance Code 10144.5.
[9] H&SC 1367.2 and IC 10123.6.
[10] CHBRP's resource *Health Insurance Benefit Mandates in California State and Federal Law* is available at http://chbrp.org/other_publications/index.php#revize_document_center_rz44.
[11] Small-group and individual market CDI-regulated policies subject to the Essential Health Benefits (EHBs) are subject to Basic Health Care Services because the chosen EHB benchmark plan is regulated by DMHC.
[12] IC 10112.27(a)(2)(A)(i); 28 CCR 1300.67.

California Code of Regulations.[13] If care following release after detention from a 5150 hold requires urgent care access, the timely access standards are 2 days if prior authorization is not required by the health plan and 4 days if prior authorization is required by the health plan; timely access for nonurgent care is 10 business days for mental health treatment with a nonphysician provider.[14] In addition, CDI requires access to mental health professionals within 30 minutes or 15 miles of a covered person's residence or workplace,[15] while DMHC does not have such geographic access requirements.

Similar requirements in other states

While several other states also have mental health parity laws, CHBRP is unaware of similar requirements or similar proposed legislation in other states related to the other AB 2242 provisions.

Federal Policy Landscape

Federal Mental Health Parity and Addiction Equity Act

The federal Mental Health Parity and Addiction Equity Act (MHPAEA) addresses parity for mental health benefits.[16] The MHPAEA requires that if mental health or substance use disorder (SUD) services are covered, cost-sharing terms and treatment limits be no more restrictive than the predominant terms or limits applied to medical/surgical benefits. The MHPAEA applies to the large-group market, but the Affordable Care Act (ACA) requires small-group and individual market plans and policies purchased through a state health insurance marketplace to comply with the MHPAEA. This federal requirement is similar to the California mental health parity law,[17] although the state law applies to some plans and policies not subject to the MHPAEA.

Affordable Care Act

A number of Affordable Care Act (ACA) provisions have the potential to or do interact with state benefit mandates. Below is an analysis of how AB 2242 may interact with requirements of the ACA as presently exists in federal law, including the requirement for certain health insurance to cover essential health benefits (EHBs).[18,19]

Any changes at the federal level may impact the analysis or implementation of this bill, were it to pass into law. However, CHBRP analyzes bills in the current environment given current law and regulations.

The ACA extended the parity requirements of the MHPAEA to nongrandfathered plans and policies in the small-group and individual markets.

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[13] Health and Safety Code sections 1367.03 and 1367.035, and title 28 of the California Code of Regulations, section 1300.67.2.2, subsections (g)(2) and (g)(2)(G).
[14] DMHC. *Timely Access to Care*. Available at: https://www.dmhc.ca.gov/HealthCareinCalifornia/YourHealthCareRights/TimelyAccesstoCare.aspx. Accessed March 24, 2020.
[15] CDI. *Provider Network Adequacy*. Available at: http://www.insurance.ca.gov/01-consumers/110-health/10-basics/pna.cfm. Accessed March 24, 2020.
[16] Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), as amended by the ACA.
[17] H&SC Section 1374.72; IC Section 10144.5 and 10123.15.
[18] The ACA requires nongrandfathered small-group and individual market health insurance — including but not limited to Qualified Health Plans (QHPs) sold in Covered California — to cover 10 specified categories of EHBs. Policy and issue briefs on EHBs and other ACA impacts are available on the CHBRP website: www.chbrp.org/other_publications/index.php.
[19] Although many provisions of the ACA have been codified in California law, the ACA was established by the federal government, and therefore, CHBRP generally discusses the ACA as a federal law.

Essential Health Benefits

Nongrandfathered plans and policies sold in the individual and small-group markets are required to meet a minimum standard of benefits as defined by the ACA as essential health benefits (EHBs). In California, EHBs are related to the benefit coverage available in the Kaiser Foundation Health Plan Small Group Health Maintenance Organization (HMO) 30 plan, the state's benchmark plan for federal EHBs.[20,21] CHBRP estimates that approximately 4 million Californians (10%) have insurance coverage subject to EHBs in 2021.[22]

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

National Quality Measures

As detailed in the *Background on 5150 Holds and Related Mental Health Services in California* section, there are measures developed by the National Committee for Quality Assurance (NCQA) related to *Follow-Up After Hospitalization for Mental Illness (FUH)*. This measure identifies the percentage of members who received follow-up within: (1) 7 days of discharge, and (2) 30 days of discharge. Data on performance of California health plans/insurers on these measures are reported by the Office of the Patient Advocate (OPA).[23] OPA reported that in 2018, 37% to 75% of persons aged 6 years and older with commercial insurance had access to an outpatient mental health appointment within 7 days after discharge for a psychiatric hospitalization and 57% to 84% had access to an outpatient appointment within 30 days of discharge.

Analytic Approach and Key Assumptions

For this analysis, CHBRP assumes that the bill:

- Does not apply to Medi-Cal managed care plans.
- Does not exceed EHBs.

The main provisions of AB 2242 are listed below, along with CHBRP's approach/assumptions for each:

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

   CHBRP assumes this provision applies to outpatient services after the 72-hour hold ends and that there would be no change in health plan/insurer or provider activities due to these provisions. This is because mental health services for those detained for 72-hour holds are believed to be covered and approved per CHBRP's responses from a survey of health plans and insurers, as well as CHBRP's content expert.

[20] CCIIO, *Information on Essential Health Benefits (EHB) Benchmark Plans*. Available at: https://www.cms.gov/cciio/resources/data-resources/ehb.html.
[21] H&SC Section 1367.005; IC Section 10112.27.
[22] CHBRP, *Estimates of Sources of Health Insurance in California in 2021*. Available at: www.chbrp.org/other_publications/index.php.
[23] OPA. *Follow-up Visit Within 7 Days After Mental Illness Hospital Stay* and *Follow-up Visit Within 30 Days After Mental Illness Hospital Stay*. Available at: https://reportcard.opa.ca.gov/rc/HMO_PPO_combinedMeasure.aspx?Category=HMO_PPOHEDIS&Topic=MentalHealthCare&Measure=FollowupVisitAfterMentalIllnessHospitalStay7 and https://reportcard.opa.ca.gov/rc/HMO_PPO_combinedMeasure.aspx?Category=HMO_PPOHEDIS&Topic=MentalHealthCare&Measure=FollowupVisitAfterMentalIllnessHospitalStay30. Accessed March 24, 2020.

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

   CHBRP assumes that patients and families, as well as providers (especially inpatient facilities), and some health plans/insurers currently are involved to some degree in scheduling follow-up outpatient appointments. When scheduling these appointments becomes the responsibility of the health plans/insurers per this provision of AB 2242, CHBRP assumes they will incur an administration cost for additional scheduled visits and models the impact of this provision as detailed in the *Benefit Coverage, Utilization, and Cost Impacts* section under a best-case scenario approach where shortages of mental health providers do not restrict the feasibility of health plans and insurers scheduling follow-up visits within 48 hours of discharge postmandate. CHBRP assumes this provision applies only to scheduling the visit and does not require any efforts by the health plan/insurer to ensure the follow-up visit is attended.

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

   Based on responses to CHBRP's survey of California regulators, CDI already requires reasonable geographic proximity of services. CHBRP assumes any potential administrative cost related to ensuring visits are within reasonable proximity are reflected in the overall standard administrative costs incurred by health plans/insurers related to scheduling the visit (#2 above).

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

   CHBRP assumes that this provision reduces cost sharing for the enrollees/insureds who see out-of-network providers for their follow-up outpatient visit, as detailed in the *Benefit Coverage, Utilization, and Cost Impacts* section.

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

   CHBRP assumes that health plans/insurers will pay noncontracting providers the out-of-network rate for follow-up outpatient mental health visits postmandate as a result of this provision, as detailed in the *Benefit Coverage, Utilization, and Cost Impacts* section.

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

BACKGROUND ON 5150 HOLDS AND RELATED MENTAL HEALTH SERVICES IN CALIFORNIA

The following sections provide an overview of 72-hour involuntary psychiatric holds (commonly known as "5150s" in reference to the California code number), including estimates of their prevalence, a description of the population at risk, issues associated with follow-up mental health care after a psychiatric hospitalization, and differences and disparities in who receives 5150s in California.

The Involuntary Hold (5150) Process

In California, the Lanterman-Petris-Short Act authorizes peace officers and mental health professionals to place an involuntary hold on persons — adults or children — who, for reasons related to mental health, are likely to cause or suffer specific kinds of harm. During involuntary holds, or 5150s, patients are taken into custody for up to 72 hours, stabilized, and evaluated for additional treatment needs. A 5150 is not a criminal arrest and, as such, does not authorize medical or psychiatric treatment against a person's will (Disability Rights California, 2018).

5150 Initiation

Persons may not be placed under an involuntary hold solely on the basis of having a mental illness. In order for a 5150 to be initiated, a person must meet one of three criteria as a result of a mental health disorder:

- **Danger to self** — a person is most commonly considered a danger to themselves if there is evidence of self-harm or if they have threatened or attempted suicide.
- **Danger to others** — danger to others is usually invoked if a person has threated or attempted to harm others while experiencing a mental health crisis.
- **Grave disability** — a person with grave disability is no longer able to provide for their basic needs (e.g., clothing, food, shelter) as a result of their mental health status and cannot identify family or friends willing to provide care (Disability Rights California, 2018).[24]

5150s may be initiated in community settings (e.g., homes or public places) or in a health care setting, but patients must be transferred to a facility capable of receiving and evaluating persons on a mental health hold.

Studies of persons undergoing involuntary holds suggest that most adult 5150s are initiated in the emergency department (ED) or through emergency medical services (CHPSO, 2018; Roy et al., 2019; Trivedi et al., 2019) whereas most 5150s for children are initiated in prehospital settings by police, school police, or psychiatric response teams (Santillanes et al., 2017).

Patient Evaluation and Inpatient Transfers

Patients with 5150s must be evaluated at facilities designated to receive persons with involuntary mental health holds; these facilities include most EDs, psychiatric hospitals, VA hospitals, and some outpatient mental health crisis centers.

Once a patient arrives at a designated facility and the 5150 is confirmed, a 72-hour evaluation period begins during which one of several scenarios will occur:

[24] Being homeless, on its own, would likely not meet the criteria for grave disability as many homeless persons are mentally capable of seeking out basic needs.

- A patient will improve and be discharged home as they no longer meet the criteria for a 5150 (the hold is lifted at the time of discharge);
- A patient will be voluntarily admitted to a psychiatric or medical ward for further treatment; or
- A patient will continue to meet the 5150 criteria and will be put on a 14-day involuntary hold[25] in order for treatment to be administered.

Two retrospective studies of adult patients with 72-hour involuntary psychiatric holds (similar to 5150s in California) evaluated at an ED in Florida found that most adults with involuntary holds were transferred to inpatient psychiatric treatment facilities or a medical acute care unit, and less than 10% were discharged home from the intake site because they improved and no longer met the requirements for the 72-hour hold (Lachner et al., 2020; Roy et al., 2019). However, other professional sources indicate that a larger proportion of patients with 5150s in California improve at the intake location and are discharged home or do not improve and are boarded in the ED due to shortages of available inpatient psychiatric beds.[26] Comparably, a study of preadolescent children with 5150s at a large ED in Los Angeles found that 56.5% were discharged home within hours of arrival at the ED, 42.2% were transferred to a psychiatric ward, and 1.3% were transferred to a pediatric medical ward (Santillanes et al., 2017).

Discharge and Outpatient Follow-up

Prompt follow-up with outpatient mental health providers after discharge from a psychiatric hospitalization is critical for maintaining continuity of treatment and preventing repeat hospitalizations (Holt, 2018). A study of Medicaid patients with preexisting mental health or substance use disorders (SUDs) found that the risk of suicide was 10 to 20 times greater in the first 90 days after an inpatient hospital discharge as compared with persons hospitalized without a mental health or SUD diagnosis (Olfson et al., 2016). In addition, multiple studies have shown that 5% to 30% of adults and children with involuntary holds have a history of repeat ED visits and hospitalizations (Lachner et al., 2020; Roy et al., 2019; Santillanes et al., 2017). In California, a study of patients receiving involuntary holds from emergency medical service units in Alameda County between 2011 and 2016 reported that 7% of patients had five or more involuntary holds during the study period and accounted for 39% of all involuntary holds (Trivedi et al., 2019).

