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Title

Analysis of California Senate Bill 855 Health Coverage: Mental Health or Substance Abuse Disorders

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Analysis of California Senate Bill 855 Health Coverage: Mental Health or Substance Abuse Disorders

A Report to the 2019–2020 California State Legislature

March 13, 2020



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.

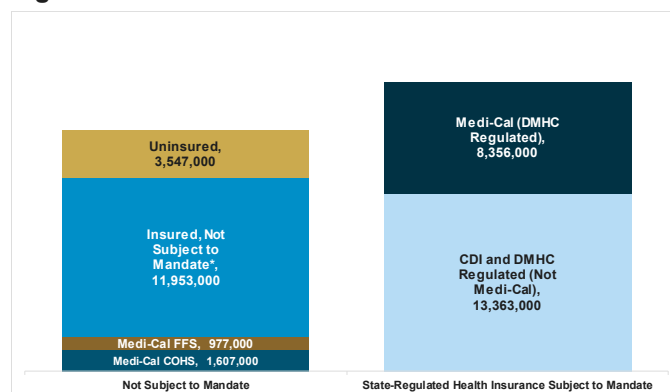
SB 855 also includes a provision that prohibits health plans and policies from denying coverage for services that should or could be covered by public entitlement programs, such as special education, individualized education programs, Medicaid, Medicare, Supplemental Security Income, Social Security 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.

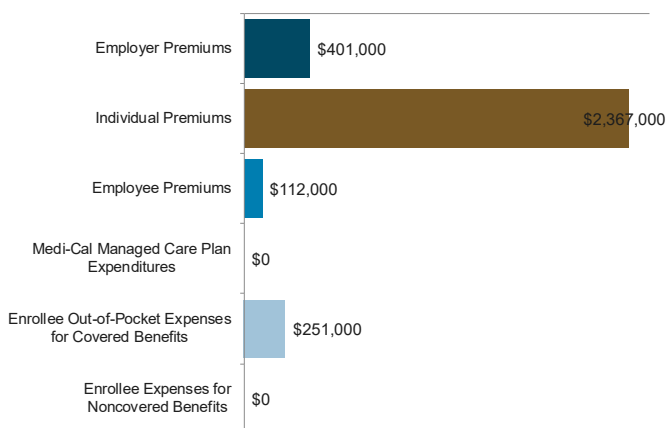
SB 855 requires necessary out-of-network services for MH/SUD to be covered immediately in cases where lack of access to a provider violates the timeliness and geographic access regulations applied to DMHC-regulated plans and CDI-regulated policies. Although the enrollee may have experienced difficulty 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.

A Report to the California State Legislature

Analysis of California Senate Bill 855
Health Coverage: Mental Health or Substance Abuse
Disorders

March 13, 2020

California Health Benefits Review Program
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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. Impacts of SB 855 on Benefit Coverage, Utilization, and Cost, 2021

	Baseline	Postmandate	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	0.00%
Total enrollees with health insurance subject to SB 855	13,363,000	13,363,000	0	0.00%
Percentage of enrollees with coverage for treatment of all MH/SUD	99.8%	100.0%	0.2%	0.17%
Percentage of enrollees with health insurance fully compliant with SB 855	0%	100%	100%	100%
Utilization and cost				
<i>Total number of services (in thousands)</i>	<i>In 1,000</i>	<i>In 1,000</i>	<i>In 1,000</i>	
Non-SMI inpatient services	4	4	0	0.00%
Non-SMI intermediate services	31	31	0	0.00%
Non-SMI outpatient visits	2,634	2,634	0	0.00%
SMI inpatient services	23	23	0	0.00%
SMI intermediate services	378	378	0	0.00%
SMI outpatient visits	9,152	9,152	0	0.00%
SUD inpatient services	10	10	0	0.00%
SUD intermediate services	258	259	1	0.39%
SUD outpatient visits	416	417	1	0.24%
Non-SUD prescription drugs	14,427	14,427	0	0.00%
SUD prescription drugs	301	301	0	0.00%
Average cost per service				
Non-SMI inpatient services	\$16,839	\$16,839	\$0	0.00%
Non-SMI intermediate services	\$595	\$595	\$0	0.00%
Non-SMI outpatient visits	\$253	\$253	\$0	0.00%
SMI inpatient services	\$25,229	\$25,229	\$0	0.00%
SMI intermediate services	\$820	\$820	\$0	0.00%
SMI outpatient visits	\$275	\$275	\$0	0.00%
SUD inpatient services	\$17,276	\$17,276	\$0	0.00%
SUD intermediate and services	\$1,108	\$1,109	\$1	0.06%
SUD outpatient visits	\$598	\$598	\$0	0.00%
Non-SUD prescription drugs	\$93	\$93	\$0	0.00%
SUD prescription drugs	\$265	\$265	\$0	0.00%
Expenditures				
<i>Premium (expenditures) by payer</i>				
Private Employers for group insurance	\$54,037,059,000	\$54,037,440,000	\$381,000	0.00%
CalPERS HMO employer expenditures (b) (c)	\$3,264,098,000	\$3,264,118,000	\$20,000	0.00%
Medi-Cal Managed Care Plan expenditures	\$29,218,820,000	\$29,218,820,000	\$0	0.00%
<i>Enrollee premiums (expenditures)</i>				
Enrollees for individually purchased insurance	\$15,689,758,000	\$15,692,125,000	\$2,367,000	0.02%
Individually purchased – outside Exchange	\$4,412,875,000	\$4,415,177,000	\$2,302,000	0.05%
Individually purchased – Covered California	\$11,276,883,000	\$11,276,948,000	\$65,000	0.00%
Enrollees with group insurance, CalPERS HMOs, Covered California, and Medi-Cal Managed Care (c)	\$15,867,227,000	\$15,867,339,000	\$112,000	0.00%
<i>Enrollee out-of-pocket expenses</i>				
For covered benefits (deductibles, copayments,	\$12,776,801,000	\$12,777,052,000	\$251,000	0.00%

etc.)

For noncovered benefits (d) (e)	\$0	\$0	\$0	0.00%
Total expenditures	\$130,853,763,000	\$130,856,894,000	\$3,130,000	0.00%

Source: California Health Benefits Review Program, 2020.

Notes: For 0.2% of enrollees, SUD inpatient, outpatient, and intermediate services are not covered at baseline and will become covered postmandate. This accounts for an increase in premiums of \$1,817,000 and an increase in cost sharing of \$251,000. An increase of \$1,062,000 in total expenditures is due to an increase in administrative costs, including due to training and education requirements included in SB 855.

(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) 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.⁶ 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) 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.

(d) 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.

(e) Although enrollees with newly compliant benefit coverage may have paid for some MH/SUD treatments before SB 855, CHBRP cannot estimate the frequency with which such situations may have occurred and therefore cannot estimate the related expense. Postmandate, such expenses would be eliminated, though enrollees with newly compliant benefit coverage might, postmandate, pay for some MH/SUD treatments for which coverage is denied (through utilization management review), as some enrollees who always had compliant benefit coverage may have done and may continue to do, postmandate.

Key: CalPERS = California Public Employees' Retirement System; CDI = California Department of Insurance; DMHC = Department of Managed Health Care; HMO = Health Maintenance Organization; MH = mental health; SMI = serious mental illness; SUD = substance use disorder.

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

⁶ For more detail, see *Estimates of Pharmacy Benefit Coverage in California for 2021*, available at http://chbrp.org/other_publications/index.php.

POLICY CONTEXT

The California Senate Committee on Health has requested that the California Health Benefits Review Program (CHBRP)⁷ conduct an evidence-based assessment of the medical, financial, and public health impacts of SB 855, mental health or substance use disorders.

Bill-Specific Analysis of SB 855, Mental Health or Substance Use Disorders

Relevant Populations

If enacted, SB 855 would apply to the health insurance of approximately 13.4 million enrollees (34% 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.

Bill Language

SB 855 amends the existing California mental health parity act⁸ 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.

An overview and comparison between SB 855, California's existing mental health parity act, and the federal Mental Health Parity and Addition Equity Act (MHPAEA) is included in Table 3 of the *Policy Context* section.

The full text of SB 855 can be found in Appendix A.

Discretionary clause

Insurance Code section 10110.6 prohibits insurers from reserving discretionary authority to determine eligibility for benefits or coverage; interpret terms of the policy; or provide standards of interpretation or review that are inconsistent with current California law. There is no matching code in the Health and Safety Code (H&SC). SB 855 would add a matching clause to the H&SC.

It is unclear what impact the discretionary clause may have on benefit coverage, utilization, and public health impacts, assuming full implementation and enforcement.

Covered MH/SUD conditions

California's existing mental health parity law 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, pervasive development disorder or autism, anorexia nervosa, and bulimia nervosa. A child is identified as having a 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

⁷ CHBRP's authorizing statute is available at www.chbrp.org/faqs.php.

⁸ Health and Safety Code (H&SC) 1374.72; Insurance Code (IC) 10144.5.

expected developmental norms” and (2) meet criteria specified in current law regarding substantial impairment as a result of their mental disorder.⁹

SB 855 expands the coverage requirement to include the diagnosis and medically necessary treatment of mental health and substance use disorders (MH/SUD) that fall under any of the diagnostic categories included in the most recent edition of the International Classification of Diseases (ICD) or the DSM, including SMI and SED as specified in current law.

Types of care settings and services covered

The existing California mental health parity act specifies plans and policies must cover the following services to treat MH/SUD: (1) outpatient services; (2) inpatient hospital services; (3) partial hospitalization; and (4) prescription drugs if a prescription drug benefit is included in the plans’ or policies’ benefits.

SB 855 maintains the categories of outpatient services and prescription drugs. Inpatient hospital services is amended to inpatient services. Partial hospitalization is amended to now require coverage of intermediate services. SB 855 states intermediate services includes the full range of levels of care as identified by specified guidelines (see Table 2 below) and which includes residential treatment, partial hospitalization, and intensive outpatient treatment. This expanded definition aligns with the categories already included in the federal MHPAEA.

Definition of “medically necessary” treatments

Although the existing California mental health parity states that medically necessary treatments must be covered, it does not define “medically necessary.”

SB 855 defines medically necessary treatments as meeting *all* of the following:

1. Recommended by the patient’s treatment provider;
2. Furnished in the manner and setting that can most effectively and comprehensively address the patient’s conditions;
3. Provided in sufficient amount, duration, and scope to do any of the following:
 - a. Prevent, diagnose, or treat a disorder;
 - b. Minimize the progression of a disorder or its symptoms;
 - c. Achieve age-appropriate growth and development,
 - d. Minimize the progression of disability; or
 - e. Attain, maintain, regain, or maximize full functional capacity.
4. And that are consistent with generally accepted standards of practice. Generally accepted standards of practice are based on either scientific evidence published in peer-reviewed medical literature generally recognized by the relevant clinical community, or on clinical specialty society recommendations, professional standards, and consensus statements.

