

Key Findings

Analysis of California Senate Bill 855

Health Coverage: Mental Health or Substance Abuse Disorders

Summary to the 2019–2020 California State Legislature, March 13, 2020



AT A GLANCE

The version of California Senate Bill 855 analyzed by CHBRP would expand the mental health and substance use disorders (MH/SUD) required to be covered by plans and policies at parity, define medical necessity, and place additional requirements on plans and policies.

1. CHBRP estimates that, in 2020, of the 21.7 million Californians enrolled in state-regulated health insurance, 13.4 million of them will have insurance subject to SB 855. Enrollees with Medi-Cal managed care coverage are not subject to SB 855.
2. **Benefit Coverage.** Although no enrollees have health insurance fully compliant with SB 855 at baseline, 99.8% of enrollees currently have coverage for all MH/SUD treatments required to be covered. The 0.2% of the population subject to SB 855 who do not have benefit coverage for MH/SUD at parity are a segment of the grandfathered individual market.
 - a. Because the essential health benefits (EHBs) benchmark plan includes coverage for the full range of inpatient and outpatient services and prescription drugs for all MH/SUD as defined in the mental disorders chapters of the Diagnostic and Statistical Manual of Mental Disorders, SB 855 is unlikely to exceed EHBs.
3. **Utilization** will change by 0.39% for SUD intermediate (including residential) services and 0.24% for SUD outpatient services due to changes in benefit coverage. However, changes in utilization due to the other provisions of SB 855 related to medical necessity, utilization management, and provider network requirements are unknown, but likely marginal.
4. **Expenditures.** Total net annual expenditures would increase by \$3,130,000 (0.002%) in the first year postmandate.
 - a. \$1,817,000 is due to an increase in premiums for enrollees with grandfathered individual market coverage due to changes in benefit coverage, and \$1,062,000 is due to an increase in premiums paid by both employers and enrollees due to an increase in administrative expenses related to training requirements.

AT A GLANCE, CONT.

- \$251,000 is due to increased enrollee cost sharing.
- b. The increases above focus only on benefit coverage changes for the 0.2% of the market who did not have coverage for all SUD services at parity at baseline and the cost of training across all enrollees in the commercial DMHC and CDI-regulated markets. All other expenditure changes are unknown due to the inability to estimate the change in use and spending due to changing the definition of medical necessity and new requirements related to paying for out-of-network services at full billed charges if plans do not meet network timeliness and geographic access standards.
 5. **Medical effectiveness.** All of the studies reviewed compared people who were enrolled in health plans subject to parity policies to people enrolled in health plans not subject to parity policies. SB 855 is likely to have less impact on use of MH/SUD services than these studies found because SB 855 expands upon parity laws that are already in effect.
 6. **Public health.** There will be an unknown marginal impact on treatment access and health outcomes. However, for the almost 27,000 enrollees who would receive full MH/SUD coverage, the removal of cost barriers to MH/SUD treatment could result in increased access, improved health outcomes, and lower out-of-pocket costs for some individuals.

CONTEXT

Approximately 18% of adults in California reported experiencing a mental illness in a given year, and almost 7.5% of Californians aged 12 and older reported a substance use disorder in the past year.¹ Care settings for the treatment of mental health disorders depend on the type and severity of the condition. The mental health continuum of care allows people to move in and out of different care settings and treatment modalities across their lifespan. Those with milder forms of MH disorders may require limited-term weekly office visits only once in

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

their lifetime. However, people with moderate and serious MH disorders may cycle through periods of more intensive inpatient care during acute psychiatric episodes, stepping down to lower levels of outpatient care as they achieve stabilization (i.e., intensive outpatient visits to monthly psychiatric medication visits).

For those who do not receive MH/SUD treatment (with or without health insurance), the most common barriers cited include no known providers, lack of providers accepting new patients, belief that they could handle the problem on their own, or patient reticence to stop substance use.

BILL SUMMARY

SB 855 amends the existing California mental health parity act by expanding the mental health and substance use disorders (MH/SUD) required to be covered by plans and policies, defines medical necessity, and places additional requirements on plans and policies.