As described in the *Policy Context* section, **AB 2242 requires access to follow-up mental health care within 48 hours after a person detained on a 5150 is released**; however, this standard differs from nationally established benchmarks for follow-up care. The National Committee for Quality Assurance (NCQA) develops measures of health care quality known as HEDIS measures. Data on various measures are gathered from health plans/insurers and used to evaluate performance and drive quality improvements. Relevant to AB 2242 is the HEDIS measure *Follow-Up After Hospitalization for Mental Illness (FUH)*. This measure assesses the timing of follow-up care of adults and children 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm and had an outpatient visit, an intensive outpatient encounter, or a partial hospitalization with a mental health practitioner. The measure identifies the percentage of members who received follow-up within: (1) 7 days of discharge, and (2) 30 days of discharge. Nationally, the average percent of enrollees receiving follow-up within 7 days was 45.6% for commercial HMO plans and 43.0% for PPO plans in 2018; for 30-day follow up, the percentages were 66.6% for HMOs and 64.9% for PPOs.[27] Data on these measures for California health plans/insurers are reported by the Office of the Patient Advocate (OPA).[28]

[25] Otherwise known as a 5250 (Welfare and Institutions Code).
[26] Personal communication with content expert Lorin Scher, MD. (March 18, 2020).
[27] NCQA. *Follow-Up After Hospitalization for Mental Illness (FUH)*. Available at: https://www.ncqa.org/hedis/measures/follow-up-after-hospitalization-for-mental-illness/. Accessed March 24, 2020.
[28] OPA. *Follow-up Visit Within 7 Days After Mental Illness Hospital Stay* and *Follow-up Visit Within 30 Days After Mental Illness Hospital Stay*. Available at: https://reportcard.opa.ca.gov/rc/HMO_PPO_combinedMeasure.aspx?Category=HMO_PPOHEDIS&Topic=MentalHealthCare&Measure=FollowupVisitAfterMentalIllnessHospitalStay7 and https://reportcard.opa.ca.gov/rc/HMO_PPO_combinedMeasure.aspx?Category=HMO_PPOHEDIS&Topic=MentalHealthCare&Measure=FollowupVisitAfterMentalIllnessHospitalStay30. Accessed March 24, 2020.

Outpatient follow-up care after a 5150 is greatly affected by where the patient is discharged from and whether that patient was undergoing treatment for a mental health condition prior to hospitalization. Patients discharged from an inpatient psychiatric hospital may have faster access to outpatient follow-up care since they are already connected to a mental health provider network; similarly, patients are more likely to have a timely appointment (i.e., within 48 hours) if they already have an established treatment relationship with a mental health professional. Patients who do not meet these two conditions are often instructed to schedule appointments with mental health providers and are sometimes assisted by hospital navigators but must often wait 30 to 60 days for an available appointment.[29]

Prevalence of Involuntary Holds in California

The California Department of Health Care Services (DHCS) reports annual data regarding the number and rate of 72-hour involuntary detentions (i.e., 5150 holds) for the state each fiscal year.[30] Statewide totals and rates of 72-hour involuntary detentions in fiscal year (FY) 2016-2017[31] are presented in Table 2; results are tabulated separately for children aged 17 years and younger and adults aged 18 years and older.

Detention totals reflect the total number of 5150s reported to DHCS each year rather than the number of individuals who received a 5150, which studies suggest may be substantially lower than the number of reported encounters due to the high frequency of repeat detentions among the 5150 population (see section on Discharge and Follow-up).

Table 2. 72-Hour Involuntary Detentions in California by Age Group, Fiscal Year 2016-2017

Age Group	Rate/10,000 Californians	Number of 72-Hour Detentions
Adults (age 18+)	46.0	136,116
Children (ages 17 and younger)	22.0	21,679

Source: California Department of Health Care Services, 2020.

As shown in Table 2, adults in California have over twice the rate of 5150s as compared with children; however, an analysis of involuntary detention data conducted by the California Health Care Foundation (CHCF) shows that the application of 5150s varies widely by region.[32] In FY 2014, the rate of involuntary detentions (per 10,000 people) among adults ranged from 13.1 in the Northern and Sierra region to 72.7 in Los Angeles county, and among children ranged from 0.0 in the Northern and Sierra region to 53.3 in the Sacramento area. Moreover, the CHCF analysis suggests that regional differences may influence how 5150s are applied to adults and children. For example, in the Sacramento Area, there was a high rate of use for both adults and children (63.1 and 53.3, respectively), whereas adults in the San Joaquin area received 5150s at almost seven times the rate of children (45.5 and 6.7, respectively) (Holt, 2018).

Populations at Risk for Involuntary Holds

A retrospective study of 251 adult patients with 72-hour involuntary psychiatric holds in an ED at a large tertiary care center in Florida found that persons with a preexisting psychiatric disorder alone or persons presenting with both a psychiatric disorder and an SUD accounted for over 85% of involuntary holds

[29] Personal communication with content expert Lorin Scher, MD. (March 18, 2020).
[30] Data are inclusive of public and private institutions and for all persons with a 5150, regardless of insurance type.
[31] The most recent fiscal year for which data were available.
[32] Regions are divided thus: Central Coast, Greater Bay Area, Inland Empire, Los Angeles County, Northern and Sierra, Orange County, Sacramento Area, San Diego Area, San Joaquin Valley. See page 54 of the CHCF report for a breakdown of counties by region: https://www.chcf.org/wp-content/uploads/2018/03/MentalHealthCalifornia2018.pdf

(51.4% and 34.3%, respectively), followed by persons with an SUD alone (9.2%). Persons without a preexisting psychiatric or SUD accounted for a small proportion of patients on involuntary holds (5.2%) (Lachner et al., 2020). Depression was the most common psychiatric disorder and alcohol was the most common SUD; suicidal ideation was the reason for involuntary hold in almost three quarters (73.3%) of patients in the analysis (Lachner et al., 2020; Roy et al., 2019).

The following prevalence estimates of serious mental health disorders among adults and children in California broadly describe the population most likely at risk for 5150s. The 2016–2017 National Survey on Drug Use and Health (NSDUH) measures three categories[33] of "past year mental health issues" applicable to persons at risk for 5150s. Estimated rates of mental illness "during the past year" for California adults were:

- 3.9% serious mental illness (SMI);[34]
- 6.5% at least one major depressive episode; and
- 4.0% thoughts of suicide (SAMHSA, 2019a,b).

Corresponding estimates of mental illness among children are not calculated for the NSDUH; therefore, CHBRP relied on estimates of three categories[35] of "past year mental health issues" from a modeling analysis based on 2014–2015 SAMHSA data presented in CHCF's *2018 Health Care Almanac*. Estimated rates of mental illness "during the past year" for California children were:

- 7.6% serious emotional disturbance (SED);[36]
- 12.3% at least one major depressive episode in the past year; and
- 8.2% high school students attempted suicide (1.9% attempted suicide and received treatment by a nurse or doctor) (Holt, 2018).

As described previously, co-occurring SMI and SUD are commonly observed among persons with an involuntary hold. In the United States, almost 40% of the 20 million adults with a SUD reported a mental illness, and almost 20% of the 42 million adults with a mental illness reported a co-occurring SUD (NIDA, 2018). In California, an analysis of 2015 national mental health outcome measures reported to SAMHSA found that 34.4% of adults and 9.2% of children who were utilizing county mental health services had co-occurring SMI/SED and SUD (Holt, 2018).

Barriers to Outpatient Mental Health Treatment

Insurance Type

The California Health Care Foundation estimates that, in 2015,[37] 50% to 72% of persons aged 6 years and older with commercial insurance in California had access to an outpatient mental health appointment within 7 days after discharge for a psychiatric hospitalization and 68% to 83% had access to an outpatient appointment within 30 days of discharge. Corresponding estimates of follow-up appointments among persons using Medi-Cal specialty mental health services suggest that timely access to outpatient mental health appointments after a psychiatric discharge may be lower among Medi-Cal recipients: 40% to 58%

[33] Note that these categories are not mutually exclusive.
[34] Serious mental illness (SMI) = calculated based on NSDUH clinical interview Global Assessment of Functioning scores of ≤50; distress levels (Kessler-6 scale), impairment levels (truncated version of the World Health Organization Disability Assessment Schedule), past year major depressive episode, and past year suicidal thoughts (SAMHSA, 2018).
[35] Estimates of any mental illness are not reported or tabulated for children.
[36] Serious emotional disturbance (SED) = a categorization for children 17 years of age and under who currently have, or at any time during the past year have had, a mental, behavioral, or emotional disorder resulting in functional impairment that substantially limits functioning in family, school, or community activities (Holt, 2018).
[37] More recent estimates of 7-day and 30-day follow-up appointments after a mental health hospitalization are available for the commercially insured population and are presented in the *Policy Context* section of the report.

of adults and children reported receiving a follow-up appointment within 7 days of discharge and 58% to 75% had a follow-up appointment within 30 days of discharge (Holt, 2018).

The percentage of nonphysician mental health/SUD professionals accepting insurance is unknown; however, one study reported that 77% of California psychiatrists responding to a survey about health insurance acceptance had any patients with private health insurance, 55% of respondents had any Medicare patients, and 46% of respondents had any Medi-Cal patients. Some mental health providers accept only direct payments from patients and do not bill insurance (Coffman et al., 2017).

Mental Health Workforce Supply in California

Coverage does not guarantee access to care for mental health/SUD. Access is also affected by the supply of providers. Among people with mental health/SUD who were seeking care, lack of provider access was a key reason cited for unmet need. Coffman et al. (2017) reported that California had 80,000 behavioral health professionals in 2016 who were disproportionately distributed across the state (measured by per capita ratios). In particular, the San Joaquin Valley and Inland Empire had supplies per capita that were far below the state per capita average ratio. Professionals include psychiatrists, psychologists, licensed social workers (LCSW), licensed marriage and family therapists (LMFT), licensed professional clinical counselors (LPCC), psychiatric mental health nurse practitioners, and psychiatric nurses.

Coffman et al. (2018) projected that — assuming current trends continue — "California will have 50% fewer psychiatrists than will be needed to meet both current patterns of demand and unmet demand for behavioral health services. California will have 28% fewer psychologists, LMFTs, LPCCs, and LCSWs combined to meet both current patterns of demand and unmet demand for behavioral health services" by 2028 (Coffman et al., 2018). Recent attention to the issue of unmet need for mental health care has resulted in the establishment of Governor Newsom's Behavioral Health Task Force and monies earmarked for mental health workforce pipeline development (Coffman et al., 2019).

A Kaiser Family Foundation representative poll of 1,404 California adults found that 52% believe that there are not enough mental health providers in local communities, and 48% do not believe there are enough SUD treatment providers. Twenty-four percent of respondents had sought mental health care for themselves or for family. Of those, two-thirds said most Californians seeking treatment are not able to get needed mental health treatment (66%) or SUD treatment (61%) (Hamel et al., 2019).

Disparities[38] and Social Determinants of Health[39] in Persons at Risk for Involuntary Holds in California

Disparities are differences between groups that are modifiable. There are significant disparities in the prevalence of mental health/SUD and use of treatment services by race, gender, age, income, and geographic region. Examples include significantly higher rates of SMI in California Native American (7.0%) and African American (5.8%) populations than in the Asian, Pacific Islander, or white populations (1.7%, 2.4%, and 4.2%, respectively) (Holt, 2018). Similarly, 9.0% of adults earning less than 100% of the Federal Poverty Level (FPL) reported SMI as compared with 1.9% of adults who earned more than 300% of the FPL. Disparities in suicide rates are evident by race/ethnicity as well as region: rates are highest among whites and Native Americans (18% and 16%, respectively) as compared with Hispanics (4%), and

[38] Several competing definitions of "health disparities" exist. CHBRP relies on the following definition: Health disparity is defined as the differences, whether unjust or not, in health status or outcomes within a population (Wyatt et al., 2016).

[39] CHBRP defines social determinants of health as conditions in which people are born, grow, live, work, learn, and age. These social determinants of health (economic factors, social factors, education, physical environment) are shaped by the distribution of money, power, and resources and impacted by policy (adapted from: CDC, 2014; Healthy People 2020, 2019). See CHBRP's SDoH white paper for further information: http://chbrp.com/analysis_methodology/public_health_impact_analysis.php.

about twice as high in Northern California (21%) as compared with the rest of the state (10%) (Holt, 2018). In addition, a recent analysis of all adult ED encounters with primary psychiatric complaints from 2009 to 2014 in California found that persons exhibiting frequent use patterns (i.e., four or more visits per year) similar to the 5150 population are significantly more likely to be male, younger than age 50, and have Medi-Cal or Medicare coverage (Moulin et al., 2018).

The Kaiser Family Foundation poll cited earlier reported racial and gender differences in perceptions of adequate supply of mental health providers. For example, statewide, 52% of Californians polled said there were not enough mental health providers; however, when broken down by race/ethnicity, blacks and Hispanics were more likely to report inadequate supply (75% and 57%, respectively) than whites and Asians (49% and 42%, respectively). This difference also extended to gender, with 57% of women reporting inadequate provider supply as compared with 47% of men (Hamel et al., 2019).