⁹ Welfare and Institutions Code Section 5600.3(a)(2) cited in Health and Safety Code Section 1374(e) and California Insurance Code Section 10144.5(e).

Definitions of medical necessity

Medical necessity or medically necessary treatments are not defined in existing California or federal parity laws. There are a few common definitions of medical necessity that may be used by health plans and policies when making coverage determinations. The first definition from the American Medical Association is similar to the one included in SB 855, although not identical. Health plans and policies surveyed by CHBRP provided the definitions of medical necessity used internally and most use the American Medical Association definition, with some variation.

- **American Medical Association¹⁰ definition:** Health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration; and (c) not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician, or other health care provider. For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community or documented physician specialty society recommendations.
 - One health plan surveyed by CHBRP uses this definition of medical necessity, but also specifies that the medically necessary service should not be "more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that covered individual's illness, injury or disease."¹¹
- One health plan surveyed uses the following definition: A service is medically necessary if it is medically appropriate and required to prevent, diagnose, or treat your condition or clinical symptoms in accord with generally accepted professional standards of practice that are consistent with a standard of care in the medical community.¹²
- **Medi-Cal¹³ definition:** A service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.
- **Medicare¹⁴ definition:** Health care services or supplies needed to diagnose or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine.

Clinical care guidelines

For medically necessary determinations concerning level of care placement, continued stay, and transfer or discharge, SB 855 states that plans and policies must rely exclusively on the most recent editions of specific guidelines and recommendations, as described in Table 2.

SB 855 directs reviewers to "err on the side of caution and safety in making medically necessary determinations by placing patients in higher levels of care when there is ambiguity as to the appropriate level of care."

¹⁰ AMA Policy H-320.953.

¹¹ Provided by a health plan to CHBRP upon request.

¹² Provided by a health plan to CHBRP upon request.

¹³ Welfare and Institutions Code 14059.5.

¹⁴ Medicare.gov Glossary. Accessed on February 12, 2020 at <https://www.medicare.gov/glossary/m>.

SB 855 also states that plans and policies cannot limit benefits or coverage for “chronic or pervasive” MH/SUD to “short-term or acute treatment.”

Some health plans and policies use established clinical guidelines when reviewing determinations for medical necessity or evaluating the appropriate level of care. Other plans and policies may develop guidelines internally or use a combination of established guidelines and internal guidelines. One commonly used set of guidelines is the Milliman Care Guidelines.¹⁵ These evidence-based care guidelines are developed using peer-reviewed papers and research studies and cover the entire continuum of care.

Table 2. Organizational Guidelines and Recommendations for Medically Necessary Determinations Concerning Level of Care Placement, Continued Stay, and Transfer or Discharge Identified by SB 855

Standard of Practice	Authoring Organization	Disorder	Age
American Society of Addiction Medicine (ASAM) criteria	ASAM	SUD	Any age
Level of Care Utilization System (LOCUS)	American Association of Community Psychiatrists	Mental health disorders	Age 18 and over
Child and Adolescent Level of Care Utilization System (CALOCUS) or the Child and Adolescent Service Intensity Instrument (CASII)	American Association of Community Psychiatrists American Academy of Child and Adolescent Psychiatry	Mental health disorders	Ages 6 to 17 years, inclusive
Early Childhood Service Intensity Instrument (ECSII)	American Academy of Child and Adolescent Psychiatry	Mental health disorders	Ages 0 to 5 years, inclusive
American Psychiatric Association criteria for eating disorders	American Psychiatric Association	Primary diagnosis of an eating disorder	Any age
<i>Clarification regarding applied behavior analysis treatment of autism spectrum disorder: practice guidelines for health funders and managers</i>	Behavior Analyst Certification Board or Association of Professional Behavioral Analysts	Individuals with ASD undergoing behavioral therapy	Not specified

Source: California Health Benefits Review Program, 2020.

Key: ASD = autism spectrum disorder; SUD = substance use disorders

¹⁵ MCG. Available at <https://www.mcg.com/care-guidelines/care-guidelines/>.

Terms and conditions

The existing California mental health parity act and SB 855 both require coverage of diagnosis and medically necessary treatment for the specified conditions at parity with other medical conditions. SB 855 clarifies that this includes patient financial responsibilities, such as maximum lifetime benefits, copayments, and individual and family deductibles.

Utilization management

SB 855 did not make changes to the utilization management component of the existing California mental health parity act. Plans and policies may utilize case management, network providers, utilization review techniques, prior authorization, and copayments or other cost sharing, to the extent permitted by other applicable laws.

Provider network requirements

The existing California mental health parity act specifies that plans and policies are required to provide mental health services within their entire service area and in emergency situations as may be required by law and regulation.

SB 855 places additional requirements on plans and policies regarding access to providers. Specifically, if medically necessary services are not available in-network within geographic and timeliness standards set by law or regulation, plans and policies must immediately cover out-of-network services. These services must be covered at an in-network benefit level and plans and policies must reimburse the providers at the full billed charge amount.

Education and monitoring requirements

SB 855 adds requirements for plans and policies to provide education and monitor compliance with the required instructions for determining medically necessary levels of care placement, continued stay, and transfer or discharge. Requirements include:

- Sponsor formal education programs by nonprofit clinical specialty associations to educate plan staff and other stakeholders, including participating providers and enrollees, about the guidelines, and provide the guidelines and any training material or resources to providers and enrollees;
- Track, identify, and analyze how the clinical guidelines are used; and
- Run interrater reliability reports about how the clinical guidelines are used and achieve interrater reliability pass rates as specified.

Services provided by public entitlement programs

SB 855 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.

Civil action

Additionally, SB 855 specifies that enrollees, subscribers, or providers on behalf of an enrollee or subscriber may bring a civil action in a court against a plan or policy for a violation of the section

amended by SB 855, the section requiring behavioral health treatment for autism and related disorders,¹⁶ or the section that requires compliance with the federal Mental Health Parity and Addiction Equity Act.¹⁷ SB 855 provides terms related to these civil actions. Because CHBRP does not provide legal analysis, CHBRP will not discuss potential impacts of this provision.

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

As described above, SB 855 would amend California's existing mental health parity act,¹⁸ which was signed into law in 1999 and implemented in 2000. In addition to requirements set forth in California's existing mental health parity act, other provisions in California law establish additional requirements related to the types of providers, access standards, and types and location of treatment for autism spectrum disorders.¹⁹ More information about these existing standards can be found in CHBRP's 2019 analysis of SB 163 Autism.²⁰

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. For example, if alcohol, nicotine, or chemical dependency treatments are covered, treatment may take place in a licensed alcoholism or chemical dependency facility.²¹ 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*.²² In most instances, the California mental health parity act supersedes these mandates with more restrictive requirements.

California DMHC-regulated plans and CDI-regulated policies that provide coverage on a group basis must *offer* coverage for the treatment of alcoholism under such terms and conditions as may be agreed upon between the group subscriber and the health care service plan.²³

Additionally, DMHC-regulated plans and most small-group and individual market CDI-regulated policies²⁴ 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.²⁵

Timeliness and geographic access standards

Current law²⁶ specifies that enrollees are required to have access to the following services within certain time periods:

¹⁶ H&SC 1374.73; IC 10144.51 and 10144.52.

¹⁷ H&SC 1374.76; IC 10144.4.

¹⁸ Health and Safety Code 1374.72; Insurance Code 10144.5.

¹⁹ H&SC 1374.73; IC 10144.51 and 10144.52.

²⁰ CHBRP's 2019 analysis of SB 163 Autism is available at http://chbrp.org/completed_analyses/index.php.

²¹ H&SC 1367.2 and IC 10123.6.

²² 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.

²³ Health and Safety Code Section 1367.2 and California Insurance Code Section 10123.6.

²⁴ Small group and individual market CDI-regulated policies subject to the Essential Health Benefits are subject to Basic Health Care Services because the chosen EHB benchmark plan is regulated by DMHC.

²⁵ IC 10112.27(a)(2)(A)(i); 28 CCR 1300.67.

²⁶ H&SC 1367.03 and 1367.035; Title 28 of CCR 1300.67.2.2 (g)(2) and (g)(2)(G).; IC 10133.5.

- Urgent care
 - No prior authorization required = within 2 days
 - Prior authorization required = within 4 days
- Nonurgent care
 - Primary care = within 10 business days
 - Specialty care = within 15 business days
 - Nonphysician mental health care = within 10 business days
 - Ancillary services (such as laboratories or physical therapy services) = within 15 business days

If the referring or treating provider determines that a longer wait time will not negatively impact the enrollee's health, these times may be extended.

Geographic distance standards vary by regulator. Although DMHC specified distance standards for access to primary care providers and hospitals,²⁷ DMHC does not specify geographic standards for specialty or mental health care, other than to say plans must demonstrate that a comprehensive range of specialty services are readily available. CDI-regulated policies must provide access to specialty care within 30 miles or 60 minutes, and access to mental health care and substance use disorder professionals within 15 miles or 30 minutes of an enrollee's home or workplace.²⁸

Although existing California law requires plans and policies to cover out-of-network services if they are not available within geographic and timeliness standards as established, plans and policies are not required to cover these services "immediately," as is required under SB 855. However, SB 855 does not specify how plans or policies (or the regulator) will determine whether no providers are available within these standards and that enrollees are therefore entitled to fully covered out-of-network services. Additionally, CHBRP assumes that as long as plans and policies include appropriate providers within the networks to meet these timeliness and geographic access standards, these plans are compliant with existing regulation. Plans are not required to provide access to any provider based on an enrollee's specific requirements, such as appointment availability that meets the enrollee's individual schedule.

Similar requirements in other states

All 50 states and Washington D.C. have implemented a variety of laws that require mental health parity (NCSL, 2015). These laws can be divided roughly into three categories: (1) mental health parity or equal coverage laws; (2) minimum mandated mental health benefit laws; and (3) mental health "mandated offering laws." CHBRP is unaware of existing or introduced state laws that are similar to SB 855.

Federal Policy Landscape

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 and are described below.

Comparison of SB 855 with existing federal and state law

The multiple federal and state health parity laws have resulted in a stacking effect regarding which services are required to be covered and the terms and conditions applied to those covered benefits. A timeline of the various mental health parity laws is included below (Figure 1). To illustrate how these laws

²⁷ CAL. CODE REGS., tit. 28, § 1300.51(c)(H)(iv).

²⁸ CAL. CODE REGS., tit. 10, § 2240.1(c)(3)-(4).

overlap with SB 855, CHBRP provides a comparison of SB 855, California’s existing mental health parity act, and the federal MHPAEA in conjunction with the ACA (Table 3).

Over time, a combination of 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. Where impacts may occur due to SB 855 are mentioned in Table 3.