Specifically, SB 855 requires coverage of treatment, when medically necessary, for any MH/SUD diagnosis identified in the most recent editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM), and the International Classification of Diseases (ICD). The DSM classifies mental disorders into 20 categories such as Anxiety Disorders, Obsessive-Compulsive Disorders, Personality Disorders, Dissociative Disorders, Feeding and Eating Disorders, and Substance Use and Addictive Disorders. The ICD is a list of diagnosis codes (with corresponding level of care) used by providers to bill insurance carriers for services rendered.

SB 855 would require health plans and policies to cover out-of-network services delivered to enrollees based on billed charges (rather than a discounted allowed amount or negotiated price) *immediately* if the plan was not able to provide in-network services in a timely manner based upon existing DMHC or CDI geographic access and timeliness requirements.

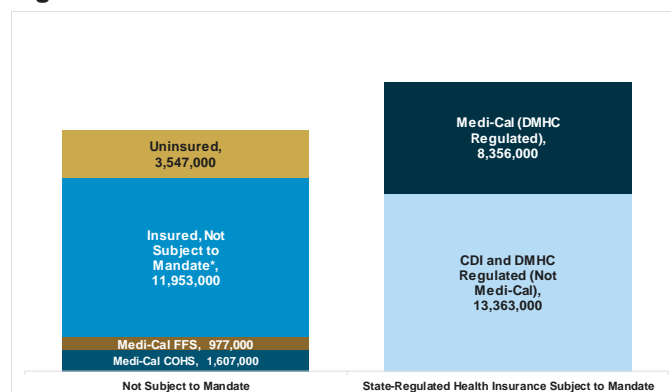
SB 855 also includes a provision that prohibits health plans and policies from denying coverage for services that should or could be covered by public entitlement programs, such as special education, individualized education programs, Medicaid, Medicare, Supplemental Security Income, Social Security Disability Insurance, or other such programs. It is unknown to what extent enrollees eligible for services through public entitlement programs, including school-based services, are being denied coverage of these services by the health plan or policy on the basis that the services should be provided by another program.

There are many overlaps between SB 855, California's existing mental health parity act, and the federal Mental Health Parity and Addiction Equity Act (MHPAEA). Other federal laws, such as the Affordable Care Act (ACA), have made additional changes to the MHPAEA. Over time, the combination of these federal and state laws moved requirements placed on MH/SUD coverage from applying only to group plans and policies to applying to almost all plans and policies. Additionally, the parity requirements moved from being limited to equivalent lifetime and annual limits to requiring parity of almost every facet of coverage, management and provision of care. As a result, SB 855 would substantially change very few components of coverage.

Recent court decisions, along with published reports from the federal Department of Labor, indicate there is variance in the implementation of federal and state health parity laws, for a variety of reasons. Potential reasons for this variance may include differing interpretations of these laws, reluctance to comply, lack of clarity, or lack of enforcement by regulatory agencies.

Figure A notes how many Californians have health insurance that would be subject to SB 855.

Figure A. Health Insurance in CA and SB 855



Source: California Health Benefits Review Program, 2020.

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

IMPACTS

Benefit Coverage, Utilization, and Cost

- Benefit Coverage:
 - 99.8% of enrollees currently have coverage for MH/SUD services at parity with other medical conditions and will not experience a change in benefit coverage.

- A portion of the grandfathered individual market (representing 0.2% of the overall population of enrollees subject to SB 855) will gain coverage for inpatient, outpatient, and intermediate SUD benefits.
- Utilization:
 - Utilization will change by 0.39% for SUD intermediate (including residential) services and 0.24% for SUD outpatient services due to changes in benefit coverage.
 - Changes in utilization due to the other provisions of SB 855 related to medical necessity, utilization management, limits on insurers denying claims that would otherwise be provided via public programs, and provider network requirements **CHBRP are unknown, but likely marginal.**
- Expenditures:
 - Total net annual expenditures would increase by \$3,130,000 (0.002%) for commercial and CalPERS enrollees. An increase of \$1,817,000 in expenditures is concentrated within the grandfathered individual market plans purchased off-exchange (0.18% increase in enrollee premiums) along with an increase of \$251,000 in enrollee cost sharing. The remaining increase of \$1,062,000 is due to a change in total premiums paid by employers and enrollees for administrative expenses for all plans due to education and training requirements.
 - Should utilization of MH/SUD services change due to the other provisions of SB 855, total net annual expenditures would likely increase.