Societal Impact of Untreated Mental Health/SUD in California

The presence of untreated mental health/SUD in California creates a societal economic impact that can be measured through indirect (e.g., lost wages) and direct costs (e.g., medical care). Please note, the societal impact discussed here is relevant to a broader population than AB 2242 impacts (see *Policy Context*).

Mental health and SUDs are among the greatest causes of disability, with high economic costs (primarily indirect), associated with premature mortality, productivity losses, and social and economic opportunity losses at the individual level. Suicide presents just one example of the significant societal impact unmanaged mental health disorders can have. The direct and indirect costs (medical and work-loss costs) from suicides result in an estimated cost of $4.9 billion per year in California. Suicide risk generally increases with age, but it is also a leading cause of premature death. The impact of suicide on young people is a major contributor of years of life lost (CHHS, 2016). Mental health and SUDs were the leading cause of disease burden in the United States (2015), accounting for 3,355 disability adjusted life-years (DALYs)/100,000 population, more than cancer, circulatory conditions, or injuries (3,131, 3,065, and 2,419 DALYs/100,000 population, respectively) (Kamal, 2017).

The association between reduced productivity and mental health disorders is seen in California's population of insured adults. In 2018, 17% of adults who needed help with emotional/mental health problems reported moderate or severe work impairment in the previous 12 months. Specifically, 22% reported being unable to work 8 to 30 days in the prior year due to mental health problems, 11% reported being unable to work 31 days to 3 months, and 20% reported being unable to work more than 3 months (CHIS, 2020).

As with mental illness, estimates on the economic cost associated with substance use vary. Estimates from National Institute on Drug Abuse (NIDA) studies show that direct and indirect costs (e.g., medical care, crime, lost work productivity) were $249 billion for alcohol abuse (based on 2010 data), $193 billion for illicit drugs (based on 2007 data), and $78.5 billion for prescription opioid misuse (based on 2013 data) (NIDA, 2020).

MEDICAL EFFECTIVENESS

As discussed in the *Policy Context* section, AB 2242 would require a health care service plan contract or a health insurance policy that is issued, amended, or renewed on or after January 1, 2021, that includes coverage for mental health services to:

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

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

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

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

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

Additional information on follow-up outpatient mental health appointments is included in the *Background on 5150 Holds and Related Mental Health Services in California* section. The medical effectiveness review summarizes findings from evidence[40] on the impact of follow-up outpatient mental health services after discharge from inpatient mental health treatment and evaluation.

Research Approach and Methods

Studies of follow-up outpatient mental health services were identified through searches of PubMed, the Cochrane Library, Web of Science, EconLit, and Business Source Complete, the Cumulative Index of Nursing and Allied Health Literature, and PsycINFO. Websites maintained by the following organizations that produce and/or index meta-analyses and systematic reviews were also searched: the Agency for Healthcare Research and Quality (AHRQ), the International Network of Agencies for Health Technology Assessment (INAHTA), the National Health Service (NHS) Centre for Reviews and Dissemination, the National Institute for Health and Clinical Excellence (NICE), and the Scottish Intercollegiate Guideline Network.

The search was limited to abstracts of studies published in English from 2010 to present.

CHBRP included two systematic reviews in this paper (Sfetcu et al., 2017; Vigod et al., 2013). Four additional studies of the impact of outpatient care following discharge from inpatient psychiatric care were published after the studies included in the Sfetcu et al. (2017) systematic review (Beadles et al., 2015; Busch et al., 2015; Marcus et al., 2017; Trask et al., 2016).

Of the 400 articles found in the literature review, 42 were reviewed for potential inclusion in this report on AB 2242 and a total of 10 studies were included in the medical effectiveness review for this report. The other articles were eliminated because they did not focus on follow-up outpatient mental health services,

[40] Much of the discussion in this section is focused on reviews of available literature. However, as noted in the section on Implementing the Hierarchy of Evidence on page 11 of the Medical Effectiveness Analysis and Research Approach document (posted at http://chbrp.com/analysis_methodology/medical_effectiveness_analysis.php), in the absence of fully applicable to the analysis peer-reviewed literature on well-designed randomized controlled trials (RCTs), CHBRP's hierarchy of evidence allows for the inclusion of other evidence.

were of poor quality, or did not report findings from clinical research studies. A more thorough description of the methods used to conduct the medical effectiveness review and the process used to grade the evidence for each outcome measure is presented in Appendix B.

The conclusions below are based on the best available evidence from peer-reviewed and grey literature.[41] Unpublished studies are not reviewed because the results of such studies, if they exist, cannot be obtained within the 60-day timeframe for CHBRP reports.

Key Questions

1. Is there evidence that receiving follow-up outpatient mental health services, after discharge from an involuntary psychiatric hold, increases use of mental health services or improves mental health outcomes?

2. Is there evidence that scheduling appointments for follow-up outpatient visits after discharge from an involuntary psychiatric hold increases the percentage of patients who attend follow-up appointments?

3. Is there evidence that having access to follow-up outpatient mental health services in close proximity to the patient's business or residence increases use of mental health services or improves mental health outcomes?

4. Is there evidence that lower cost sharing for follow-up outpatient mental health services increases the use of mental health services or improves mental health outcomes relative to higher cost sharing?

Methodological Considerations

CHBRP did not identify any studies that exclusively assess the impacts of follow-up outpatient visits on people who were placed on a psychiatric hold. Most studies only examine people who were hospitalized for psychiatric care and do not include people who were placed on a psychiatric hold but not admitted for inpatient care. The studies of people admitted for inpatient psychiatric care do not distinguish between people who are hospitalized involuntarily or voluntarily. Findings for people who are hospitalized voluntarily may differ from findings for people subject to psychiatric holds because the former may be more aware of their mental health needs and more willing to seek treatment regardless of the setting in which it is provided.

In addition, few studies of outpatient visits following discharge from inpatient psychiatric care are conducted among commercially insured populations in the United States. Some studies are conducted in other countries whose mental health systems and cultural norms may differ from those of the United States. In the United States, many studies are conducted among Medicaid beneficiaries, Medicare beneficiaries, and veterans who obtain care at Department of Veterans Affairs (VA) health care facilities. Findings from studies of these populations may not be generalizable to the population whose coverage would be affected by AB 2242 because they are older (Medicare), have lower incomes (Medicaid), and are more likely to have disabilities (veterans).

[41] Grey literature consists of material that is not published commercially or indexed systematically in bibliographic databases. For more information on CHBRP's use of grey literature, visit http://chbrp.com/analysis_methodology/medical_effectiveness_analysis.php.

Outcomes Assessed

This literature review focuses on the potential impact of AB 2242 on a variety of measures including hospital readmissions, ED visits, medication adherence, use of mental health services, and mental health outcomes. CHBRP did not find any studies of the effects on mental health outcomes of timely access to follow-up outpatient mental health services, access to outpatient providers in close proximity, or reduction in cost sharing for outpatient visits.

Study Findings

This following section summarizes CHBRP's findings regarding the strength of evidence for the effectiveness of follow-up outpatient mental health services addressed by AB 2242. Each section is accompanied by a corresponding figure. The title of the figure indicates the test, treatment, or service for which evidence is summarized. The statement in the box above the figure presents CHBRP's conclusion regarding the strength of evidence about the effect of a particular test, treatment, or service based on a specific relevant outcome and the number of studies on which CHBRP's conclusion is based. Definitions of CHBRP's grading scale terms is included in the box below, and more information is included in Appendix B.

The following terms are used to characterize the body of evidence regarding an outcome:

Clear and convincing evidence indicates that there are multiple studies of a treatment and that the large majority of studies are of high quality and consistently find that the treatment is either effective or not effective.

Preponderance of evidence indicates that the majority of the studies reviewed are consistent in their findings that treatment is either effective or not effective.

Limited evidence indicates that the studies have limited generalizability to the population of interest and/or the studies have a fatal flaw in research design or implementation.

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

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

More information is available in Appendix B.

The Impact of Timely Mental Health Outpatient Visits on Use of Mental Health Services

Impact on hospital readmissions

CHBRP found one systematic review (Sfetcu et al., 2017) and four studies published after June 2014, the cutoff date for studies included in the systematic review, that examined the impact of mental health outpatient follow-up services after discharge from an inpatient psychiatric hospitalization (Beadles et al., 2015; Busch et al., 2015; Marcus et al., 2017; Trask et al., 2016). All of these studies examined the use of follow-up outpatient visits by all persons discharged from an inpatient psychiatric hospitalization regardless of whether the hospitalization was voluntary or involuntary. None assessed the use of follow-up outpatient visits by people who were treated and released from an involuntary hold in in a nonhospital setting.

In the systematic review, Sfetcu et al. (2017) examined the effects of follow-up visits within 7 days and within 30 days from hospital discharge on readmission rates. The results from five studies included in the systematic review that examined the impact of follow-up visits within 7 days after discharge on hospital readmission were inconsistent. Two studies that examined follow-up with a contact in the community within the first week of discharge showed this contact was effective in reducing readmission rates (Mark et al., 2013; Yeaman et al., 2003). By contrast, two other studies found that a contact in the community on the day of discharge and follow up by the mental health team within 7 days of discharge led to increased readmission (Callaly et al., 2011; Owen et al., 1997). Finally, one study (Pfeiffer et al., 2012) found no significant changes in the percentage of patients re-hospitalized after the VA's adoption of a quality measure that called for providing outpatient follow-up within 7 days of discharge. The generalizability of findings from four of these studies to people whose coverage would be affected by AB 2242 is limited because they examined the impact of follow-up visits on Medicaid beneficiaries (Mark et al., 2013), veterans (Pfeiffer et al., 2012), or people in Australia (Callaly et al., 2011; Owen et al., 1997), a country that has a different health insurance system than the United States. Yeaman et al. (2003) was the only study of follow-up visits within 7 days included in Sfetcu et al. (2017) that included people with commercial health insurance.

Four additional studies of the impact of outpatient care following discharge from inpatient psychiatric care were published after the studies included in the systematic review (Beadles et al., 2015; Busch et al., 2015; Marcus et al, 2017; Trask et al., 2016).

Among these studies, findings from Marcus et al. (2017) are most likely to generalize to AB 2242 because the study examined postdischarge claims data for patients with schizophrenia (N=25,401) or bipolar disorder (N=46,375) who were enrolled in either commercial or Medicaid health plans. The authors assessed whether having a follow-up visit within 7 days or 30 days of discharge was associated with hospital readmission. The authors found a follow-up visit within 30 days of discharge was associated with a slightly lower adjusted odds ratio of hospital readmission in days 31 to 120 of discharge. There was no significant difference in the adjusted odds of readmission among people who had a follow-up visit within 7 days of discharge. The latter finding is likely more pertinent to AB 2242 because it would require health plans/insurers to schedule a follow-up outpatient visit within two days of discharge from a 5150 hold.

Another study (Trask et al., 2016) examined 569 youth aged 6 to 18 years with a psychiatric illness who received publicly funded inpatient psychiatric services in San Diego County. The authors found that, among youth that had been hospitalized for psychiatric illness, outpatient therapy alone reduced hospital readmission but the finding was not significant. However, the authors found that when medication was added to outpatient therapy, the reduction in the risk of hospital readmission was statistically significant. The risk of re-hospitalization was reduced by 10% for each additional hour of follow-up outpatient therapy and medication support received.

One study (Beadles et al., 2015) examined the effects of the timing of the first postdischarge follow-up visit among 18,341 adults (24,934 discharges) enrolled in North Carolina Medicaid who had a diagnosis of depression or schizophrenia and were discharged and not readmitted within 30 days. The first follow-up visit was categorized as occurring within 0 to 7 days, 8 to 30 days, or not within 30 days of discharge. The authors found that for adults with depression, there were no statistically significant differences in the number of hospital admissions for depression among people who received a first outpatient visit with a mental health specialist within 7 days of discharge versus people who received follow-up care within 8 to 30 days of discharge or did not receive follow-up within 30 days of discharge.

By contrast, Beadles et al. (2015) found that among adults with schizophrenia *who did not have a medical home*, patients who received a first outpatient visit with a mental health specialist within 0 to 7 days of discharge had fewer hospital admissions and fewer admissions for schizophrenia relative to people who did not receive follow-up outpatient care within 30 days of discharge. Among adults with schizophrenia *who had a medical home*, people who had a first outpatient visit within 0 to 7 days of discharge had fewer hospital admissions for any reason relative to people who had a first outpatient visit within 8 to 30 days of discharge.

One study (Busch et al., 2015) of administrative claims data in 18 state Medicaid programs (274 counties, representing 103,967 enrollees with schizophrenia, 28,083 received ≥1 mental health hospitalization) examined county health care characteristics associated with 30-day readmission in schizophrenic patients. The authors found that Medicaid enrollees with schizophrenia in counties with lower rates of follow-up within 7 days of discharge had a higher risk of readmission for inpatient psychiatric care.