Figure 1. Timeline of Mental Health Parity Laws

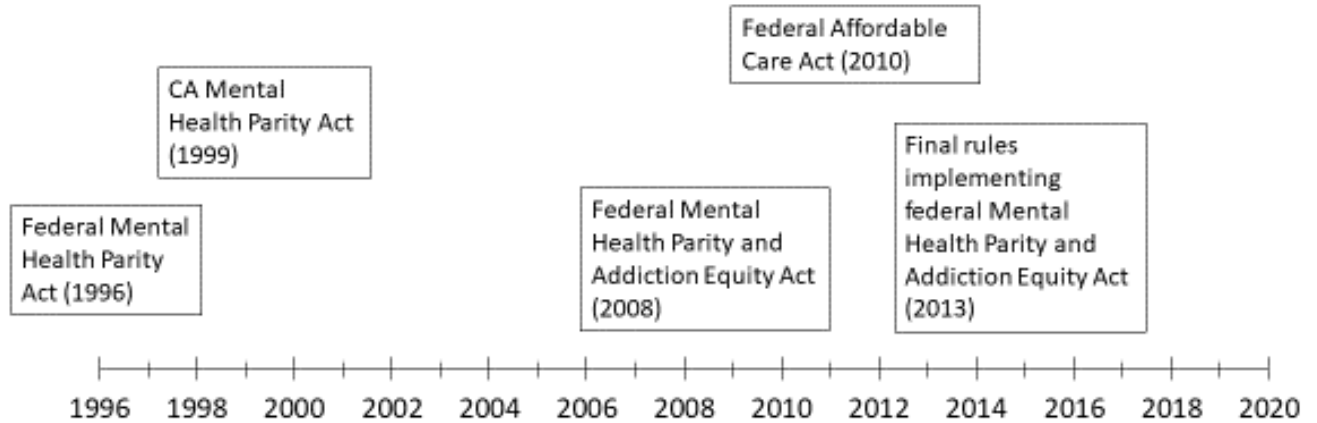


Table 3. Comparison Between SB 855, Existing California Mental Health Parity Act, and the Federal MHPAEA

Provision	CA Mental Health Parity Act (1999)	MHPAEA (2008, 2013)	ACA (2010)	SB 855 (2020)	Change due to SB 855
Covered MH/SUD conditions	Diagnosis and medically necessary treatment of SMI for individuals of any age; SED in children.	No requirements to cover diagnosis and treatments of specific conditions.	Requires coverage of MH/SUD treatments for nongrandfathered plans and policies subject to EHBs.	Diagnosis and medically necessary treatment of MH/SUD listed in the most recent ICD or DSM.	Expands number of treatments large-group and grandfathered small-group and individual plans and policies are required to cover.
Plans and policies subject to law	All DMHC/CDI regulated plans and policies, excluding Medi-Cal.	Group health plans with more than 50 employees.	Extended MHPAEA requirements to all nongrandfathered plans and policies in the small and individual markets.	All DMHC/CDI regulated plans and policies, excluding Medi-Cal.	Grandfathered small-group and individual market plans now subject to requirement to cover <i>all</i> medically necessary MH/SUD treatments.
Types of services covered	<ul style="list-style-type: none"> • Outpatient services • Inpatient hospital services • Partial hospitalization • Prescription drugs 	<ul style="list-style-type: none"> • Outpatient services • Inpatient services • Emergency services • Prescription drugs 	N/A	<ul style="list-style-type: none"> • Outpatient services • Inpatient services • Intermediate services • Prescription drugs 	Although the categories may be different, the treatments have remained the same. Therefore, this provision will not result in a change from current law.
Definition of “medically necessary” treatments	Not specified.	Not specified. Insurer standards for determination must be	Not specified.	Included in bill language. Plans/policies must also use specific guidelines	Plans/policies will now need to include the definitions specified by SB 855.

		provided upon request.		when making placement of care determinations.	
				Plans/policies cannot limit coverage to short term or acute treatment.	
Terms and conditions	Same terms and conditions as applied to other medical conditions.	Terms cannot be less favorable than terms for other medical conditions.	Prohibits annual and lifetime coverage limits; included other requirements regarding deductibles and cost sharing.	Same terms and conditions as applied to other medical conditions.	SB 855 does not result in a change of terms and conditions for covered MH/SUD treatments, as long as the terms and conditions are at parity.
Utilization management	Allowed at parity.	Allowed. Defines quantitative and nonquantitative treatment limits.		Allowed at parity (no change from current CA law).	
Provider network requirements	Required to meet timeliness and geographic requirements as specified by existing regulation.	Geographic standards and network adequacy must be at parity with standards for other medical conditions. If out-of-network coverage is provided for other medical conditions, out-of-network coverage must also be provided for MH/SUD. Does not specify cost-sharing responsibility.		Required to meet timeliness and geographic requirements as specified by existing regulation. If services are not available in network within the timeliness and geographic requirements, plans/policies must immediately cover out-of-network services at no additional cost	Does not change existing timeliness and geographic standards, but specifies that insurers must immediately cover qualified out-of-network services.

sharing to the enrollee.

Education and monitoring requirements	None included.	None included.	<p>Formal education program to educate staff, in-network providers, and enrollees about clinical guidelines.</p> <p>Requirements to assess use of clinical guidelines and to run inter-rater reliability reports.</p>	May result in an increase in administrative costs.
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Source: California Health Benefits Review Program, 2020.

Key: ACA = Affordable Care Act; DSM = Diagnostic and Statistical Manual; EHBs = Essential Health Benefits; ICD = International Classification of Diseases; MHPAEA = Mental Health Parity and Addiction Equity Act; MH/SUD = mental health and substance use disorders; SED = serious emotional disturbances; SMI = severe mental illness.

Mental Health Parity Act

In 1996, Congress passed the Mental Health Parity Act (MHPA), which prohibited group health plans and health insurance issuers from placing annual and lifetime benefit limitations on mental health benefits that are more restrictive than annual and lifetime benefit limitations for other medical and surgical benefits. The law required that dollar limits on mental health benefits be no lower than for other medical and surgical benefits offered by a group health plan, but allowed more restrictive limits on MH/SUD days of care or visits and cost sharing, and did not address parity in individual plans or for SUDs.

Federal Mental Health Parity and Addiction Equity Act

The federal Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 addresses parity for mental health and substance use disorder benefits, attempting to close some of the gaps of the MHPA.²⁹ The MHPAEA requires that *if* mental health or substance use disorder 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 group health insurance plans with more than 50 employees. This federal requirement is similar to the California mental health parity law,³⁰ although the state law applies to some plans and policies not captured in the MHPAEA and requires plans and policies to provide coverage for specified mental health disorders.

The MHPAEA provides additional information regarding quantitative treatment limitations and non-quantitative treatment limitations:

- **“Quantitative treatment limitations”** refers to annual, episodic, lifetime, day, and/or visit limits.³¹ Plans are prohibited from imposing more restrictive quantitative treatment limitations for MH/SUD than the predominant financial requirement for substantially all medical/surgical benefits.
- **“Nonquantitative treatment limitations”** refers to those operational terms of the plan, processes, and evidentiary standards. Examples are the criteria used to determine medical necessity, medical management, utilization management techniques, methods for determining “reasonable charges,” and step therapy.

The MHPAEA Final Rule released in 2013 provided further clarification of permissible and impermissible quantitative and nonquantitative treatment limits.

Additionally, California codified the requirements of the MHPAEA into state law, including the final regulations, meaning that all large-group, small-group, and individual market DMHC-regulated plans and CDI-regulated policies would need to comply.³²

Affordable Care Act

A number of ACA provisions have the potential to, or do, interact with state and federal benefit mandates. Below is an analysis of how SB 855 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).^{33,34}

²⁹ Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), as amended by the ACA. CCIIO, MHPAEA Fact Sheet, 2016. Accessed February 11, 2020 at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.

³⁰ H&SC Section 1374.72; IC Section 10144.5 and 10123.15.

³¹ 45 CFR Subtitle A, Subchapter B, Section 146.136 [b].

³² H&SC 1374.76; IC 10144.4.

³³ The ACA requires nongrandfathered small-group and individual market health insurance — including, but not limited to, 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.

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.

Categories of 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.^{35,36} CHBRP estimates that approximately 4 million Californians (10%) have insurance coverage subject to EHBs in 2021.³⁷

One of the required EHB categories is "mental health and substance use disorder" services.³⁸ California's chosen benchmark plan, the Kaiser Foundation Health Plan Small Group HMO 30 plan, includes coverage for the full range of inpatient and outpatient services and prescription drugs for all mental disorders as defined in the DSM, including substance use disorders.

Exceeding essential health benefits

States may require plans and policies to offer benefits that exceed EHBs.³⁹ However, a state that chooses to do so must make payments to defray the cost of those additionally mandated benefits, either by paying the purchaser directly or by paying the qualified health plan.^{40,41} Health plans and policies sold outside of the health insurance marketplaces are not subject to this requirement to defray the costs. State rules related to provider types, cost sharing, or reimbursement methods would not meet the definition of state benefit mandates that could exceed EHBs.⁴²

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 not to exceed the definition of EHBs in California.

³⁴ 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.

³⁵ CCIIIO, Information on Essential Health Benefits (EHB) Benchmark Plans. Available at: <https://www.cms.gov/cciiio/resources/data-resources/ehb.html>.

³⁶ H&SC Section 1367.005; IC Section 10112.27.

³⁷ CHBRP, *Estimates of Sources of Health Insurance in California in 2021*. Available at: www.chbrp.org/other_publications/index.php.

³⁸ Affordable Care Act, Section 1302(b)(1)(E).

³⁹ ACA Section 1311(d)(3).

⁴⁰ State benefit mandates enacted on or before December 31, 2011, may be included in a state's EHBs, according to the U.S. Department of Health and Human Services (HHS). Patient Protection and Affordable Care Act: Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation. Final Rule. Federal Register, Vol. 78, No. 37. February 25, 2013. Available at: <https://www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf>.

⁴¹ However, as laid out in the Final Rule on EHBs HHS released in February 2013, state benefit mandates enacted on or before December 31, 2011, would be included in the state's EHBs, and there would be no requirement that the state defray the costs of those state-mandated benefits. For state benefit mandates enacted after December 31, 2011, that are identified as exceeding EHBs, the state would be required to defray the cost.

⁴² Essential Health Benefits. Final Rule. A state's health insurance marketplace would be responsible for determining when a state benefit mandate exceeds EHBs, and QHP issuers would be responsible for calculating the cost that must be defrayed.

Prohibition on annual and lifetime limits

The ACA prohibits lifetime and annual limits on the dollar value of benefits for group and most individual plans and policies.⁴³ Because the federal MHPAEA and California mental health parity act both require that plans and policies provide terms and conditions for mental health and substance use disorders that are in parity with other medical conditions, plans and policies were not able to place more restrictive lifetime limits on mental health and substance use disorder services prior to the enactment of the ACA.

Relevant Court Decisions

The bill authors and sponsors of SB 855 have referenced four recent court decisions as a basis for the language included in SB 855. These court decisions include: *Harlick v. Blue Shield of California*; *Rea v. Blue Shield of California*; *Smith v. Health Care Services Corporation and MCG*; and *Wit v. United Behavioral Health*. The *Harlick* and *Rea* court decisions involve California regulated plans and policies, whereas the *Smith* and *Wit* court decisions involve application of the MHPAEA to Employee Retirement Income Security Act (ERISA) regulated plans.