Benefit Coverage

Currently, 99.8% of enrollees with health insurance that would be subject to SB 855 have coverage for outpatient services, inpatient services, intermediate services (including residential and intensive outpatient care), and outpatient prescription drugs related to all Serious Mental Illnesses (SMI), Serious Emotional Disturbances (SED), non-SMI mental health conditions, and Substance Use Disorders (SUD) in the ICD or DSM. Based on the CHBRP carrier survey, all (100%) nongrandfathered plans and policies in all market segments and grandfathered plans in the small- and large-group markets provide benefit coverage for all MH/SUD at parity with medical benefits. The 0.2% of the population subject to SB 855 who do not have benefit coverage for MH/SUD at parity are a segment of the grandfathered individual market.

According to the CHBRP carrier survey, none of the health plans use the explicit definition of medical necessity or clinical guidelines mentioned in SB 855 to guide medical necessity determinations. However, plans do report using similar criteria despite not applying the specific guidelines from SB 855, and generally state they follow standards of care for physician practice based on clinically appropriate services to deliver care to enrollees with MH/SUD diagnoses. The plans do not differentiate between non-SMI, SMI, SED, or SUD, diagnoses in responding to the carrier survey.

Utilization

Postmandate, CHBRP estimates that utilization will change by 0.39% for SUD intermediate (including residential) services and 0.24% for SUD outpatient services due to changes in benefit coverage. However, changes in utilization due to the other provisions of SB 855 related to medical necessity, utilization management, and provider network requirements CHBRP are **unknown, but likely marginal.**

It is likely that the definition of medical necessity and the clinical guidelines that SB 855 would require health plans and policies to use would be roughly equivalent to existing clinical guidelines used to make medical necessity decisions, and would have **an unknown, but marginal, impact** on overall levels of utilization and/or spending for the four main categories of health care utilization described in SB 855.

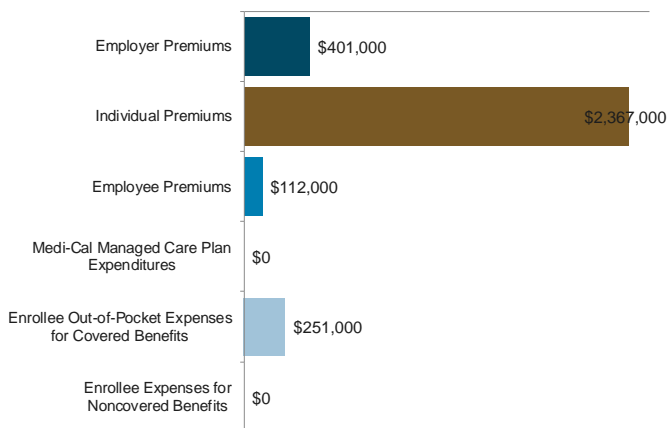
SB 855 requires necessary out-of-network services for MH/SUD to be covered immediately in cases where lack of access to a provider violates the timeliness and geographic access regulations applied to DMHC-regulated plans and CDI-regulated policies. Although the enrollee may have experienced difficulty accessing providers in a timely manner who met their needs, DMHC and CDI do not require plans to provide timely access to any provider chosen by the enrollee, but to ensure only that there is a provider in the area that can meet the timely access requirement. It is unlikely that a significant number of services would be delivered out-of-network and paid for by the plan at the billed rate, given SB 855 does not change the timely and geographic access requirements. CHBRP found that there is an **unknown impact** for coverage for out-of-network services when network providers are unavailable within DMHC and CDI timeliness and geographic access standards.