Summary of findings regarding the impact of timely mental health outpatient visits on hospital readmissions: There is *inconclusive evidence* that mental health outpatient visits reduce hospital readmissions based on nine studies. The study that examined the population that is most similar to the population whose coverage would be affected by AB 2242 found that receipt of follow-up outpatient care within 30 days of discharge was associated with a reduction in the odds of readmission for psychiatric care but that there was no statistically significant difference in odds of readmission between people who receive follow-up outpatient care within seven days of discharge and people who did not receive follow-up care within seven days of discharge.

Figure 1. Impact of Timely Mental Health Outpatient Visits on Hospital Readmissions

Impact on emergency department visits

CHBRP found one study that examined the effect on ED visits of follow-up care with a mental health provider after a psychiatric hospitalization. Beadles et al. (2015) found that, for adults with depression or schizophrenia, there was no statistically significant difference in the number of ED visits among people receiving follow-up care with a mental health provider within 7 days versus within 8 to 30 days versus people who did not receive follow-up care within 30 days of discharge.

Summary of findings regarding the impact of timely mental health outpatient visits on emergency department visits: There is *insufficient evidence* that timely follow-up care with a mental health provider reduces ED visits based on one study. The absence of evidence is not an indication that follow-up outpatient visits do not affect ED visits; it is an indication that the impact is unknown.

Figure 2. Impact of Timely Mental Health Outpatient Visits on Emergency Department Visits

Impact on medication adherence

Beadles et al. (2015) also assessed the impact of follow-up outpatient visits after a psychiatric hospitalization on adherence to medications used to treat depression and schizophrenia. People with depression or schizophrenia who received follow-up outpatient care within 0 to 7 days of discharge or 8 to 30 days of discharge were more likely to fill any prescription for an antidepressant or antipsychotic medication than people who received no follow-up outpatient care within 30 days of discharge. However, there were no statistically significant differences in the percentage of days of medication covered by an insurance claim during the 6 months following discharge.

Summary of findings regarding the impact of timely mental health outpatient visits on medication adherence: There is *insufficient evidence* that timely follow-up care with a mental health provider improves medication adherence based on one study. The absence of evidence is not an indication that follow-up outpatient visits do not improve medication adherence; it is an indication that the impact is unknown.

Figure 3. Impact of Timely Mental Health Outpatient Visits on Medication Adherence

The Impact of Timely Mental Health Outpatient Visits on Mental Health Outcomes

CHBRP did not find any studies that address the effect of timely access to follow-up outpatient mental health services after discharge from inpatient mental health care on mental health outcomes.

Summary of findings regarding the impact of timely mental health outpatient visits on mental health outcomes: There is *insufficient evidence* that timely follow-up care with a mental health provider improves mental health outcomes. The absence of evidence is not an indication that timely access to mental health services does not affect mental health outcomes; it is an indication that the impact is unknown.

Figure 4. Impact of Timely Mental Health Outpatient Visits on Mental Health Outcomes

The Impact of Scheduling Follow-up Outpatient Visits on Hospital Readmissions

In a systematic review of 13 studies, Vigod et al. (2013) examined the impact of interventions aimed at easing the transition from inpatient to outpatient mental health care on hospital readmission rates among adults with mental illness. Two of seven studies included in the systematic review found that a telephone follow-up asking about mental health status and whether or not the patients had visited their outpatient mental health provider significantly reduced hospital readmission rates. Two of six studies found that efforts to ensure timely follow-up appointments significantly reduced hospital readmission rates. It is important to note that only one article in this review includes patients in a commercial insurance plan, the population most relevant to the coverage provided by AB 2242 (Cuffel et al., 2002). In addition, most of these interventions included other services such as telephone-based counseling in addition to scheduling a follow-up outpatient visit. Where scheduling follow-up appointments is combined with other interventions, one cannot determine whether increases in receipt of follow-up care are due to scheduling versus other interventions.

One additional study (Habit et al., 2018) analyzed readmission data from 3 months before and after implementation of mailed letters for patients discharged from one inpatient psychiatric hospital that reminded recipients to attend outpatient visit appointments that had been scheduled for them. The letters resulted in a 1% decrease in 30-day readmission rates. The average readmission rate 3 months prior to implementation was 10%; 3 months after the appointment reminder letters program was implemented, the

rate was 9%. However, this study did not have a comparison group and, thus, does not control for other factors that may have affected the readmission rate.

Summary of findings regarding the impact of scheduling follow-up mental health outpatient visits on hospital readmissions: CHBRP found *inconclusive evidence* that scheduling mental health outpatient visits reduces hospital readmissions based on 13 studies included in the systematic review (Vigod et al., 2013) and one additional study published after the studies included in the systematic review. The generalizability of findings from these studies to AB 2242 is uncertain because most of the interventions studied involved more than scheduling an outpatient visit.

Figure 5. Impact of Scheduling Follow-Up Mental Health Outpatient Visits on Hospital Readmissions

The Impact of Distance from Providers on the Use of Mental Health Services

CHBRP found one study conducted in Italy that assessed the impact of distance on the use of community mental health services. Zulian et al. (2011) found that people who live closer to outpatient mental health facilities are more likely to use them. It is important to note that the population studied includes all people with mental health conditions, not just those who recently completed involuntary treatment and, thus, the findings may not fully generalize to health plan enrollees in California who were on a 5150 hold.

Summary of findings regarding the impact of distance from providers on the use of mental health services: There is *insufficient evidence* on the impact of distance on the use of mental health services based on one study. The absence of evidence is not an indication that proximity of providers does not affect use of mental health services; it is an indication that the impact is unknown.

Figure 6. The Impact of Distance from Providers on the Use of Mental Health Services

The Impact of Distance from Providers on Mental Health Outcomes

CHBRP did not identify any studies that address the effect of access to follow-up outpatient mental health services in close proximity to a patient's business or residence on mental health outcomes.

Summary of findings regarding the impact of distance from providers on mental health outcomes: There is *insufficient evidence* on the impact of proximity of follow-up outpatient mental health services to a patient's business or residence on mental health outcomes. The absence of evidence is not an indication that proximity of mental health services does not affect mental health outcomes; it is an indication that the impact is unknown.

Figure 7. The Impact of Distance from Providers on Mental Health Outcomes

The Impact of Cost Sharing on the Use of Mental Health Services

CHBRP's literature review for AB 2242 identified two studies that examined the impact of copayments on the use of mental health services (Ndumele et al., 2011; Trivedi et al., 2008). Although these studies did not specifically examine cost sharing for out-of-network outpatient mental health services, their findings are relevant to AB 2242 because the bill would reduce cost sharing for out-of-network mental health providers to the same level as cost sharing for in-network providers.

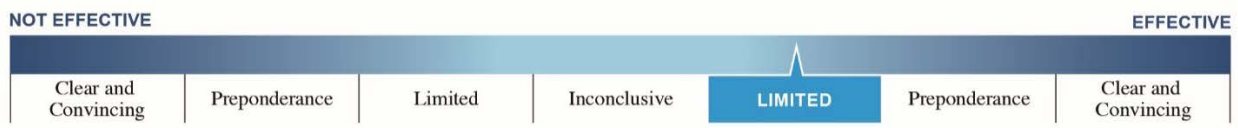
Trivedi et al. (2008) is the most relevant to AB 2242 because the authors examined the relationship between parity in cost sharing for physical and mental health services and receipt of outpatient mental health follow-up visits within 7 days and 30 days after discharge from a psychiatric hospitalization. This study compared cost-sharing benefits for outpatient mental health versus general medical services among 43,892 enrollees in 173 Medicare managed care plans who were hospitalized for a psychiatric illness. Researchers grouped plans into three categories depending on the health plan's mental health cost sharing: full parity (mental health cost sharing less than or equal to primary care cost sharing) versus intermediate parity (greater than primary care cost sharing but less than or equal to nonpsychiatrist specialist cost sharing), or no parity (greater than both primary care and nonpsychiatrist specialist cost sharing). The researchers found that the percentage of Medicare beneficiaries who had an outpatient follow-up visit within 7 days or 30 days after a psychiatric hospitalization was greater among beneficiaries enrolled in plans with full parity compared with plans with no parity. This study also found a significant relationship between copayment costs and follow-up visits. Rates of 7-day follow-up visits were 37.5% in health plans with mental health copayments of $15 or less versus 7-day follow-up rates of 29.6% among health plans with copayments of more than $30 (Trivedi et al., 2008).

By contrast, Ndumele et al. (2011) found little change in the use of mental health services after Medicare managed care plans implemented changes in copayments. However, results from this study may not generalize to AB 2242 because they concern use of mental health services regardless of whether patients have recently been released from involuntary psychiatric treatment. Findings from Trivedi et al. (2008) are more likely to be generalizable because that study only assessed use of follow-up outpatient care among Medicare beneficiaries who had a psychiatric hospitalization.

Multiple studies have examined the impact of reductions in cost sharing for mental health services among people with commercial health insurance that are associated with the establishment of laws or policies that mandate parity in coverage for mental health and physical health services. These studies, which are discussed in greater detail in CHBRP's report on SB 855 (Wiener, Mental Health Parity), have inconclusive findings regarding the impact of parity on the probability that enrollees will use any mental health services. However, a preponderance of evidence from these studies suggests that numbers of visits increase among people who use mental health services. The generalizability of findings from these studies to AB 2242 is unclear because they examine the effects of cost-sharing reductions associated with mental health parity on all enrollees, not just those who recently had a psychiatric hospitalization. In addition, the most sweeping mental health parity mandate, the Mental Health Parity and Addiction Equity Act (MHPAEA), lifted quantitative limits on coverage (e.g., the number of outpatient visits covered) and nonquantitative limits on coverage (e.g., prior authorization, medical necessity review), in addition to mandating parity in cost sharing for mental health and physical health services. Any increases in use of outpatient visits among people enrolled in plans/policies that become subject to parity are likely due to the combination of reductions in cost sharing and the easing of quantitative and nonquantitative limits on coverage. AB 2242 may have a smaller effect because it only addresses cost sharing for out-of-network outpatient visits.

Summary of findings regarding the impact of cost sharing on the use of mental health services: There is *limited evidence* that reducing cost sharing for follow-up outpatient visits increases the rate at which people recently discharged from an involuntary psychiatric hold will have outpatient visits. Most studies of the impact of reductions in cost sharing for outpatient mental health services that have examined effects on people with commercial health insurance have not focused exclusively on people who were recently discharged from an involuntary psychiatric hold and are not able to isolate the effects of reductions in cost sharing from other changes in mental health benefits. However, CHBRP identified one study that found that lower cost sharing was associated with higher rates of use of outpatient mental health services following discharge from a psychiatric hospitalization, but the study was conducted among Medicare beneficiaries.

Figure 8. The Impact of Cost Sharing on the Use of Mental Health Services



The Impact of Cost Sharing on Mental Health Outcomes

CHBRP did not identify any studies that address the relationship between cost sharing for follow-up outpatient mental health services and mental health outcomes.

Summary of findings regarding the impact of cost sharing on mental health outcomes: There is *insufficient evidence* regarding the impact of cost sharing for mental health services on mental health outcomes. The absence of evidence is not an indication that cost sharing for mental health services does not affect mental health outcomes; it is an indication that the impact is unknown.

Figure 9. The Impact of Cost Sharing on Mental Health Outcomes

Summary of Findings

CHBRP found evidence from nine studies that receiving follow-up outpatient mental health services, after discharge from inpatient mental health care, affects use of mental health services including hospital readmission, ED visits, and medication adherence. Although the evidence is *inconclusive*, the most pertinent studies (i.e., those that assess people with commercial health insurance) suggest that receiving follow-up outpatient mental health services within 30 days of discharge is associated with a small reduction in hospital readmissions. The impact of receiving follow-up outpatient care within two days of discharge is unknown because none of the studies assessed the impact of receiving follow-up care during this time interval. There is also insufficient evidence of the effect of timely follow-up outpatient care on ED visits and medication adherence.

There is *insufficient evidence* to determine whether receiving timely follow-up outpatient mental health services, after discharge from inpatient mental care, improves mental health outcomes.

CHBRP found inconclusive evidence from one systematic review (13 studies) and one additional study that scheduling visits for follow-up outpatient mental health services, after discharge from inpatient mental care, affects use of mental health services including hospital readmissions. Findings from these studies are difficult to generalize to AB 2242 because most studies assessed interventions that included other components, in addition to scheduling a follow-up outpatient visit. In these cases, one cannot determine whether effects on readmissions are due to scheduling a follow-up visit or to other intervention components.