These court decisions, along with published reports from the federal Department of Labor,⁴⁴ 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. More information about implementation and enforcement action is included in the *Public Health* section.

Analytic Approach and Key Assumptions

CHBRP focused the analysis on the marginal impact of SB 855, assuming full compliance with existing federal and state mental health parity laws.

CHBRP analyzed legislation with similar language previously: AB 154 in 2011; AB 1600 in 2010; AB 244 in 2009; AB 1887 in 1008; AB 423 in 2007; and SB 572 in 2005.⁴⁵ Where applicable, CHBRP's analysis of SB 855 builds upon these previous analyses.

⁴³ Section 1001 modifying section 2711 of the PHSA.

⁴⁴ Employee Benefit Security Administration, Department of Labor. MHPAEA Enforcement Fact Sheets. Accessed on February 17, 2020. Available at <https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/fact-sheets/mhpaea-enforcement>.

⁴⁵ CHBRP's completed analyses are available at http://chbrp.org/completed_analyses/index.php.

BACKGROUND ON MENTAL HEALTH CONDITIONS AND SUBSTANCE USE DISORDER

SB 855 would require health insurance coverage at parity with medical coverage for the diagnosis and medically necessary treatment of all mental health conditions (including substance use disorder) included in the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Classification of Diseases (ICD). This section provides contextual information for SB 855, including the definitions of DSM and ICD codes, the prevalence of mental health and substance use disorders, as well as facility and workforce supply information. CHBRP uses the most recent data available, with a focus on California data when possible.

DSM-5 and ICD-10-CM

SB 855 requires coverage of treatment, when medically necessary, for *any* mental health and substance use disorder (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).

DSM-5 (fifth edition published in 2013) is a reference tool published by the American Psychiatric Association (APA) that is used by health care providers to diagnose recognized mental disorders, including substance use disorders (SUD). There are approximately 300 diagnoses across 20 categories.

ICD-10-CM is a list of diagnosis codes (with corresponding level of care) used by providers to bill insurance carriers for services rendered. The 10th revision was adopted in 2015 with clinical modification [CM]. The code set lists “mental and behavioral disorders” (F00-F99), and ICD-10 designates more than 700 diagnosis codes total.

The APA notes that DSM-5 and ICD-10 should be “thought of as companion publications. *DSM-5* contains the most up-to-date criteria for diagnosing mental disorders, along with extensive descriptive text, providing a common language for clinicians to communicate about their patients. The ICD contains the code numbers used in *DSM-5* and all of medicine, needed for insurance reimbursement and for monitoring of morbidity and mortality statistics by national and international health agencies.” (APA, 2020).

Defining Mental Health Conditions

The DSM classifies more than 300 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 (see Appendix D for the complete list). Disorders range in severity; however, the rating scales providers use are quite varied within and among the disorders. This report addresses mental health in aggregate to manage the breadth and depth of information across the subject.

Defining Substance Use Disorder

Although the DSM-5 classifies substance use disorders (SUD) as a subcategory of mental disorders, SB 855 specifically identifies SUD as a covered benefit; thus, this report will address SUD in aggregate, but separately from mental disorders where data are available. The DSM-5 defines SUD as “patterns of symptoms that result from the use of one or more of these substances that a person continues to use, despite experiencing problems as a result” (Gray and Argaez, 2019). There are 10 classes of drugs for which SUD is recognized: alcohol, caffeine, cannabis, hallucinogens, inhalants, opioids, sedatives, hypnotics, anxiolytics, stimulants and tobacco, and other or unknown substances. The DSM-5 also describes 11 possible symptoms of substance use disorder. The SUD severity scale includes mild (2 to 3 symptoms); moderate (4 to 5 symptoms); and severe (6+ symptoms). The diagnosed severity ranges across mild (2 to 3 symptoms); moderate (4 to 5 symptoms); and severe (6+ symptoms). Examples of symptoms include taking the substance in larger amounts or for longer than prescribed, spending a lot of time getting, using, or recovering from use of the substance, and development of withdrawal symptoms, which can be relieved by taking more of the substance (see Appendix D for the full list).

Prevalence of Mental Health Disorders and SUD in California

Prevalence of Mental Health Disorders

Mental disorders are common in California. The 2016–2017 National Survey on Drug Use and Health (NSDUH) measures four categories of “past year mental health issues.” Estimated rates of mental illness “during the past year” for California adults were:

- 18.2% (5,419,000) any mental illness^{46,47} in the past year;
- 3.9% (1,174,000) serious mental illness (SMI);⁴⁸
- 4.0% (1,205,000) thoughts of suicide in the last 12 months; and
- 6.5% (1,933,000) at least one major depressive episode in their lifetime.

(Note that these categories are not mutually exclusive [SAMHSA, 2019a,b].)

Prevalence of Substance Use Disorders

Substance use disorder is a significant burden in California. Results from the 2016–2017 NSDUH show that 7.48% (2,459,000) of the population (aged 12 years and older) reported a substance use disorder in

⁴⁶ Any mental illness = a diagnosable mental, behavioral, or emotional disorder in the past year. AMI can vary in impact, ranging from no impairment to mild, moderate, and even severe impairment with at least one functional impairment (e.g., interference with a major life activity) (NIMH, 2019).

⁴⁷ Subcategories are not mutually exclusive.

⁴⁸ 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. (SAMSHA, 2018).

the past year (SAMHSA, 2019a,b). Specifically, 1,811,000 (5.51%) reported an alcohol use disorder, and 975,000 (2.97%) Californians reported an illicit drug use disorder. (Illicit drug use disorder includes misuse of prescription psychotherapeutic drugs and cocaine, heroin, marijuana, inhalants, hallucinogens, and methamphetamine.)

The California Opioid Overdose Surveillance Dashboard reports overdoses related opioids, illicit drugs, and cannabis. Table 4 shows of rates of overdose-related events by opioids and amphetamines (including methamphetamine) (CDPH, 2020).

Table 4. Rates of Drug Overdose in California, 2018

Overdose-Related Events	Rate/100,000 Californians	Number of People
By opioids		
Deaths	5.82	2,428
ED visits	21.44	8,832
Hospitalizations	8.38	3,672
By amphetamines		
Deaths	5.82	2,427
ED visits	4.98	1,954
Hospitalizations	5.55	2,249

Source: California Health Benefits Review Program, 2020. (Based on California Opioid Overdose Surveillance Dashboard [CDPH, 2020].)

These state averages obscure those areas with the highest incidence of addiction. For example, Lake, Plumas, and San Francisco counties experience opioid-related death rates three to five times greater than the state average. Note that the California rate of methamphetamine overdose deaths is almost equal to that of opioid overdose, in contrast with the eastern U.S. where opioids dominate the overdose events.

Co-occurring SMI and SUD are not uncommon, and the interaction between these conditions can exacerbate poor health outcomes. In the U.S., about 7.7 million (3.3%) adults reported co-occurring conditions (Han et al., 2017). Almost 40% of the 20 million adults with SUD reported a mental illness, and almost 20% of the 42 million adults with a mental illness reported a co-occurring SUD (NIDA, 2018a).

Treatment of Mental Health and SUD

Mental Health Disorders and SUD in California: Seeking and Receiving Help

The California Health Interview Survey (CHIS) asked whether survey respondents *needed help for emotional/mental problems or use of alcohol/drugs and whether they sought treatment* during the previous 12 months. In 2018, 24% of employment-based/private insured adults in California (3.4 million) reported needing help for emotional/mental problems or alcohol/drug use problems; of those, 60.6% (2.07 million) reported that they *sought and received help* (CHIS, 2020). Additionally, 23% (419,000) of teens (ages 12-17) with employment-based/private insurance reported needing help for emotional/mental health problems; of those, 14.3% (262,000) received psychological or emotional counseling in the past year (CHIS, 2020).

Mental Health Treatment Settings

Care settings for the treatment of mental health disorders depends 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 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). (See Appendix D for common categories of mental health care settings.)

SUD Treatment Settings

Nationally, 2017 NSDUH results show that of those adults (18 years and older) receiving treatment for SUD, most used an outpatient rehabilitation facility followed by self-help groups (Table 5). Use of facilities are not mutually exclusive and patients frequently move between two or more treatment facilities/locations as their needs change (e.g., stabilize and/or relapse). The most common source of payment for this treatment was private health insurance (47%) followed by Medicaid (41%) and out-of-pocket savings/earnings (41%). Payment sources are not mutually exclusive. Alcohol treatment showed a similar distribution of payment sources. (See section below on Barriers to Treatment for discussion about those who do not receive treatment.)

Table 5. SUD Treatment Settings in the United States, 2017

Location of Treatment for SUD	Percent
Rehabilitation facility (outpatient)	65%
Self help group	56%
Mental health center (outpatient)	45%
Rehabilitation facility (inpatient)	36%
Hospital inpatient	33%
Private doctor's office	26%
Emergency room	20%
Prison/jail	11%

Source: California Health Benefits Review Program, 2020. (Based on SAMHSA, 2017a,b.)
Note: Categories are not mutually exclusive.

Similar to the care setting categories for the treatment of mental disorders, options for the clinical treatment of substance use disorders vary according to the needs of the individual and the intensity of the disorder. The American Society of Addiction Medicine defines a continuum of care across five levels of care for treating alcohol and drug use disorder:

- Level 0.5 (early intervention services);
- Level I (outpatient services);
- Level II (intensive outpatient services, including detoxification services);
- Level III (residential and in-patient services); and
- Level IV (medically-managed, intensive in-patient services).

Residential treatment, which typically lasts 28 days to 60 days, but may last up to a year, provides intensive support to help people with substance use disorders attain stability in their recovery before “stepping down” to outpatient settings and returning to an unsupervised environment, which may otherwise be detrimental to their recovery process (ASAM, 2015).

Barriers to Treatment

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 (Han et al., 2017; Kumar and Luo, 2019). Other reasons include family/employer/neighbor stigma, fear, shame, hopelessness, and transportation or childcare challenges (Han et al., 2017).

Mental health care workforce supply in California

Parity in coverage does not guarantee access to care for MH/SUD. Access is also affected by the supply of providers. Among people with MH/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, which were disproportionately distributed across the state (measured by per capita ratios). In particular, the San Joaquin Valley and Inland Empire 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. The percentage of nonphysician MH/SUD professionals accepting insurance is unknown; however, an earlier 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).

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 the Governor Newsom’s Behavioral Health Task Force and monies earmarked for mental health workforce pipeline development (Coffman et al., 2019).

Finally, a Kaiser Family Foundation representative poll of 1,404 California adults found that 57% 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 MH treatment (66%) or SUD treatment (61%) (Hamel et al., 2019).