Expenditures

SB 855 would increase total net annual expenditures by \$3,130,000 (0.002%) for enrollees with DMHC-regulated plans and CDI-regulated policies. An increase of

\$1,817,000 in expenditures is concentrated within the grandfathered individual market plans purchased off-exchange (0.18% increase in enrollee premiums). The remaining increase of \$1,062,000 is due to a change in total health insurance premiums paid by employers and enrollees for administrative expenses for all plans due to education and training requirements, and \$251,000 in additional enrollee cost sharing in the grandfathered individual market.

Figure B. Expenditure Impacts of SB 855



Source: California Health Benefits Review Program, 2020.

Medi-Cal

Medi-Cal is not subject to SB 855, and therefore, there is no impact for these enrollees.

CalPERS

Total expenditures for enrollees with health insurance through CalPERS subject to SB 855 would increase by 0.0006% in the first year postmandate, due to an increase in administrative expenses.

Number of Uninsured in California

Because the change in average premiums does not exceed 1% for any market segment, CHBRP would expect no measurable change in the number of uninsured persons due to the enactment of SB 855.

Medical Effectiveness

The effectiveness review for this report summarizes the literature on the effects of parity in coverage for MH/SUD services on out-of-pocket costs, utilization, receipt of recommended care, and health outcomes. All of the studies reviewed compared people who were enrolled in health plans subject to parity policies to people enrolled

in health plans not subject to parity policies. **Findings from these studies may not generalize to SB 855 because health plans in California are already required to comply with state and federal parity laws.** SB 855 is likely to have less impact on use of MH/SUD services than these studies found because SB 855 expands upon parity laws that are already in effect.

The Medical Effectiveness review finds:

- There is *inconclusive evidence*² that MH/SUD parity policies affect out-of-pocket costs for MH/SUD services.
- There is *inconclusive evidence* that MH/SUD parity policies affect the probability people will use MH/SUD services.
- There is a *preponderance of evidence*³ that MH/SUD parity policies significantly increase the number of MH/SUD related encounters per person using MH/SUD services.
- There is *inconclusive evidence* that MH/SUD parity policies increase receipt of recommended care for MH/SUD.
- There is *insufficient evidence*⁴ to conclude whether parity improves MH/SUD health outcomes.

Public Health

Should SB 855 become law, CHBRP concludes that there will be an unknown marginal impact on MH/SUD treatment access and health outcomes. This is due to weak evidence of effectiveness of parity laws; unknown changes to carriers' application of medical necessity; unknown changes to use of out-of-network services; and challenges with provider supply in California.

However, for the almost 27,000 (of 13.4 million) enrollees who would receive full MH/SUD coverage, the

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

⁴ *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.

removal of cost barriers to MH/SUD treatment could result in increased access, improved health outcomes, and lower out-of-pocket costs for some individuals.

staff turnover, and retrain staff and providers when changes to the guidelines are made.

Long-Term Impacts

The long-term impacts for utilization are unknown due to the changes in medical necessity criteria likely resulting in an unknown marginal impact due to the relative similarity of current clinical guidelines. The out-of-network coverage provisions of SB 855 would lead to unknown impacts in the long-term, given the lack of data about out-of-network use, enforcement by insurance regulators, and response by providers to join or not join insurance networks.

CHBRP assumes that the long-term costs for training and dissemination to comply with the medical necessity requirements on SB 855 will be similar in Year 1 as in future years, due to the need to train new employees, address

Essential Health Benefits and the Affordable Care Act

One of the required EHB categories is “mental health and substance use disorder” services. California’s chosen benchmark plan, the Kaiser Foundation Health Plan Small Group HMO 30 plan, includes coverage for the full range of medically necessary inpatient and outpatient services and prescription drugs for to treat mental disorders as defined in the DSM, including substance use disorders. SB 855 would not require coverage for a new state benefit mandate and instead modifies the terms of existing benefit coverage. Therefore, SB 855 appears unlikely to exceed the definition of EHBs in California.