There is *insufficient evidence* to determine whether access to outpatient mental health providers in close proximity to a patient's business or residence increases receipt of outpatient mental health services following discharge from inpatient mental care or improves mental health outcomes.

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

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

BENEFIT COVERAGE, UTILIZATION, AND COST IMPACTS

As discussed in the *Policy Context* section, AB 2242 would require a health care service plan contract or a health insurance policy that is issued, amended, or renewed on or after January 1, 2021, that includes coverage for mental health services to:

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

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

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

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

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

This section describes the potential incremental impacts of AB 2242 on estimated baseline benefit coverage, utilization, and overall cost. This analysis makes the methodologic considerations and assumptions outlined below and described in more detail in Appendix C. With the application of these assumptions, CHBRP emphasizes this analysis represents a "**best-case scenario**" and notes that projected impacts may be further reduced since provider shortages may limit the feasibility of scheduling follow-up visits within the 48-hour timeframe for all enrollees postmandate. It is important to note that even if provider shortages do result in follow-up visits occurring later than the 48-hour timeframe required by AB 2242, it would not change the cost analysis since the visit would still occur, and CHBRP has not found evidence that the later visit (i.e. a visit more than 48 hours after discharge versus within 48 hours of discharge) would be more costly.

- **Follow-up visit utilization:** CHBRP assumes plans/policies would overcome supply-side barriers to be able to schedule outpatient follow-up visits within 48 hours of discharge from the 5150 hold and within reasonable proximity postmandate. At baseline, CHBRP assumes patients and families, as well as providers (especially inpatient facilities), and some health plans/insurers share the responsibility of scheduling follow-up appointments after hospitalization. Postmandate, when the responsibility of scheduling shifts to the plans/policies, it is possible that patients discharged from a 5150 hold would be given special attention or consideration by plans/policies and providers to ensure these follow-up visits are scheduled.
    - Since health plans and insurers would be responsible for scheduling the follow-up visits, the proportion of in-network utilization could increase as a result of AB 2242, but there are no data or literature to support this hypothesis; consequently, CHBRP modeled no change in the proportion of in-network versus out-of-network utilization postmandate. CHBRP further notes that because 63% of enrollees have mental health follow-up visits at baseline (discussed in further detail in this section below), a utilization increase estimate applies only to those enrollees who did not have a follow-up visit at baseline.
    - Per CHBRP's content expert, who described a serious shortage of licensed mental health professionals that may limit utilization increases due to AB 2242,[42] CHBRP assumed a small postmandate increase in follow-up visits for those who had no visits at baseline (explained in more detail in the Baseline and Postmandate Utilization section below and in Appendix C).

[42] Personal communication with content expert Lorin Scher, MD. (March 18, 2020).

- **Average cost of follow-up visit:** CHBRP estimated the average cost of 5150 holds and follow-up visits using the MarketScan® database and Milliman's proprietary 2017 Consolidated Health Cost Guidelines™ Sources Database by identifying inpatient psychiatric admissions with the diagnosis codes that most represent 5150 holds (see Appendix C). The average cost of the follow-up visit was further estimated for visits that occurred in network and out of network. CHBRP assumes that while AB 2242 mandates enrollees who receive follow-up visits out of network would pay the same cost-sharing amount as if the visit were in network, plans/policies would cover the difference between the in-network cost sharing that the enrollee pays and the amount the out-of-network provider charges.
- **Administrative costs:** CHBRP assumes plans/policies comply with AB 2242 postmandate and that follow-up visit scheduling is something that they can do with appropriate information technology software and personnel. While plans/policies likely vary in their ability to make appointments at baseline, CHBRP assumes all would be able to commence this task starting in year 1 postmandate. This simplifying assumption is consistent with the assumptions described above that offer a best-case scenario of the impact of the bill. CHBRP used Milliman's estimates of administrative costs of appointment scheduling and applied it to the number of enrollees impacted by AB 2242 (see Appendix C for details).
- **Offsets:** CHBRP does not calculate offsets in the cost model. Following from the conclusions of the medical effectiveness review of inconclusive evidence for readmission, CHBRP assumes that while improvements in timely follow-up visits after discharge from 5150 holds may reduce subsequent hospitalizations (which are costly) and improve downstream health outcomes, there are too few studies that can be used to quantify an impact of follow-up visits within 48 hours of discharge on offsets in the cost model.

For further details on the underlying data sources and methods used in this analysis, please see Appendix C.

Baseline and Postmandate Benefit Coverage

Currently, 100% of the 13,363,000 enrollees in commercial and CalPERS DMHC-regulated plans and CDI-regulated policies would be subject to AB 2242; these enrollees make up 62% of all enrollees subject to state-level benefit mandates. All enrollees (100%) have coverage for 72-hour treatment and evaluation holds as well as follow-up visits after being discharged from a hold. CHBRP estimates there are 59,200 enrollees who are subject to AB 2242 and detained for 72-hour treatment and evaluation holds at baseline. There is no change in this number postmandate (Table 1).

Current coverage for 72-hour treatment and evaluation holds and for follow-up visits after a hold was determined by a survey of the largest (by enrollment) providers of health insurance in California. Responses to this survey represent 68% of enrollees with private market health insurance that can be subject to state mandates.

Baseline and Postmandate Utilization

Using MarketScan data (see Appendix C for more detail), CHBRP estimates 14,300 (or 24% the 59,200 enrollees who had a 5150 hold) have a follow-up visit scheduled within 48 hours of discharge and 23,100 (or 39% of all who had a 5150 hold) have a visit between 3 and 90 days (see Tables 1 and 3). Note, per CHBRP's content expert, a visit that occurs more than 90 days after discharge would not be considered a follow-up visit. Breaking down these follow-up visits by in- and out-of-network providers, CHBRP finds at baseline about 11,900 of enrollees have a follow-up visit with an in-network provider and 2,400 have a visit with an out-of-network provider (not shown in Table 1). Lastly, 21,800 (or 37% of all who had a 5150 hold) do not have a follow-up visit at all at baseline.

Table 3. Proportion of Inpatient Psychiatric Admissions with Length of Stay <= 3 days with Outpatient Follow-Up Visit by Follow-Up Time

Outpatient Visit Follow-Up Time	Proportion of Inpatient Psychiatric Admissions
In days 0–2 (48 hours)	24%
In days 3–30	31%
In days 31–60	6%
In days 61–90	2%
Subtotal: 0–90 days	**63%**
No outpatient follow-up visit (within 90 days)	37%
Total	**100%**

Source: MarketScan and Milliman's 2017 Consolidated Health Cost Guidelines™ Sources Database, 2020.

Postmandate, CHBRP assumes all those who had follow-up visits between 3 and 90 days at baseline would shift to having a visit scheduled within 48 hours (2 days). This results in 23,100 enrollees shifting from having a visit after more than 48 hours to having a visit within 48 hours, which results in a 187% increase in enrollees who have a visit within 48 hours postmandate. CHBRP notes that this assumption of shifting enrollees who have a visit between 3 and 90 days at baseline to having a visit within 48 hours postmandate does not impact cost because these visits occurred at baseline and are not new visits that generate new costs to the health plan/insurer.

CHBRP's content expert stated that utilization of outpatient visits may not increase as a result of the bill given the shortage in supply of licensed mental health professionals and that those in practice are already saturated with appointments; thus, it will be difficult to increase visit volume.[43] To acknowledge this limitation while staying consistent with the approach of demonstrating a best-case scenario as described at the beginning of the *Benefit Coverage, Utilization, and Cost Impacts* section, CHBRP assumes that for enrollees who do not attend a follow-up visit at baseline, only 17% of them would attend their follow-up visit as a result of AB 2242. This assumption is based on literature that suggests there will be some degree of "lost to follow-up" or nonattendance of scheduled mental health outpatient visits (Batscha et al., 2011). Batscha et al. (2011) estimate approximately 42% of patients do not attend a scheduled mental health follow-up visit post hospitalization; in a hospital-based pilot study that involved appointment scheduling and reminders along with pre- and postdischarge meetings, attendance increased to 92%. Since AB 2242 only mandates plans/policies to schedule the follow-up visit after the 5150 hold and does not specify that they would need to ensure the visit is attended (e.g., via case management[44] or appointment reminders), CHBRP assumes postmandate attendance increases to a smaller degree than what is seen in the Batscha et al. (2011) study. In applying CHBRP's previously described 17% increase in follow-up visits postmandate, the percent of attended visits increases from 63% to 69% and the percent with no follow-up outpatient visit decreases from 37% to 31% (37% x [100%-17%] = 31%). The result of this is that 3,700 more enrollees will have a follow-up visit postmandate (Table 1).

[43] Personal communication with content expert Lorin Scher, MD. (March 18, 2020).
[44] The Health Homes Program for select Medi-Cal beneficiaries is an example of a program that includes enhanced care management and coordination activities beyond scheduling the follow-up appointment. https://www.dhcs.ca.gov/services/Pages/HealthHomesProgram.aspx

Baseline and Postmandate Per-Unit Cost

Using claims data, CHBRP finds at baseline the average cost is $140 for an in-network outpatient follow-up visit and $197 for an out-of-network outpatient follow-up visit. For in-network follow-up outpatient visits, CHBRP expects no change in average cost (remains at $140) or member cost sharing postmandate. For out-of-network follow-up outpatient visits, CHBRP expects no change in average cost (remains at $197) postmandate, but member cost sharing is expected to be reduced while health plan/insurer costs are expected to increase (see assumptions at the beginning of the *Benefit Coverage, Utilization, and Cost Impacts* section and Appendix C).

Baseline and Postmandate Expenditures

Table 4 and Table 5 present baseline and postmandate expenditures by market segment for DMHC-regulated plans and CDI-regulated policies. The tables present per-member-per-month (PMPM) premiums, enrollee expenses for covered benefits, and total expenditures (premiums plus enrollee expenses).

AB 2242 would increase total net annual expenditures by $1,559,000 or about 0.001% for enrollees with DMHC-regulated plans and CDI-regulated policies (Table 5). This is due to an increase of $1,840,000 in total health insurance premiums paid by employers and enrollees for newly covered benefits, adjusted by a $281,000 decrease in enrollee expenses for covered benefits.

Premiums

The AB 2242 mandate is estimated to increase premiums by about $1,840,000. Total premiums for private employers purchasing group health insurance are estimated to increase by $1,139,000, or 0.002%. Total employer premium expenditures for CalPERS HMOs are estimated to increase by $59,000, or 0.002%. Changes in premiums as a result of AB 2242 by market segment vary only slightly. Note that such changes are related to the number of enrollees (see Table 1, Table 4, and Table 5) with health insurance that would be subject to AB 2242. Increases in premiums as a result of AB 2242 are about 0.002% for all plans/policies.

Among publicly funded plans, DMHC-regulated Medi-Cal Managed Care is not subject to AB 2242. For CalPERS HMO enrollees, the impact on premiums is an increase of 0.002%.

Enrollee Out-of-Pocket Expenses

AB 2242 related changes in enrollee out-of-pocket expenses (e.g., deductibles, copays, coinsurance) for covered benefits would vary by market segment. Note that such changes are related to the number of enrollees (see Table 1, Table 4, and Table 5) with health insurance that would be subject to AB 2242 who are expected to attend follow-up outpatient visits during the year after enactment.

All market segments see a similar-sized reduction in enrollee out-of-pocket expenditures due to AB 2242 of approximately $0.002 PMPM due to enrollees seeing out-of-network providers but paying in-network cost-sharing postmandate.

Average enrollee out-of-pocket expenses per user

CHBRP estimates that 3,900 enrollees who had visits with an out-of-network provider at baseline and who were paying a greater share out of pocket for these visits compared to in-network visits would experience a decrease in cost sharing postmandate as enrollees would pay in-network cost sharing according to AB 2242. The reduction for these enrollees is about $57 for each follow-up visit (Table 1).

Potential Cost Offsets or Savings in the First 12 Months After Enactment

As reviewed in the *Medical Effectiveness* section of this report, there is *inconclusive/insufficient evidence* for subsequent utilization and clinical outcomes attributable to the follow-up visit post-hospitalization for 5150 holds. Thus, while it is possible improvements in timely follow-up visits after release from 5150 holds may reduce subsequent hospitalization and improve downstream health outcomes, CHBRP is unable to estimate these quantitatively in the cost model.

Postmandate Administrative Expenses and Other Expenses

CHBRP estimates that the increase in administrative costs of DMHC-regulated plans and/or CDI-regulated policies are proportional to the increase in premiums. CHBRP assumes that if health care costs increase as a result of increased utilization or changes in unit costs, there is a corresponding proportional increase in administrative costs. All health plans and insurers include a component for administration and profit in their premiums.