SUD Treatment Workforce Supply in California

A variety of professionals provide SUD treatment. Psychiatrists or other physicians may obtain an addiction specialty certification; in California, 678 physicians maintain an addiction specialty certification. Some SUD treatment providers employ LCSWs or similarly licensed clinicians. Other SUD professionals, such as people trained specifically as substance use counselors and peer providers, are not licensed in California and are not billable to most insurance companies. However, California provides oversight of programs by requiring licensure of SUD treatment programs, which includes the aforementioned certified counseling staff. Holt (2018) reported that, in 2015, 1,671 people graduated from training in substance abuse/ addiction counseling programs in California.

Physicians, physician assistants, and nurse practitioners may also obtain a waiver to prescribe buprenorphine, one of several prescription drugs used in medication-assisted treatment. In 2018, there were 5,821 physicians waived to prescribe buprenorphine in California (CHCF, 2018). Several studies suggest that only 44% to 66% of certified buprenorphine providers actually prescribe the medication for opioid use disorder, and most do not choose to reach their maximum-allowed patient caseload (Hutchinson et al., 2014; Jones et al., 2015; Walley et al., 2008). This leads to wait lists in some areas,

which have been shown to decrease uptake of opioid use disorder medications by people with opioid use disorders (Fisher et al., 2017). An analysis by Clemans-Cope et al. (2018) estimated that an additional 3,500 to 4,100 providers would need to be trained and certified to treat the opioid use disorder population in California.

Disparities⁴⁹ and Social Determinants of Health⁵⁰ in MH/SUD

Disparities are differences between groups that are modifiable, and there are significant disparities in the prevalence of MH/SUD and use of treatment services by race, gender, age, income, and geographic region. Examples include significantly higher rates of serious mental illness 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, 2018b). 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 +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 about twice as high in Northern California (21%) as compared with the rest of the state (10%) (Holt, 2019).

Nationally, illicit drug use is highest among those aged 18 to 30 years, although illicit drug use is increasing among those aged 50 to 64 years; 4.3% of adults aged 50 to 64 years reported illicit drug use in 2008 compared with 7.9% in 2013 (NIDA, 2015). Binge drinking is more common among men than women (30% and 16%, respectively).

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 MH 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 report inadequate provider supply as compared with 47% of men (Hamel et al., 2019).

Societal Impact of MH/SUD in California

The presence of MH/SUD in California creates a societal economic impact that can be measured through indirect (lost wages, etc.), and direct costs (medical care, etc.). Please note, the societal impact discussed here is relevant to a broader population than SB 855 impacts (see *Policy Context*).

MH/SUD 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 (Razzouka et al., 2017). 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). MH/SUD 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).

⁴⁹ 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).

⁵⁰ 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.

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 studies show that direct and indirect costs (i.e., medical care, crime, lost work productivity, etc.) were \$249 billion for alcohol abuse (2010); \$193 billion for illicit drugs (2007); and \$78.5 billion for prescription opioid misuse (2013) (NIDA, 2020).

MEDICAL EFFECTIVENESS

As discussed in the *Policy Context* section, SB 855 would amend 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. Additional information on MH/SUD is included in the *Background* section. The medical effectiveness section of this report summarizes findings from evidence⁵¹ on the effectiveness of treatments for MH/SUD and the impact of MH/SUD parity policies.

Guidelines for Treatment of MH/SUD

CHBRP only reviewed guidelines for treatment of MH/SUD and did not review journal articles about the effectiveness of the numerous treatment options for the more than 300 diagnoses to which SB 855 applies because that was not feasible during the 60-day time frame allotted for this analysis. Guidelines published by a variety of organizations recommend psychotherapy and/or pharmacotherapy for multiple types of MH/SUD disorders as described below.

Table 6. Mental Health Treatment Guidelines

Condition	Psychotherapy Recommended	Pharmacotherapy Recommended	References
Anxiety	X	X (a)	AACAP, 2007a; AHRQ, 2017; NICE, 2011b
Attention deficit hyperactivity disorder	X	X (b)	AAP, 2019; NICE, 2019a
Autism spectrum disorder	X	X (c)	AAP, 2020; NICE, 2016a
Bipolar disorder	X	X (b)	AHRQ, 2018; NICE, 2020
Depression in children	X	X (a)	AACAP, 2007b; AAP, 2018; APA, 2019b; NICE, 2019b; SIGN, 2010
Depression in nonelderly adults	X	X (b)	AACAP, 2007b; AAP, 2018; APA, 2019b; NICE, 2019; SIGN, 2010
Depression in older adults	X	X (d)	AACAP, 2007b; AAP, 2018; APA, 2019b; NICE, 2009, 2019; SIGN, 2010
Eating disorders	X	X (d)	AAP, 2010; NICE, 2017
Psychosis/schizophrenia	X	X (d)	APA, 2019; NICE, 2016b

Source: California Health Benefits Review Program, 2020.

⁵¹ 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.

Notes: (a) Pharmacotherapy is recommended for treating this condition if receipt of psychotherapy does not improve symptoms. Pharmacotherapy may be provided alone or in combination with psychotherapy.

(b) Pharmacotherapy is recommended for treating this condition alone or in combination with psychotherapy.

(c) Pharmacotherapy is recommended as part of a comprehensive approach to treating autism spectrum disorder when used to manage coexisting mental or behavioral health disorders (e.g., ADHD, mood disorders, or anxiety disorders) and associated problem behaviors or symptoms causing significant impairment and distress (e.g., aggression, self-injurious behavior, sleep disturbance, and hyperactivity)

(d) Pharmacotherapy is recommended for treating this condition in combination with psychotherapy.

Key: AACAP = American Academy of Child and Adolescent Psychiatry; AAP = American Academy of Pediatrics; AHRQ = Agency for Healthcare Research and Quality; APA = American Psychiatric Association; ASAM = American Society of Addiction Medicine; NICE = National Institute for Health and Clinical Excellence; NIDA = National Institute on Drug Abuse; SIGN = Scottish Intercollegiate Guideline Network.

Table 7. Substance Use Disorder Treatment Guidelines

Condition	Psychotherapy Recommended	Pharmacotherapy Recommended	References
Alcohol misuse/alcohol use disorder	X	X (a) (b)	AHRQ, 2014; APA, 2018; NICE, 2011a
Marijuana dependence	X		AACAP, 2005; NICE, 2007b; NIDA, 2018b
Opioid dependence	X	X (b)	ASAM, 2015; NICE, 2007a
Stimulants (cocaine, methamphetamine, etc.)	X		NIDA, 2018b
Tobacco/nicotine dependence	X	X (b)	AACAP, 2005; NICE, 2007b, 2018b; NIDA, 2018b

Source: California Health Benefits Review Program, 2020.

Notes: (a) Pharmacotherapy is recommended for treating this condition if receipt of psychotherapy does not improve symptoms. Pharmacotherapy may be provided alone or in combination with psychotherapy.

(b) Pharmacotherapy is recommended for treating this condition in combination with psychotherapy.

Key: AACAP = American Academy of Child and Adolescent Psychiatry; AHRQ = Agency for Healthcare Research and Quality; APA = American Psychiatric Association; ASAM = American Society of Addiction Medicine; NICE = National Institute for Health and Clinical Excellence; NIDA = National Institute on Drug Abuse.

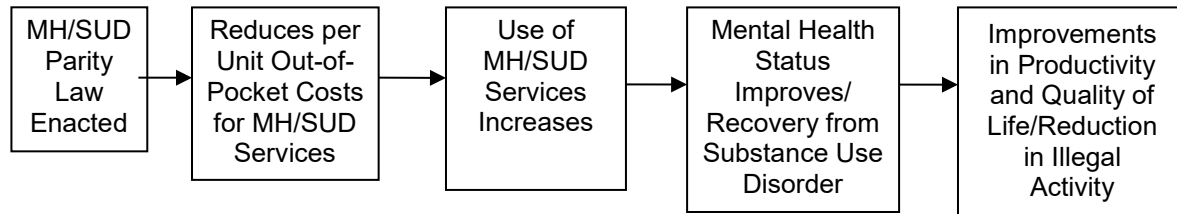
Research Approach and Methods

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. This approach is consistent with the approach CHBRP took in its analyses of previous bills on MH/SUD parity.

The potential of MH/SUD parity legislation to improve consumers’ mental health status and recovery from substance use disorders depends on a hypothetical chain of events, as illustrated in Figure 2. MH/SUD parity laws are expected to reduce consumers’ out-of-pocket expenditures for each unit of MH/SUD services they use (e.g., outpatient visits, inpatient admissions), which could lead to greater use of MH/SUD services. If consumers obtain more MH/SUD services, and if those services are appropriate and effective, parity could lead to improvements in mental health status and increase the number of persons

who recover from substance use disorders. Improvement in mental health and recovery from substance use disorders may lead to improvements in productivity and quality of life and reduction in illegal activity.⁵² Thus, MH/SUD parity laws do not directly affect MH/SUD outcomes. These laws affect outcomes if and only if they lead to a decrease in per unit out-of-pocket costs for MH/SUD services and an increase in use of MH/SUD services.

Figure 2. Hypothesized Linkages between MH/SUD Parity and Improvement in Mental Health Status or Recovery from Substance Use Disorder



Studies of MH/SUD parity policies were identified through searches of PubMed, the Cochrane Library, Web of Science, EconLit, 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 American Academy of Child and Adolescent Psychiatry (AACAP), American Academy of Pediatrics (AAP), American Psychiatric Association (APA), American Psychological Association (APA), American Society of Addiction Medicine (ASAM), the National Health Service (NHS) Centre for Reviews and Dissemination, the National Institute on Drug Abuse (NIDA), the National Institute for Health and Clinical Excellence (NICE), and the Scottish Intercollegiate Guideline Network (SIGN).

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

The search was limited to studies published from 2011 to present because CHBRP had previously conducted thorough literature searches on these topics in 2011 for AB 154.

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.⁵³ 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. Does parity in coverage for MH/SUD services affect consumers' out-of-pocket costs for MH/SUD services?

⁵² Rates of illegal activity vary widely across persons with different MH/SUD disorders. Much of the literature on illegal activity among persons with MH/SUD disorders has examined persons with severe mental illnesses or persons with substance use disorders (Lamb and Weinberger, 1998; ONDCP, 2000).

⁵³ 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.

2. Does parity in coverage for MH/SUD services affect consumers' use of MH/SUD services?
3. Does parity in coverage for MH/SUD services increase the likelihood that people will receive recommended care for MH/SUD?
4. Does parity in coverage for MH/SUD services affect health outcomes for people with MH/SUD?

Methodological Considerations

The impact of parity policies depends upon the comparison being made. Most studies have assessed the impact of implementing MH/SUD parity policies among people who previously did not have parity in coverage for medical and MH/SUD conditions. Findings from these studies may not generalize to SB 855 because health plans in California are already required to comply with the state's existing MH/SUD parity law and with the MHPAEA and the ACA. The impact of SB 855 is likely to be less than these previous parity laws because it augments existing requirements, whereas the previous laws established initial requirements for parity.