CHBRP estimated the potential increase in administration costs associated with developing an information technology infrastructure to schedule appointments for enrollees. Milliman provided administrative cost estimates for this type of appointment scheduling platform. Because AB 2242 does not require plans/policies to ensure the follow-up visit is attended, CHBRP assumes only an appointment scheduling platform would be needed to fulfill the requirement of the bill and no further case management or programmatic change would be needed to ensure enrollees attend their visits. Administrative costs for scheduling were estimated at $14 per scheduled appointment postmandate. This cost was calculated by estimating staff costs per productive work hour ($27), estimated time taken to schedule an appointment (30 minutes), and a 5% general and administrative overhead loading.

Other Considerations for Policymakers

In addition to the impacts a bill may have on benefit coverage, utilization, and cost, related considerations for policymakers are discussed below.

Postmandate Changes in the Number of Uninsured Persons

Because the change in average premiums does not exceed 1% for any market segment (see Table 1, Table 4, and Table 5), CHBRP would expect no measurable change in the number of uninsured persons due to the enactment of AB 2242.

Changes in Public Program Enrollment

CHBRP estimates that the mandate would produce no measurable impact on enrollment in publicly funded insurance programs due to the enactment of AB 2242.

How Lack of Benefit Coverage Results in Cost Shifts to Other Payers

CHBRP estimates that AB 2242 would not result in a shift of payment or service delivery to public payers.

Table 4. Baseline Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2021

	DMHC-Regulated						CDI-Regulated			
	Privately Funded Plans (by Market) (a)			Publicly Funded Plans			Privately Funded Plans (by Market) (a)			
	Large Group	*Small Group*	*Individual*	*CalPERS HMOs (b)*	*MCMC (Under 65) (c)*	*MCMC (65+) (c)*	*Large Group*	*Small Group*	*Individual*	**Total**
Enrollee counts										
Total enrollees in plans/policies subject to state mandates (d)	7,797,000	2,127,000	1,938,000	522,000	7,481,000	875,000	645,000	174,000	160,000	21,719,000
Total enrollees in plans/policies subject to AB 2242	7,797,000	2,127,000	1,938,000	522,000	0	0	645,000	174,000	160,000	13,363,000
Premiums										
Average portion of premium paid by employer	$421.33	$387.36	$0.00	$521.09	$262.75	$536.28	$493.36	$435.79	$0.00	$86,519,976,000
Average portion of premium paid by employee	$109.79	$140.13	$632.59	$97.10	$0.00	$0.00	$137.09	$167.01	$509.49	$31,556,986,000
Total premium	**$531.12**	**$527.49**	**$632.59**	**$618.19**	**$262.75**	**$536.28**	**$630.44**	**$602.80**	**$509.49**	**$118,076,962,000**
Enrollee expenses										
For covered benefits (deductibles, copays, etc.)	$41.92	$115.98	$170.63	$51.02	$0.00	$0.00	$123.80	$161.70	$161.76	$12,776,801,000
For noncovered benefits (e)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0
Total expenditures	**$573.05**	**$643.47**	**$803.22**	**$669.20**	**$262.75**	**$536.28**	**$754.24**	**$764.50**	**$671.25**	**$130,853,763,000**

Source: California Health Benefits Review Program, 2020.

Notes: (a) Includes enrollees with grandfathered and nongrandfathered health insurance acquired outside or through Covered California (the state's health insurance marketplace).

(b) Approximately 57.36% of CalPERS enrollees in DMHC-regulated plans are state retirees, state employees, or their dependents. About one in five (20.5%) of these enrollees has a pharmacy benefit not subject to DMHC. CHBRP has projected no impact for those enrollees. However, CalPERS could, postmandate, require equivalent coverage for all its members (which could increase the total impact on CalPERS).

(c) Medi-Cal Managed Care Plan expenditures for members over 65 include those who are also Medicare beneficiaries. This population does not include enrollees in COHS.

(d) Enrollees in plans and policies regulated by DMHC or CDI aged 0 to 64 years as well as enrollees 65 years or older in employer-sponsored health insurance. This group includes commercial enrollees (including those associated with Covered California or CalPERS) and Medi-Cal beneficiaries enrolled in DMHC-regulated plans.

(e) Includes only those expenses that are paid directly by enrollees or other sources to providers for services related to the mandated benefit that are not currently covered by insurance. This only includes those expenses that will be newly covered, postmandate. Other components of expenditures in this table include all health care services covered by insurance.

Key: CalPERS HMOs = California Public Employees' Retirement System Health Maintenance Organizations; CDI = California Department of Insurance; COHS = County Organized Health Systems; DMHC = Department of Managed Health Care; MCMC = Medi-Cal Managed Care.

Table 5. Postmandate Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2021

	DMHC-Regulated						CDI-Regulated			
	Privately Funded Plans (by Market) (a)			Publicly Funded Plans			Privately Funded Plans (by Market) (a)			
	Large Group	*Small Group*	*Individual*	*CalPERS HMOs (b)*	*MCMC (Under 65) (c)*	*MCMC (65+) (c)*	*Large Group*	*Small Group*	*Individual*	**Total**
Enrollee counts										
Total enrollees in plans/policies subject to state mandates (d)	7,797,000	2,127,000	1,938,000	522,000	7,481,000	875,000	645,000	174,000	160,000	21,719,000
Total enrollees in plans/policies subject to AB 2242	7,797,000	2,127,000	1,938,000	0	0	0	645,000	174,000	160,000	13,363,000
Premiums										
Average portion of premium paid by employer	$0.0089	$0.0087	$0.0000	$0.0095	$0.0000	$0.0000	$0.0088	$0.0085	$0.0000	$1,198,000
Average portion of premium paid by employee	$0.0023	$0.0031	$0.0123	$0.0018	$0.0000	$0.0000	$0.0024	$0.0033	$0.0118	$642,000
Total premium	$0.0112	$0.0118	$0.0123	$0.0112	$0.0000	$0.0000	$0.0112	$0.0118	$0.0118	**$1,840,000**
Enrollee expenses										
For covered benefits (deductibles, copays, etc.)	-$0.0017	-$0.0018	-$0.0018	-$0.0017	$0.0000	$0.0000	-$0.0017	-$0.0018	-$0.0018	-$281,000
For noncovered benefits (e)	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0
Total expenditures	$0.0095	$0.0101	$0.0105	$0.0095	$0.0000	$0.0000	$0.0094	$0.0101	$0.0100	**$1,559,000**
Percent change										
Premiums	0.0021%	0.0022%	0.0019%	0.0018%	0.0000%	0.0000%	0.0018%	0.0020%	0.0023%	0.0016%
Total expenditures	0.0017%	0.0016%	0.0013%	0.0014%	0.0000%	0.0000%	0.0013%	0.0013%	0.0015%	0.0012%

Source: California Health Benefits Review Program, 2020.

Notes: (a) Includes enrollees with grandfathered and nongrandfathered health insurance acquired outside or through Covered California (the state's health insurance marketplace).

(b) Approximately 57.36% of CalPERS enrollees in DMHC-regulated plans are state retirees, state employees, or their dependents. About one in five (20.5%) of these enrollees has a pharmacy benefit not subject to DMHC. CHBRP has projected no impact for those enrollees. However, CalPERS could, postmandate, require equivalent coverage for all its members (which could increase the total impact on CalPERS).

(c) Medi-Cal Managed Care Plan expenditures for members over 65 include those who are also Medicare beneficiaries. This population does not include enrollees in COHS.

(d) Enrollees in plans and policies regulated by DMHC or CDI aged 0 to 64 years as well as enrollees 65 years or older in employer-sponsored health insurance. This group includes commercial enrollees (including those associated with Covered California or CalPERS) and Medi-Cal beneficiaries enrolled in DMHC-regulated plans.

(e) Includes only those expenses that are paid directly by enrollees or other sources to providers for services related to the mandated benefit that are not currently covered by insurance. This only includes those expenses that will be newly covered, postmandate. Other components of expenditures in this table include all health care services covered by insurance.

Key: CalPERS HMOs = California Public Employees' Retirement System Health Maintenance Organizations; CDI = California Department of Insurance; COHS = County Organized Health Systems; DMHC = Department of Managed Health Care; MCMC = Medi-Cal Managed Care.

PUBLIC HEALTH IMPACTS

As discussed in the *Policy Context* section, AB 2242 would require a health care service plan contract or a health insurance policy that is issued, amended, or renewed on or after January 1, 2021, that includes coverage for mental health services to:

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

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

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

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

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

The public health impact analysis includes estimated impacts in the short term (within 12 months of implementation) and in the long term (beyond the first 12 months postmandate). CHBRP identified several outcomes as important measures of the public health impact of AB 2242 and evaluated the evidence available to estimate these impacts. Measures of the short-term impact of AB 2242 include ED visits/emergency medical services use, hospital readmissions, medication adherence, suicide and suicide attempts, and disparities. See the *Long-Term Impacts* section for discussion of premature death, economic loss, and social determinants of health.

Estimated Public Health Outcomes

As presented in the *Medical Effectiveness* section, there is *insufficient evidence* to determine whether:

- Receiving timely follow-up outpatient mental health services, after discharge from inpatient mental health care, improves mental health outcomes;
- Access to outpatient mental health providers in close proximity to a patient's business or residence increases receipt of outpatient mental health services following discharge from inpatient mental health care or improves mental health outcomes; or
- Reducing cost sharing for follow-up outpatient mental health services, after discharge from inpatient mental health care, improves mental health outcomes.

Additionally, there is *inconclusive evidence* regarding the impact of follow-up reminders for outpatient mental health services on appointment attendance or hospital readmissions and there is *limited evidence* that reducing cost sharing for follow-up outpatient mental health services, after discharge from inpatient mental health care, increases use of these services.

As presented in the *Benefit Coverage, Utilization, and Cost Impacts* section, in the first 12 months postmandate, CHBRP estimates that the number of 48-hour outpatient mental health appointments after 72-hour involuntary psychiatric holds (5150s) would increase by 187%, and 26,800 enrollees with commercial insurance would attend these timely appointments (22,300 with in-network providers and 4,500 with out-of-network providers). A large portion of the increase in appointments within 48 hours

would be due to patients who previously had follow-up outpatient appointments between 3 and 90 days of discharge shifting to appointments within 48 hours. In addition, although CHBRP estimates that all patients without a visit at baseline would have a timely appointment scheduled postmandate, the proportion of patients who would attend these appointments is unknown.

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

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

Please note that the absence of evidence is not "evidence of no effect." For the proportion of enrollees who would receive follow-up outpatient mental health care within 48 hours of a 5150 discharge as a result of AB 2242, it stands to reason that more treatment might be beneficial, but current evidence is insufficient to inform a population-level estimate of the impact of new or earlier access to outpatient mental health visits after release from a 5150 hold.

Benefit Mandate Structure and Unequal Racial/Ethnic Health Impacts

AB 2242 would require compliance from the health insurance of enrollees in CDI-regulated policies and other enrollees in DMHC-regulated plans but would not be applicable to the health insurance of Medi-Cal beneficiaries enrolled in DMHC-regulated plans.

As previously noted, there is *insufficient or inconclusive evidence* that the provisions enumerated in AB 2242 regarding outpatient mental health follow-up after 5150 holds (i.e., 48-hour follow-up with any local mental health providers with in-network cost-sharing) results in a reduction of ED/emergency medical services use, hospital readmissions, or suicides and suicide attempts. Furthermore, there was no evidence in the reviewed literature regarding differences by race or ethnicity in these outcomes for persons with involuntary psychiatric holds. However, due to an unequal distribution of racial and ethnic minority groups between the commercially insured population and the Medi-Cal population (higher representation of some racial/ethnic groups in Medi-Cal), it is possible that there could be a greater improvement in health outcomes for white and Asian beneficiaries with 5150s relative to Latino and African American beneficiaries.

LONG-TERM IMPACTS

In this section, CHBRP estimates the long-term impacts of AB 2242, which CHBRP defines as impacts occurring beyond the first 12 months after implementation. These estimates are qualitative and based on the existing evidence available in the literature. CHBRP does not provide quantitative estimates of long-term impacts because of unknown improvements in clinical care, changes in prices, implementation of other complementary or conflicting policies, and other unexpected factors.

Long-Term Utilization and Cost Impacts

Utilization Impacts

CHBRP estimates that after the initial 12 months from the enactment of AB 2242, utilization of follow-up visits after release from 72-hour involuntary psychiatric holds (5150s) will likely be similar to utilization estimates during the first 12 months postmandate. If supply-side constraints are addressed such that there is an increase in the number of licensed mental health professionals who could meet the demand for outpatient mental health outpatient visits, utilization could improve significantly over time. However, it is unknown if and when such increases in the number of mental health professionals are likely to occur.