An additional limitation of the literature on MH/SUD parity is that CHBRP did not identify any randomized controlled trials (RCTs) of the implementation of parity. The lack of RCTs is understandable because parity policies have not been implemented in a randomized manner. Observational studies cannot control for factors other than parity laws that change over time and may affect the outcomes of interest as effectively as RCTs. Although many of the studies included in the review used rigorous methods to control for these factors, it is possible that some of the findings included in the review were due to factors other than MH/SUD parity laws.

Outcomes Assessed

CHBRP assessed the impact of MH/SUD parity policies on out-of-pocket costs for MH/SUD services, use of MH/SUD services, receipt of recommended processes of care for MH/SUD, and the health status of people with MH/SUD.

Study Findings

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.

Findings Regarding the Impact of MH/SUD Parity on Consumers' Out-of-Pocket Costs

Eighteen articles have summarized findings from 12 studies regarding the impact of parity in coverage for MH/SUD services on out-of-pocket expenditures per user. One study (five articles) examined the effects of parity in coverage for MH/SUD services among people who obtain health insurance through the Federal Employee Health Benefits (FEHB) program. Two studies assessed the effects of state MH/SUD parity laws. Nine studies (11 articles) have investigated the impact of the MHPAEA.

The studies summarized in Table 8 examine total out-of-pocket costs, which combine the impact of parity on per-unit out-of-pocket costs with the impact of parity on quantity of services used. The findings of these studies are difficult to interpret because changes in out-of-pocket costs per user could occur for several reasons. For instance, if total out-of-pocket costs fall, it is unclear whether they are lower because per-unit out-of-pocket costs fall or utilization falls. Alternatively, if out-of-pocket costs increase, it is possible that per-unit out-of-pocket costs fell, but were offset by increases in the quantity of MH/SUD services used.

Table 8. Summary of Evidence of the Impact of MH/SUD Parity Policies on Out-of-Pocket Costs

Article	MH/SUD Parity Policy	Intervention Group	Comparison Group	Measure	Finding*
Goldman et al., 2006	FEHB	Federal employees and adult dependents enrolled in preferred provider	Adults enrolled in PPOs that did not provide MH/SUD parity	Annual out-of-pocket costs per user for MH services	Decrease

		organizations (PPOs)			
Azrin et al., 2007	FEHB	Children of federal employees enrolled in PPOs	Children enrolled in PPOs that did not provide MH/SUD parity	Annual out-of-pocket costs per user for MH services	No statistically significant difference
Azzone et al., 2011	FEHB	Federal employees and adult dependents enrolled in PPOs	Adults enrolled in PPOs that did not provide MH/SUD parity	Annual out-of-pocket costs per user for SUD services	Decrease
Barry et al., 2013	FEHB	Children of federal employees enrolled in PPOs	Children enrolled in PPOs that did not provide MH/SUD parity	Annual out-of-pocket costs per child with total MH/SUD expenditures $\geq 90\%$	Decrease
Busch et al., 2013	FEHB	Federal employees and dependents with bipolar, depression, or adjustment disorder enrolled in PPOs	People enrolled in PPOs that did not provide MH/SUD parity	Annual out-of-pocket costs per user for MH/SUD services	Decrease
Barry and Busch, 2007	State parity laws	Children in states that had parity laws	Children in states that did not have parity laws	Annual out-of-pocket expenditures for MH services > \$1,000 per year	Less likely
McConnell et al., 2012	Oregon state parity law	People enrolled in health plans subject to Oregon's parity law	People enrolled in health plans exempt from Oregon's parity law	Out-of-pocket costs per year for SUD services	No statistically significant difference
Busch et al., 2014	MHPAEA	People in self-insured plans in states that	People in fully-insured plans in states that	Annual out-of-pocket costs per user for	No statistically significant

		enacted SUD parity laws	enacted SUD parity laws	SUD services	difference
Ettner et al., 2016	MHPAEA	People in self-insured plans that carved out behavioral health services and were subject to MHPAEA	People in fully insured plans in states with strong pre-existing parity laws	Monthly out-of-pocket costs per user for MH/SUD services	Decrease
Grazier et al., 2016	MHPAEA	Enrollees and dependents enrolled in a large self-insured regional employer plan	None	Annual out-of-pocket costs per user for MH/SUD services	For MH services, Increase for both enrollees and dependents For SUD services, increase for enrollees and decrease for dependents
Friedman et al., 2017	MHPAEA	People in self-insured plans that were subject to MHPAEA	None – interrupted time series design	Monthly out-of-pocket costs per user for SUD services	Increase
Harwood et al., 2017	MHPAEA	People in self-insured plans that carved in behavioral health services and were subject to MHPAEA	None – interrupted time series design	Monthly out-of-pocket costs per user for MH/SUD services	No statistically significant difference
Stuart et al., 2017	MHPAEA	Children with autism who are dependents of employees of 100 large employers and health plans in the U.S. (mostly self-insured)	None – interrupted time series	Monthly out-of-pocket costs per user for MH services	No statistically significant difference

Walter et al., 2017	MHPAEA	Children enrolled in various types of private health plans	None	Average out-of-pocket costs per visit for MH services	Decrease for clinicians who can prescribe medications
Huskamp et al., 2018	MHPAEA	Non-elderly adults and adolescents with eating disorders enrolled in a self-insured regional employer plan	None – interrupted time series design	Annual out-of-pocket costs per user for MH services	No statistically significant difference
Drake et al., 2019	MHPAEA	Adults enrolled in insurance plans sponsored by employers with ≥50 employees (subject to MHPAEA)	Adults enrolled in insurance plans sponsored by employers with <50 employees (not subject to MHPAEA)	Annual out-of-pocket costs per user for MH services	No statistically significant difference
Haffajee et al., 2019	MHPAEA	Adults enrolled in insurance plans sponsored by employers with ≥50 employees (subject to MHPAEA)	Adults enrolled in insurance plans sponsored by employers with <50 employees (not subject to MHPAEA)	Mean out-of-pocket cost per visit for MH services	Decrease
Mulvaney-Day et al., 2019	MHPAEA	Enrollees of insurance plans sponsored by large employers	None – interrupted time series	Monthly out-of-pocket costs per user for MH/SUD services	No statistically significant difference

Source: California Health Benefits Review Program, 2020.

Note: *Findings are statistically significant unless otherwise indicated.

Key: FEHB = Federal Employee Health Benefits; MH = mental health; MHPAEA = Mental Health Parity and Addiction Equity Act Program; SUD = substance use disorder.

Summary of findings regarding MH/SUD parity’s impact on out-of-pocket costs: There is inconclusive evidence, based on 12 studies (18 articles), regarding the impact of MH/SUD parity on consumers’ out-of-pocket costs. Three studies found evidence of lower out-of-pocket costs, one study found evidence of higher out-of-pocket costs, and 6 studies did not find any significant effects on out-of-pocket costs. Two studies from which multiple articles were published reported different findings depending on the population studied and the benefit designs of the health plans studied. More specifically, some studies examined effects on out-of-pocket costs per visit or per service, whereas others assessed effects on total consumer spending. All of these studies compared people enrolled in health plans subject to parity policies to people enrolled in health plans not subject to parity policies. Findings may not be generalizable to SB 855 because health plans in California are already required to comply with state and federal parity laws.

Figure 3. Impact of MH/SUD Parity on Consumers’ Out-of-Pocket Costs



Findings Regarding the Impact of MH/SUD Parity on Use of MH/SUD Services

Studies of the impact of MH/SUD parity policies on use of MH/SUD services have measured the use of services in several different ways. Some studies assess the impact of parity policies on the probability that enrollees will use MH/SUD services. Other studies examine impact on the number of enrollees who use MH/SUD services or the volume of MH/SUD services provided to people who use these services. Tables 9 and 10 summarize the findings on probability of using MH/SUD services and amount of MH/SUD services used, respectively.

Probability of using MH/SUD services

Twelve studies (18 articles) assessed the impact of MH/SUD parity on the probability of using MH/SUD services. These studies include the evaluation of parity in the FEHB (four articles), five studies of state MH/SUD parity laws (six articles), and six studies (eight articles) of the MHPAEA.

Table 9. Summary of Evidence of the Impact of MH/SUD Parity Policies on Probability of Using MH/SUD Services

Article	MH/SUD Parity Policy	Intervention Group	Comparison Group	Measure	Finding*
Goldman et al., 2006	FEHB	Federal employees and adult dependents enrolled in PPOs	Adults enrolled in PPOs that did not provide MH/SUD parity	Probability of using MH services	No statistically significant difference
Azrin et al.,	FEHB	Children of federal	Children enrolled in	Probability of using MH	No statistically

2007		employees enrolled in PPOs	PPOs that did not provide MH/SUD parity	services	significant difference
Azzone et al., 2011	FEHB	Federal employees and adult dependents enrolled in PPOs	Adults enrolled in PPO that did not provide MH/SUD parity	Probability of using SUD services	No statistically significant difference
Neelon et al., 2011	FEHB	Federal employees and adult dependents enrolled in PPOs	Adults enrolled in PPOs that did not provide MH/SUD parity	Probability of using MH services	Increase among “moderate” spenders
Bao and Sturm, 2004	State parity laws	Adults in states that had parity laws	Adults in states that did not have parity laws	Probability of having any MH specialty visits	No statistically significant difference
Harris et al., 2006	State parity laws	Privately insured adults in states that had parity laws	Privately insured adults in states that did not have parity laws	Probability of using MH services	Increase among people with mild to moderate mental distress
Barry and Busch, 2008	State parity laws	Privately insured children in states that had parity laws	Privately insured children in states that did not have parity laws	Probability of having any outpatient MH visits	No statistically significant difference
Busch and Barry, 2008	State parity laws	Adults with employer-sponsored insurance in states that had parity laws	Adults with employer-sponsored insurance in states that did not have parity laws	Probability of using MH services	Increase among people covered by employers with 50 to 100 employees
McConnell et al., 2012	Oregon state parity law	Oregonians enrolled in health plans subject to Oregon’s parity law	Oregonians and Washingtonians enrolled in health plans exempt from Oregon’s parity law	Probability of using SUD services	Decrease
Wen et al., 2013	State parity laws	People in states that enacted or extended	People in states that did not enact or extend MH/SUD parity	Probability of using SUD treatment	Increase in the state-level SUD treatment rate

		MH/SUD parity laws			
Busch et al., 2014	MHPAEA	People in self-insured plans in states that enacted SUD parity laws	People in fully-insured plans in states that enacted SUD parity laws	Probability of using SUD treatment	No statistically significant difference
Ettner et al., 2016	MHPAEA	People in self-insured plans that carved out behavioral health services and were subject to MHPAEA	People in fully insured plans in states with strong pre-existing parity laws	Probability of using MH/SUD services	Decrease
Grazier et al., 2016	MHPAEA	Enrollees and dependents enrolled in a large self-insured regional employer plan	None	Probability of MH/SUD visits	For MH visits, increase among both enrollees and dependents For SUD visits, increase among enrollees and decrease among dependents
Friedman et al., 2017	MHPAEA	People in self-insured plans that were subject to MHPAEA	None – interrupted time series design	Probability that people would use SUD services	Increase
Harwood et al., 2017	MHPAEA	People in self-insured plans that carved in behavioral health services and were subject to MHPAEA	None – interrupted time series design	Probability of using MH/SUD services	Small increase for assessment/evaluation and individual psychotherapy visits Decrease for structured outpatient visits No statistically significant differences for other outpatient services or intermediate care services or for inpatient services
Stuart et al., 2017	MHPAEA	Children with autism who are dependents of employees of 100 large employers and health plans in	None – interrupted time series	Probability that children with autism spectrum disorder (ASD) would use outpatient	No immediate change, but rate of change in the probability of use of MH services increased over time

		the U.S. (mostly self-insured)		MH services	
Drake et al., 2019	MHPAEA	Adults in insurance plans sponsored by employers with ≥50 employees	Adults enrolled in insurance plans sponsored by employers with <50 employees	Probability of using MH services	No statistically significant difference
Mulvaney-Day et al., 2019	MHPAEA	Enrollees insurance plans sponsored by large employers	None – interrupted time series	Probability of using MH/SUD outpatient services	No statistically significant difference for MH services Small increase in use of SUD services

Source: California Health Benefits Review Program, 2020.

Note: *Findings are statistically significant unless otherwise indicated.

Key: FEHB = Federal Employee Health Benefits; MH = mental health; MHPAEA = Mental Health Parity and Addiction Equity Act Program; PPO = preferred provider organization; SUD = substance use disorder.

Summary of findings regarding effects of MH/SUD parity policies on probability of use: There is inconclusive evidence based on 12 studies (18 articles) regarding the impact of MH/SUD parity policies on the probability that people will use MH/SUD services. The evidence is inconclusive for studies that assessed all people affected by parity policies, as well as for studies of people with MH/SUD conditions. Among studies that indicated significant impact, there was variation in terms of the direction of impact. Four studies found increases, one study found a decrease, and three studies found no statistically significant difference in the probability of using MH/SUD services. The evaluation of the FEHB found that parity only affected the probability of use among people with moderate amounts of spending on MH/SUD services before parity was implemented. One study of state parity laws found that findings differed for children and adults. One study of the MHPAEA from which three articles have been published also reported mixed results as did another study of the MHPAEA. All of these studies compared people enrolled in health plans subject to parity policies to people enrolled in health plans not subject to parity policies. Findings may not be generalizable to SB 855 because health plans in California are already required to comply with state and federal parity laws.

Figure 4. Impact of MH/SUD Parity Policies on Probability of Use



Amount of MH/SUD services used

Twelve studies (14 articles) assessed the impact of MH/SUD parity on the amount MH/SUD services used. These studies include the evaluation of parity in the FEHB (one article), four studies of state MH/SUD parity laws (four articles), and seven studies (nine articles) of the MHPAEA. The studies measured the effects of MH/SUD parity in several different ways. Some studies examined all MH/SUD visits regardless of whether the enrollee visited a mental health provider or a primary care provider,

whereas others limited their analyses to visits for MH specialty care. Two studies investigated effects of parity on numbers of admissions for SUD treatment.

Table 10. Summary of Evidence of the Impact of MH/SUD Parity Policies on Amount of MH/SUD Services Used

Article	MH/SUD Parity Policy	Intervention Group	Comparison Group	Measure	Finding*
Busch et al., 2013	FEHB	Federal employees and dependents with bipolar, depression, or adjustment disorder enrolled in PPOs	People enrolled in PPOs that did not provide MH/SUD parity	Use of MH/SUD treatment	No statistically significant difference in total annual utilization across all diagnoses Decrease in annual psychotherapy visits among individuals with adjustment disorder
Pacula and Sturm, 2000	State parity laws	Adults in states that had parity laws	Adults in states that did not have parity laws	# of MH specialty care visits	No statistically significant difference
Bao and Sturm, 2004	State parity laws	Adults in states that had parity laws	Adults in states that did not have parity laws	# of MH specialty care visits	No statistically significant difference
Dave and Mukerjee, 2011	State parity laws	Adults in states that had parity laws	Adults in states that did not have parity laws	# of admissions for SUD treatment	Increase
Mulia et al., 2019	State parity laws	People in states with parity mandates for alcohol treatment	People in states with “weak” or non-existent parity laws	# of alcohol treatment admissions	Significant increase among people in states with mandated health plan coverage of alcohol treatment and partial parity prior to MHPAEA
Ettner et al., 2016	MHPAEA	People in self-insured plans that carved out behavioral health services and were subject to MHPAEA	People in fully insured plans in states with strong pre-existing parity laws	Mean #s of MH/SUD visits	No statistically significant difference
Grazier et al., 2016	MHPAEA	Enrollees and dependents enrolled in a	None	# of MH/SUD encounters per	Large increase among enrollees and

		large self-insured regional employer plan		person	dependents
Harwood et al., 2017	MHPAEA	People in self-insured plans that carved in behavioral health services and were subject to MHPAEA	None – interrupted time series design	Use of specific types of outpatient and inpatient MH/SUD services	Small increases in mean days of inpatient care and assessment/diagnostic evaluation visits and individual and family psychotherapy visits. Decrease in mean days of intermediate care
Stuart et al., 2017	MHPAEA	Children with autism who are dependents of employees of 100 large employers and health plans in the U.S. (mostly self-insured)	None – interrupted time series	# of MH outpatient visits per month	Increase
Walter et al., 2017	MHPAEA	Children enrolled various types of private health plans	None	Average annual # of MH visits	Increase for both clinicians who can prescribe medications and clinicians who cannot prescribe medications.
Huskamp et al., 2018	MHPAEA	Non-elderly adults and adolescents with eating disorders enrolled in a self-insured regional employer plan	None – interrupted time series design	# of outpatient MH services	Increase
Drake et al., 2019	MHPAEA	Adults enrolled in insurance plans sponsored by employers with ≥50 employees	Adults enrolled in insurance plans sponsored by employers with <50 employees	# of MH visits	No statistically significant difference
Haffajee et al., 2019	MHPAEA	Adults enrolled in insurance plans sponsored by	Adults enrolled in insurance plans sponsored by employers	# of MH visits	Increase

		employers with ≥50 employees (subject to MHPAEA)	with <50 employees (not subject to MHPAEA)		
Mulvaney- Day et al., 2019	MHPAEA	Enrollees insurance plans sponsored by large employers	None – interrupted time series	# of MH/SUD encounters per person	Increase in average frequency of services for MH and SUD services

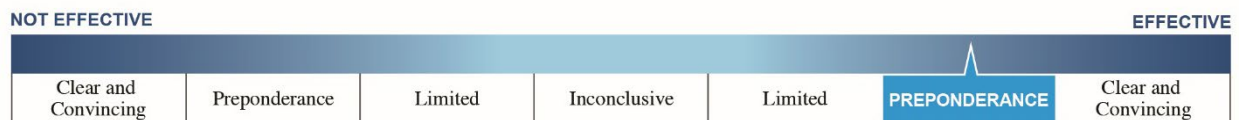
Source: California Health Benefits Review Program, 2020.

Note: *Findings are statistically significant unless otherwise indicated.

Key: FEHB = Federal Employee Health Benefits; MH = mental health; MHPAEA = Mental Health Parity and Addiction Equity Act Program; PPO = preferred provider organization; SUD = substance use disorder.

Summary of findings regarding effects of MH/SUD parity policies on amount of MH/SUD services used: There is a preponderance of evidence based on 12 studies that MH/SUD parity policies significantly increase the number of MH/SUD related visits or admissions, among people with or without MH/SUD conditions. Among studies that indicated significant impact, eight studies found that there was an increase in number of MH/SUD outpatient visits or inpatient admissions. Three studies found no statistically significant difference. The evaluation of the FEHB found that findings differed by type of MH condition. One study of MHPAEA from which two articles have been published regarding effects on the amount of MH/SUD services used concluded that findings differed by type of service and by health plan benefit design. All of these studies compared people enrolled in health plans subject to parity policies to people enrolled in health plans not subject to parity policies. Findings may not be generalizable to SB 855 because health plans in California are already required to comply with state and federal parity laws.

Figure 5. Impact of MH/SUD Parity Policies on Amount of MH/SUD Services Used



Findings Regarding the Impact of MH/SUD Parity on Receipt of Care Recommended by Guidelines

The studies summarized in Table 11 assess whether MH/SUD parity policies increase the likelihood that persons will receive treatment for MH/SUD recommended by clinical guidelines. Two articles presented findings from the evaluation of the implementation of MH/SUD parity in the FEHB. One article assessed effects on receipt of recommended care for an acute episode of major depressive disorder and one examined effects on engagement in SUD treatment. One study investigated the impact of Oregon’s state parity law on receipt of follow-up care within 30 days of inpatient MH treatment. One study presented findings regarding the impact of MHPAEA on engagement in SUD treatment.

Table 11. Summary of Evidence of the Impact of MH/SUD Parity Policies on Receipt of Care Recommended by Guidelines

Article	MH/SUD Parity Policy	Intervention Group	Comparison Group	Measure	Finding*
Busch et al., 2006	FEHB	Federal employees and adult dependents enrolled in PPOs	People enrolled in PPOs that did not provide MH/SUD parity	Receipt of follow-up care for an acute episode of major depressive disorder	Increase
Azzone et al., 2011	FEHB	Federal employees and adult dependents enrolled in PPOs	People enrolled in PPOs that did not provide MH/SUD parity	Engagement in SUD treatment	No statistically significant difference
Wallace and McConnell, 2013	Oregon state parity law	People enrolled in health plans subject to Oregon’s parity law	People enrolled in health plans exempt from Oregon’s parity law	Receipt of follow-up care within 30 days of a psychiatric inpatient stay	Increase
Busch et al., 2014	MHPAEA	People in self-insured plans in states that enacted SUD parity laws	People in fully-insured plans in states that enacted SUD parity laws	Engagement in SUD treatment	No statistically significant increase

Source: California Health Benefits Review Program, 2020.

Note: *Findings are statistically significant unless otherwise indicated.

Key: FEHB = Federal Employee Health Benefits; MH = mental health; MHPAEA = Mental Health Parity and Addiction Equity Act Program; PPO = preferred provider organization; SUD = substance use disorder.

Summary of findings regarding the impact of MH/SUD parity on receipt of recommended care:
 There is inconclusive evidence, based on four studies, that MH/SUD parity is effective in increasing the receipt of recommended care. Two studies found evidence of increased likelihood of receipt of recommended care. One of these studies did not include a comparison group which makes it difficult to determine whether observed change in receipt of recommended care was due to MH/SUD parity. Two studies found no statistically significant difference between people who had parity in coverage for MH/SUD services and people who did not have parity in coverage.