Cost Impacts

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

Long-Term Public Health Impacts

Some interventions in proposed mandates provide immediate measurable impacts (e.g., maternity service coverage or acute care treatments), whereas other interventions may take years to make a measurable impact (e.g., coverage for tobacco cessation or vaccinations). When possible, CHBRP estimates the long-term effects (beyond 12 months postmandate) to the public's health that would be attributable to the mandate, including impacts on social determinants of health, premature death, and economic loss.

As described in the *Background on 5150 Holds and Related Mental Health Services in California* section, mental health provider supply is a significant barrier to outpatient follow-up appointment access. In California, the mental health workforce is distributed unevenly throughout the state and it is projected that, by 2028, California will have 50% fewer psychiatrists and 28% fewer nonphysician mental health professionals than will be needed to meet current patterns of behavioral health demand and unmet demand (Coffman et al., 2017; Coffman et al., 2018). It is possible that mental health providers and plans/policies may prioritize patients with recent 5150s due to their high-risk status; however, given the projected diminishing supply of providers relative to demand, the ability of mental health providers to meet the 48-hour appointment standard for persons with a 5150 discharge, as mandated by AB 2242, will likely decrease over time along with potential improvements in health outcomes attributable to increased and earlier outpatient appointment access. Moreover, in areas with current mental health professional shortages, such as the San Joaquin Valley and the Inland Empire, these diminishing health returns may be experienced sooner than for areas with more robust supplies of mental health providers. Therefore, the short-term impacts presented in this report are representative of a best-case scenario.

Impacts on Premature Death and Economic Loss

Premature death

Premature death is often defined as death occurring before the age of 75 years (NCI, 2019).[45] In California, it is estimated that there were nearly 5,300 years of potential life lost (YPLL) per 100,000 population each year between 2015 and 2017 (CDPH, 2019; County Health Rankings, 2019).[46]

As described in the *Public Health Impacts* section, the impact of AB 2242 on health outcomes, including suicide and attempted suicide, is unknown; therefore, the impact on premature death is also unknown.

Economic loss

Economic loss associated with disease is generally presented in the literature as an estimation of the value of the YPLL in dollar amounts (i.e., valuation of a population's lost years of work over a lifetime). In addition, morbidity associated with the disease or condition of interest can also result in lost productivity by causing a worker to miss days of work due to illness or acting as a caregiver for someone else who is ill.

As described in the *Public Health Impacts* section, the impact of AB 2242 on health outcomes associated with work disruption and lost productivity (e.g., due to persistent mental illness) is unknown; therefore, the impact on premature death is also unknown.

[45] For more information about CHBRP's public health methodology, see http://chbrp.com/analysis_methodology/public_health_impact_analysis.php.
[46] The overall impact of premature death due to a particular disease can be measured in years of potential life lost prior to age 75 and summed for the population (generally referred to as "YPLL") (Gardner and Sanborn, 1990).

APPENDIX A TEXT OF BILL ANALYZED

On February 21, 2020, the California Assembly Committee on Health requested that CHBRP analyze SB 2242.

ASSEMBLY BILL NO. 2242

Introduced by Assembly Member Levine

February 13, 2020

An act to add Section 1367.014 to the Health and Safety Code, and to add Section 10112.34 to the Insurance Code, relating to mental health.

LEGISLATIVE COUNSEL'S DIGEST

AB 2242, as introduced, Levine. Mental health services.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires an individual or small group health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2017, to include coverage for essential health benefits, which include mental health services.

Existing law, the Lanterman-Petris-Short Act, sets forth procedures for the involuntary detention, for up to 72 hours for evaluation and treatment, of a person who, as a result of a mental health disorder, is a danger to others or to themselves or is gravely disabled.

This bill would require a health care service plan or a health insurance policy issued, amended, or renewed on or after January 1, 2021, that includes coverage for mental health services to, among other things, approve the provision of mental health services for persons who are detained for 72-hour treatment and evaluation under the Lanterman-Petris-Short Act and to schedule an initial outpatient appointment for that person with a licensed mental health professional on a date that is within 48 hours of the person's release from detention. The bill would prohibit a noncontracting provider of covered mental health services from billing the previously described enrollee or insured more than the cost-sharing amount the enrollee or insured would pay to a contracting provider for those services. Because a willful violation of the bill's requirement by a health care service plan would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority Appropriation: no Fiscal Committee: yes Local Program: yes

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THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 1367.014 is added to the Health and Safety Code, to read:

1367.014. (a) A health care service plan contract issued, amended, or renewed on or after January 1, 2021, that includes coverage for mental health services shall do all of the following:

(1) Approve the provision of mental health services for enrollees under the plan who are detained for 72-hour treatment and evaluation pursuant to Article 1 (commencing with Section 5150) of Chapter 2 of Part 1 of Division 5 of the Welfare and Institutions Code.

(2) Schedule an initial outpatient appointment for the enrollee described in paragraph (1) with a licensed mental health professional. The appointment shall be scheduled for a date that is within 48 hours of the enrollee's release from detention.

(3) Ensure that the location of facilities providing the covered mental health services for the enrollee described in paragraph (1) be within reasonable proximity of the business or personal residences of the enrollee, and so located as to not result in unreasonable barriers to accessibility.

(4) (A) Provide that if an enrollee described in paragraph (1) receives covered mental health services from a noncontracting provider, the enrollee shall pay no more than the same cost-sharing amount that the enrollee would pay for the same covered services received from a contracting provider. This amount shall be referred to as the "in-network cost-sharing amount."

(B) An enrollee shall not owe the noncontracting provider more than the in-network cost-sharing amount for covered mental health services. At the time of payment by the plan to the noncontracting provider, the plan shall inform the enrollee and the noncontracting provider of the in-network cost-sharing amount owed by the enrollee.

(C) A noncontracting provider shall not bill or collect any amount from the enrollee for covered mental health services, except for the in-network cost-sharing amount.

(D) For purposes of this paragraph, covered mental health services are mental health services that are urgently needed to prevent serious deterioration of the enrollee's health resulting from unforeseen illness or injury for which treatment cannot be delayed until the enrollee can receive services from a contracting provider.

(b) This section does not apply to Medi-Cal managed care plans that contract with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) of, Chapter 8 (commencing with Section 14200) of, or Chapter 8.75 (commencing with Section 14591) of, Part 3 of Division 9 of the Welfare and Institutions Code.

SEC. 2. Section 10112.34 is added to the Insurance Code, to read:

10112.34. (a) A health insurance policy issued, amended, or renewed on or after January 1, 2021, that includes coverage for mental health services shall do all of the following:

(1) Approve the provision of mental health services for insureds under the policy who are detained for 72-hour treatment and evaluation pursuant to Article 1 (commencing with Section 5150) of Chapter 2 of Part 1 of Division 5 of the Welfare and Institutions Code.

(2) Schedule an initial outpatient appointment for the insured described in subdivision (a) with a licensed mental health professional. The appointment shall be scheduled for a date that is within 48 hours of the insured's release from detention.

(3) Ensure that the location of facilities providing the covered mental health services for the insured described in paragraph (1) be within reasonable proximity of the business or personal residences of insureds, and so located as to not result in unreasonable barriers to accessibility.

(4) (A) Provide that if an insured described in paragraph (1) receives covered mental health services from a noncontracting provider, the insured shall pay no more than the same cost-sharing amount that the insured would pay for the same covered services received from a contracting provider. This amount shall be referred to as the "in-network cost-sharing amount."

(B) An insured shall not owe the noncontracting provider more than the in-network cost-sharing amount for covered mental health services. At the time of payment by the insurer to the noncontracting provider, the insurer shall inform the insured and the noncontracting provider of the in-network cost-sharing amount owed by the insured.

(C) A noncontracting provider shall not bill or collect any amount from the insured for covered mental health services, except for the in-network cost-sharing amount.

(D) For purposes of this paragraph, covered mental health services are mental health services that are urgently needed to prevent serious deterioration of the insured's health resulting from unforeseen illness or injury for which treatment cannot be delayed until the insured can receive services from a contracting provider.

(b) This section does not apply to an insurance policy issued, sold, renewed, or offered for health care services or coverage provided in the Medi-Cal program (Chapter 7 (commencing with Section 14000), Chapter 8 (commencing with Section 14200), or Chapter 8.75 (commencing with Section 14591) of Part 3 of Division 9 of the Welfare and Institutions Code).

SEC. 3. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

APPENDIX B LITERATURE REVIEW METHODS

This appendix describes methods used in the medical effectiveness literature review conducted for this report. A discussion of CHBRP's system for grading evidence, as well as lists of MeSH Terms, publication types, and keywords, follows.

Studies of the effects of follow-up outpatient mental health services that are timely and in close proximity to the patients home or business, after discharge from inpatient mental health care, were identified through searches of PubMed, the Cochrane Library, Web of Science, EconLit, Business Source Complete, the Cumulative Index of Nursing and Allied Health Literature (CINAHL), and PsycINFO. Websites maintained by the following organizations were also searched: Agency for Healthcare Research and Quality; Institute for Clinical Systems Improvement; National Institute for Clinical Excellence; National Institutes of Health; Scottish Intercollegiate Guideline Network; and World Health Organization, the International Network of Agencies for Health Technology Assessment (INAHTA), the National Health Service (NHS) Centre for Reviews and Dissemination, the National Institute for Health and Clinical Excellence (NICE).

The search was limited to abstracts of studies published in English. The medical effectiveness search was limited to studies published from 2010 to present. The literature on the effectiveness of follow-up mental health services after inpatient hospitalization did not include any randomized controlled trials. The majority of the papers returned were retrospective cohort studies using claims data. The report also includes two systematic reviews.

Reviewers screened the title and abstract of each citation retrieved by the literature search to determine eligibility for inclusion. The reviewers acquired the full text of articles that were deemed eligible for inclusion in the review and reapplied the initial eligibility criteria.

The literature review returned abstracts for 400 articles, of which 42 were reviewed for inclusion in this report. A total of 10 studies were included in the medical effectiveness review for AB 2242.

Evidence Grading System

In making a "call" for each outcome measure, the medical effectiveness lead considers the number of studies as well the strength of the evidence. Further information about the criteria CHBRP uses to evaluate evidence of medical effectiveness can be found in CHBRP's *Medical Effectiveness Analysis Research Approach*.[47] To grade the evidence for each outcome measured, the team uses a grading system that has the following categories:

- Research design;
- Statistical significance;
- Direction of effect;
- Size of effect; and
- Generalizability of findings.

The grading system also contains an overall conclusion that encompasses findings in these five domains. The conclusion is a statement that captures the strength and consistency of the evidence of an intervention's effect on an outcome. The following terms are used to characterize the body of evidence regarding an outcome:

- *Clear and convincing evidence;*
- *Preponderance of evidence;*

[47] Available at: http://chbrp.com/analysis_methodology/medical_effectiveness_analysis.php.

- *Limited evidence;*
- *Inconclusive evidence; and*
- *Insufficient evidence.*

A grade of *clear and convincing evidence* indicates that there are multiple studies of a treatment and that the large majority of studies are of high quality and consistently find that the treatment is either effective or not effective.

A grade of *preponderance of evidence* indicates that the majority of the studies reviewed are consistent in their findings that treatment is either effective or not effective.

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

A grade of *inconclusive evidence* indicates that although some studies included in the medical effectiveness review find that a treatment is effective, a similar number of studies of equal quality suggest the treatment is not effective.

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

Search Terms for AB 2242

5150 Hold
72 Hour Hold
Ability Level
Admission
Aftercare
Assisted Outpatient Treatment
Barriers
Case Management
Coercive
Commitment
Commitment of Mentally Ill
Continuity of Patient Care
Cost of Illness
Cost Sharing
Costs
Cultural Bias
Daily Functioning
Death
Detention
Discharge
Disparities
Drug Utilization
Economic
Economic Aspects of Illness
Emergency Visits
Ethnic Groups
Facilities
Follow-up Care
Forced Commitment
Forced Psychiatric Treatment
Gay
Gender
Gender Bias
Gender Minorities
Gender Nonconformity
GLBTQ
Health-Related Quality of Life
Health Care Access
Health Care Outcome Assessment
Health Care Outcomes
Health Care Utilization
Health Equity
Health Outcomes
Health Services Accessibility
Health Services Needs and Demand
Health Status Disparities
Healthcare Disparities
Homosexual
Hospitalization
Incidence
Income Level
Inpatient Mental Health
Involuntary Commitment
Lesbian

LGBTQ
Life Quality
Long Term Outcome
Lower Income Level
Manpower and Services Facilities
Medication Adherence
Medication Compliance
Mental Disorders
Mental Health
Mental Health Services
Mental Health Treatment
Middle Income Level
Minority Groups
Minority Stress
Morbidity
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Psychiatric Involuntary Treatment
Psychiatric Patients
Psychiatric Service
Psychological Well-Being
Psychosis
Psychosocial Outcomes
Psychotherapeutic Outcomes
Psychotic Disorders
Quality of Life
Quality of Working Life
Queer
Race and Ethnic Discrimination
Rates
Readmission
Residences
Schizophrenia Spectrum
Services Utilization
Sex Factors
Sexism
Sexist
Sexual Identity
Sexual Minorities
Sexual Minority Groups
Social Determinants of Health
Social Equality
Socioeconomic Factors
Statistics
Status
Substance Use Disorder
Suicide
Transsexual
Treatment Outcomes
Upper Income Level
Usage
Use
Utilization Review
Vulnerable Populations
Wages
Workplace

APPENDIX C COST IMPACT ANALYSIS: DATA SOURCES, CAVEATS, AND ASSUMPTIONS

The cost analysis in this report was prepared by the members of the cost team, which consists of CHBRP task force members and contributors from the University of California, Los Angeles, and the University of California, Davis, as well as the contracted actuarial firm, Milliman, Inc.[48]

Information on the generally used data sources and estimation methods, as well as caveats and assumptions generally applicable to CHBRP's cost impacts analyses, are available at CHBRP's website.[49]

This appendix describes analysis-specific data sources, estimation methods, caveats, and assumptions used in preparing this cost impact analysis.

Analysis-Specific Caveats and Assumptions

This subsection discusses the caveats and assumptions specifically relevant to the cost impact analysis of AB 2242.

The population subject to the bill mandate includes individuals covered by DMHC-regulated commercial plans, CDI-regulated policies, and publicly funded plans (including CalPERS) subject to the requirements of the Knox-Keene Health Care Service Plan Act. Enrollees covered by Medi-Cal are not affected by AB 2242.

Utilization of 72-Hour/5150 Holds

- CHBRP used publicly available data published by the Department of Health Care Services (DHCS)[50] that reports on the number of involuntary detentions per 10,000 lives in California. The latest available data reports on fiscal year 2016/2017, and reported rates per 10,000 lives have been applied to total estimated lives in 2020 and 2021.
- The California Health Interview Survey (CHIS) for 2017/2018 reports that of the lives that are likely to have serious psychological distress, 38.2% have employment-based, privately purchased health care coverage while the remaining 61.8% of lives are uninsured or are covered by Medi-Cal or other public funding sources (AskCHIS). Consequently, it has been assumed that 38.2% of total 5150 holds are accounted for by the lives affected by AB 2242.
- Health plans and insurers currently provide coverage for 5150 holds as part of their existing mental health benefits, and there are no expected changes in the frequency of 5150 holds as a result of AB 2242.

Average Cost of 72-Hour/5150 Holds

- There are no specific diagnosis, revenue, or DRG codes used by health plans or insurers to identify 5150 holds. To estimate the average cost of a 5150 hold, CHBRP examined the 2017 MarketScan® database (MarketScan) and Milliman's proprietary 2017 Consolidated Health Cost Guidelines™ Sources Database (CHSD) to identify a subset of inpatient psychiatric admissions that most closely resemble 72-hour treatment and evaluation holds. The inpatient psychiatric

[48] CHBRP's authorizing statute, available at http://chbrp.com/CHBRP authorizing statute_2018_FINAL.pdf, requires that CHBRP use a certified actuary or "other person with relevant knowledge and expertise" to determine financial impact.
[49] See method documents posted at http://chbrp.com/analysis_methodology/cost_impact_analysis.php; in particular, see *2020 Cost Impact Analyses: Data Sources, Caveats, and Assumptions*.
[50] California Involuntary Detentions Data Report Fiscal Year (FY) 2016/2017. Retrieved March 18, 2020 from https://www.dhcs.ca.gov/services/MH/Pages/InvoluntaryDetention-MH.aspx

admissions considered in the subset have a length of stay of less than or equal to three days with at least one of the following ICD-10 diagnosis codes: F23, F332, F29, F3181, F329, F99, F333, F314, F319, F250, F3113, F339, F209, F3112, F322, F39, F840, F323, F3481, F200, F3163, F315, F259, F312, F320, F330, F3289, F331, F3131, F061, F310. These diagnosis codes were provided by a respondent from the health plan/insurer survey and correspond to the 72-hour hold diagnosis types shared by the content expert. These diagnosis codes account for 88% of total inpatient psychiatric admissions.

- There are no expected changes to the average cost of a 5150 hold as a result of AB 2242, and the same estimated average cost has been included in the baseline and postmandate views. The average cost has been trended from 2017 to 2021 using an annual trend rate of 6.0% from the 2019 Milliman Health Cost Guidelines (HCGs).

Baseline Utilization: Follow-Up Outpatient Visits

- CHBRP estimated the frequency of initial outpatient follow-up visits from the MarketScan and CHSD data by calculating the proportion of the identified subset of inpatient psychiatric admissions described above that have a professional mental health visit within 90 days of discharge. Initial follow-up outpatient visits occur within 90 days for 63% of the identified subset of inpatient psychiatric admissions. The extended time period has been used to recognize that a proportion of 5150 holds currently have a follow-up visit later than the 48 hours mandated by AB 2242. In these cases, the bill would not increase the utilization of outpatient follow-up visits but rather would shift this existing utilization to occur within 48 hours of discharge. A 90-day cut-off period has been used as per the content expert's recommendation.[51]
- Table 3 in the report and Table 6 below show the distribution of outpatient follow-up visits by duration. To allow sufficient time for outpatient follow-up visits to be captured in the data, only inpatient visits with discharges in the first half of 2017 were used in these calculations.

Table 6. Proportion of Inpatient Psychiatric Admissions With Outpatient Follow-Up Visit

Outpatient Visit Follow-Up Time	Proportion of Inpatient Psychiatric Admissions
In days 0–2	24%
In days 3–30	31%
In days 31–60	6%
In days 61–90	2%
Subtotal: 0–90 days	**63%**
No outpatient follow-up visit (within 90 days)	37%
Total	**100%**

Source: MarketScan and Milliman's 2017 Consolidated Health Cost Guidelines™ Sources Database, 2020.

- Using the MarketScan and CHSD data described above, it has been estimated that 83% of follow-up outpatient visits are with an in-network provider while 17% are with an out-of-network provider.

[51] Personal communication with content expert Lorin Scher, MD. (March 18, 2020).

Postmandate Utilization: Follow-Up Outpatient Visits

- Postmandate, 100% of 5150 holds should have an outpatient follow-up visit scheduled within 48 hours of discharge. However, a proportion of these scheduled visits will not be attended. Batscha et al. (2011) suggest that only 42% of initial appointments following psychiatric hospitalization are kept nationally. In a pilot study, Batscha et al. found that when patients were provided with interventions to remove barriers to attendance, attendance rates increased to 92%.
- The interventions described in the Batscha et al. study are more intensive than scheduling an appointment, and it is not expected that AB 2242 would result in an attendance rate increase as high as that observed in the pilot study. CHBRP assumes that postmandate, 17% of the enrollees who previously did not attend a follow-up outpatient visit would now attend a follow-up visit such that the proportion of 5150 holds with a follow-up outpatient visit increases from 63% to 69% and the percent with no follow-up outpatient visit decreases from 37% to 31% (37% x [100%-17%] = 31%). Also, the content expert described a serious shortage of licensed mental health professionals, which may limit any utilization increase possible due to AB 2242.[52]
- The proportion of in-network and out-of-network follow-up outpatient visits is assumed to remain unchanged from the baseline. Since health plans or insurers are scheduling the appointments, the proportion of in-network utilization could increase as a result of AB 2242, but there is no data or literature to support this hypothesis, and consequently, CHBRP modeled no change in the proportion of in-network utilization.

Baseline Average Cost: Follow-Up Outpatient Visits

- The CHSD and MarketScan data were used to calculate the average allowed cost and member cost sharing of an initial follow-up mental health outpatient visit for in-network and out-of-network visits.
- The average cost has been trended from 2017 to 2021 using an annual trend rate of 7.0% from the 2019 Milliman HCGs.

Postmandate Average Cost: Follow-Up Outpatient Visits

- CHBRP expects no change in average cost or member cost sharing postmandate for in-network follow-up outpatient visits.
- For out-of-network visits, member cost sharing has been set at the same rate as in-network visits. CHBRP assumed that plans/policies will pay the out-of-network rate for out-of-network visits as a result of AB 2242. Although member cost sharing will be reduced for out-of-network visits, the total allowed cost per visit will remain unchanged.

Administration Costs for Scheduling Outpatient Follow-Up Visits

- CHBRP assumed that premandate, plans/policies are not currently scheduling outpatient follow-up appointments and that baseline administration costs are $0.
- Administration costs have been estimated at $14 per scheduled appointment postmandate. This cost was calculated by estimating staff costs per productive work hour ($27), estimated time taken to schedule an appointment (30 minutes), and a 5% general and administrative overhead loading.

Determining Public Demand for the Proposed Mandate

This subsection discusses public demand for the benefits AB 2242 would mandate. Considering the criteria specified by CHBRP's authorizing statute, CHBRP reviews public demand for benefits relevant to a proposed mandate in two ways. CHBRP:

[52] Personal communication with content expert Lorin Scher, MD. (March 18, 2020).

- Considers the bargaining history of organized labor; and
- Compares the benefits provided by self-insured plans or policies (which are not regulated by the DMHC or CDI and therefore not subject to state-level mandates) with the benefits that are provided by plans or policies that would be subject to the mandate.

On the basis of conversations with the largest collective bargaining agents in California, CHBRP concluded that unions currently do not include cost-sharing arrangements for specific treatments or services or identify the entity responsible for scheduling appointments for enrollees. In general, unions negotiate for broader contract provisions such as coverage for dependents, premiums, deductibles, and broad coinsurance levels.

Among publicly funded self-insured health insurance policies, the preferred provider organization (PPO) plans offered by CalPERS currently have the largest number of enrollees. The CalPERS PPOs currently provide benefit coverage similar to what is available through group health insurance plans and policies that would be subject to the mandate.

To further investigate public demand, CHBRP used the bill-specific coverage survey to ask carriers who act as third-party administrators for (non-CalPERS) self-insured group health insurance programs whether the relevant benefit coverage differed from what is offered in group market plans or policies that would be subject to the mandate. The responses indicated that there were no substantive differences.

Second Year Impacts on Benefit Coverage, Utilization, and Cost

CHBRP has considered whether continued implementation during the second year of the benefit coverage requirements of AB 2242 would have a substantially different impact on utilization of either the tests, treatments, or services for which coverage was directly addressed, the utilization of any indirectly affected utilization, or both. CHBRP reviewed the literature and consulted a content expert about the possibility of varied second year impacts and determined the second year

impacts of AB 2242 would be substantially the same as the impacts in the first year (see Table 1). Minor changes to utilization and expenditures may occur due to population changes between the first year postmandate and the second year postmandate.

APPENDIX D INFORMATION SUBMITTED BY OUTSIDE PARTIES

In accordance with the California Health Benefits Review Program (CHBRP) policy to analyze information submitted by outside parties during the first 2 weeks of the CHBRP review, the following parties chose to submit information.

The following information was submitted by Diego Emilio J. Lopez, Legislative Aide, Office of Assemblymember Marc Levine, in March 2020.

California Knox-Keene Health Care Service Plan Act And Regulations, 2019 Edition.

California Department of Health Care Services – Mental Health and Substance Use Disorder Services Division, *California Involuntary Detentions Data Report, Fiscal Year (FY) 2016/2017.*

Submitted information is available upon request. For information on the processes for submitting information to CHBRP for review and consideration please visit: www.chbrp.org/requests.html.

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CALIFORNIA HEALTH BENEFITS REVIEW PROGRAM COMMITTEES AND STAFF

A group of faculty, researchers, and staff complete the analysis that informs California Health Benefits Review Program (CHBRP) reports. The CHBRP **Faculty Task Force** comprises rotating senior faculty from University of California (UC) campuses. In addition to these representatives, there are other ongoing researchers and analysts who are **Task Force Contributors** to CHBRP from UC that conduct 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 manages all external communications, including those with the California Legislature. As required by CHBRP's authorizing legislation, UC contracts with a certified actuary, **Milliman**, to assist in assessing the financial impact of each legislative proposal mandating or repealing a health insurance benefit.

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 of its National Advisory Council. CHBRP assumes full responsibility for the report and the accuracy of its contents.

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CHBRP assumes full responsibility for the report and the accuracy of its contents. All CHBRP bill analyses and other publications are available at www.chbrp.org.

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Please direct any questions concerning this document to: California Health Benefits Review Program; MC 3116; Berkeley, CA 94720-3116, info@chbrp.org, or www.chbrp.org