Figure 6. Impact of MH/SUD Parity on Receipt of Recommended Care



Findings Regarding the Impact of MH/SUD Parity on Health Outcomes

The studies summarized in Table 12 assess whether MH/SUD parity policies impact MH/SUD health outcomes. Both studies assessed the effects of state parity laws on a single MH/SUD outcome: suicide rates.

Table 12. Summary of Evidence of the Impact of MH/SUD Parity Policies on MH/SUD Outcomes

Article	MH/SUD Parity Policy	Intervention Group	Comparison Group	Measure	Finding*
Klick and Markowitz, 2006	State parity laws	Nonelderly adults in states that enacted MH/SUD parity laws	Nonelderly adults in states that did not enact MH/SUD parity laws	Suicide rate	No statistically significant difference
Lang, 2013	State parity laws	Adults in states that enacted MH/SUD parity laws	Adults in states that did not enact MH/SUD parity laws	Suicide rate	Decrease

Source: California Health Benefits Review Program, 2020.

Note: *Findings are statistically significant unless otherwise indicated.

Key: MH = mental health; SUD = substance use disorder.

Summary of findings regarding the impact of MH/SUD parity on health outcomes: There is insufficient evidence to conclude whether parity improves MH/SUD health outcomes. Only two studies examining parity’s impact on suicide rates were reviewed and they reached opposite conclusions about the impact of MH/SUD parity laws. No studies examining parity’s impact on other MH outcomes were identified. No studies on the impact of parity on recovery from substance use disorders were identified. Insufficient evidence is not evidence of no effect on health outcomes.

Figure 7. Impact of MH/SUD Parity on Health Outcomes

NOT EFFECTIVE		INSUFFICIENT EVIDENCE				EFFECTIVE	
Clear and Convincing	Preponderance	Limited	Inconclusive	Limited	Preponderance	Clear and Convincing	

Summary of Findings

The Medical Effectiveness review reached the following conclusions regarding the effects of MH/SUD parity policies.

- There is inconclusive evidence 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 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 to conclude whether parity improves MH/SUD health outcomes.

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. All of these studies 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 it expands upon parity laws that are already in effect.

BENEFIT COVERAGE, UTILIZATION, AND COST IMPACTS

As discussed in the *Policy Context* section, SB 855 would require commercial DMHC-regulated health plans and CDI-regulated policies to expand the mental health and substance use disorders (MH/SUD) currently covered under California's mental health parity law to include all MH/SUD conditions included in the most recent ICD or the DSM, define medical necessity, and place additional requirements on plans and policies related to training and disseminating information about the use of clinical guidelines to make coverage decisions.

This section reports the potential incremental impacts of SB 855 on estimated baseline benefit coverage, utilization, and overall cost. This analysis makes the following assumptions:

- 1) Due to existing federal mental health parity law, the Affordable Care Act (ACA) and the intersection with current state mental health parity requirements for SMI and SED, all health plans that currently provide MH/SUD coverage already cover services for the non-SMI and SUD services targeted by SB 855 at parity with other medical services. Covered MH/SUD conditions will not change in those plans who are already offering the full range of MH/SUD benefits (see Table 3).
- 2) Plans vary in the way they apply clinical guidelines or the clinical guidelines they use to make coverage decisions or medical necessity decisions. The guidelines used to determine whether a service is medically necessary could differ from the currently used guideline, but actual changes in use of services will be marginal due to utilization management and limited differences between existing guidelines and the required guidelines listed in SB 855.
- 3) Codifying requirements around MH/SUD parity via SB 855 will continue to result in some services being provided out-of-network in both PPO and HMO plans due to constraints on the supply of MH/SUD services. Existing state provider network requirements from DMHC and CDI will continue to be used in determining whether an out-of-network service should be paid for by the plan at in-network rates.
- 4) Administrative costs for Education and Monitoring will be driven by the dissemination of guideline training and information by plans to their staff and contracted providers. Plans are likely to meet this requirement through remote dissemination methods, such as e-mail communications and webinar-based training. CHBRP assumed that training needs could be met via a three hour webinars per year and e-mail information dissemination to key staff, leadership, and providers.

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

Baseline and Postmandate Benefit Coverage

Current coverage of MH/SUD services was determined by a survey of the largest (by enrollment) providers of health insurance in California. Responses to this survey represent 87% of enrollees with private market health insurance that can be subject to state mandates.

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 or intermediate 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 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 segment.

SB 855 also specifies medical necessity requirements for MH/SUD services. 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, SUD, SMI, or SED diagnoses in responding to the carrier survey.

Almost all — over 94% — enrollees in commercial or CalPERS plans and policies regulated by DMHC or CDI have a pharmacy benefit regulated by DMHC or CDI that covers both generic and brand name outpatient prescription medications.⁵⁴ Because SB 855 does not require creation of a pharmacy benefit — only compliant benefit coverage when a pharmacy benefit is present — baseline benefit coverage for enrollees without a pharmacy benefit or whose pharmacy benefit is not regulated by DMHC or CDI is considered compliant. In this case, for the 6% of enrollees who do not have an outpatient prescription drug benefit, implementation of SB 855 would not change their coverage for outpatient prescription drugs.

Based on the SB 855 survey of health insurers and content expert information, CHBRP concluded that existing compliance with federal mental health parity law and the ACA, informal changes in industry practice around MH/SUD, and California's existing mental health parity law resulted in 99.8% of enrollees having coverage for all four treatment service types across all ICD and DSM MH/SUD diagnoses, as medically necessary. The 99.8% of enrollees with existing coverage represents 100% of the nongrandfathered market across all market segments, plus the grandfathered small- and large-group markets. CHBRP estimates that there will be no change in benefit coverage for 99.8% of the enrollee population.

The one market segment that did not report full benefit coverage for MH/SUD services was the grandfathered individual market. 96% of enrollees in DMHC-regulated grandfathered individual market plans and 76% of enrollees in CDI-regulated grandfathered individual market policies (0.2% of all enrollees subject to SB 855) do not have coverage for SUD inpatient, outpatient, or intermediate treatments at baseline. Postmandate, benefit coverage will increase to 100%.

SB 855 would define medical necessity and add additional requirements related to training providers and staff on medical necessity determinations and use of guidelines that would increase administrative costs in all market segments (see section on Postmandate Administrative Expenses and Other Expenses) because the new requirement applies to all enrollees regardless of premandate benefit coverage.

Baseline and Postmandate Utilization

At baseline, a portion of the grandfathered individual market (representing 0.2% of the overall population of enrollees subject to SB 855) did not cover inpatient, outpatient, or intermediate SUD benefits (see above). Postmandate, CHBRP estimates that utilization will change by 0.39% for SUD intermediate (including residential) services and 0.24% for SUD outpatient services. 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.

SB 855 requires the use of specific clinical guidelines for medical necessity determinations that differ from existing internal guidelines currently reported by plans in the carrier survey. Carrier survey responses indicated that some insurers used similar definitions of medical necessity, while others included broader or narrower definitions. Many health plans and policies also responded that they used national guidelines

⁵⁴ For more detail, see *Estimates of Pharmacy Benefit Coverage in California for 2021*, available at http://chbrp.org/other_publications/index.php.

to inform their medical necessity determinations, while others created internal guidelines or referred to some of the guidelines specified by SB 855.

It is likely that 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 (i.e. outpatient services, inpatient services, intermediate services, and prescription drugs). Although there are limited changes in overall benefit coverage due to SB 855, CHBRP concludes that there will be **an unknown, but marginal impact** due to changes in medical necessity requirements and the specified definition and explicit clinical guideline requirements.

In addition, SB 855 would require health plans to cover out-of-network services delivered to enrollees based on billed charges (rather than a discounted allowed amount or negotiated price) 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.

Evidence suggests that out-of-network service use decreased overall after the original implementation of mental health parity laws, but increased for patients already using out-of-network benefits (Busch et al. 2017). 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 timely access regulations applied to DMHC-regulated plans and CDI-regulated policies. However typically in these cases it is not up to the enrollee to determine if timely access standards were not followed. While 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 access requirements. It appears that these timely access provisions may already be used by enrollees using MH/SUD services. Based on paid claims data, 3% of HMO enrollees and almost one-third of PPO enrollees use out-of-network services and have part or all of the claim paid by their health plan.

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 access standards. Based on existing information from paid claims, CHBRP cannot estimate the impact, and it would likely change if strict enforcement by DMHC or CDI under current law around network adequacy and timely access occurred, resulting in more patients receiving out-of-network care at in-network rates due to noncompliance.

SB 855 prohibits insurers from denying claims due to the existence of public programs that could provide the same services. There is currently no evidence on the impact of this provision, and because CHBRP does not have data on denied claims or on the provision of services via public entities, the impact of this provision on utilization is unknown.

Baseline and Postmandate Per-Unit Cost

SB 855 would not change the unit cost for MH/SUD services because SB 855 does not explicitly address the unit costs of services and the services mandated by SB 855 are already included as covered benefits. While SB 855 does mention out-of-network services being covered due to enforcement of timely access standards at the rate of billed charges, the Milliman claims data analyzed already includes out-of-network services for HMO and PPO enrollees paid above typical negotiated rates such that the overall unit cost already includes some out-of-network services that were paid by plans.

Baseline and Postmandate Expenditures

Table 13 and Table 14 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 both covered and noncovered benefits, and total expenditures (premiums as well as enrollee expenses).

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) 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 increase in total health insurance premiums paid by employers and enrollees for administrative expenses for all plans due to education and training requirements (see *Postmandate Administrative Expenses and Other Expenses* section).

Some enrollees paying for these services out-of-pocket due to the lack of benefit coverage will experience a decrease in out-of-pocket expenses.

SB 855 prohibits insurers from denying claims due to the existence of public programs that could provide the same services. There is currently no evidence on the impact of this provision, and because CHBRP does not have data on denied claims or on the provision of services via public entities the impact of this provision on expenditures is unknown. For the 99.8% of enrollees with baseline benefit coverage (in all nongrandfathered plans, plus grandfathered small- and large-group market plans), changes in premiums as a result of SB 855 would only vary based on size of the enrollee population and staffing model within each plan due to the Monitoring and Evaluation requirements (see *Postmandate Administrative Expenses and Other Expenses* section). Note that such changes are related to the number of enrollees (see Table 1, Table 13, and Table 14), with health insurance that would be subject to SB 855.

Enrollee Expenses

SB 855-related changes in enrollee expenses for covered benefits (deductibles, copays, etc.) and enrollee expenses for noncovered benefits would not necessarily vary by market segment for the 99.8% of enrollees with baseline coverage for all medically necessary MH/SUD treatments. Note that such changes are related to the number of enrollees (see Table 1, Table 13, and Table 14) with health insurance that would be subject to SB 855 affected by SB 855's training requirements. CHBRP estimates that 0.2% of enrollees who have uncovered SUD expenses at baseline could receive a reduction in their out-of-pocket spending for covered and noncovered expenses associated with SB 855 (Table 1).

Currently, despite 99.8% benefit coverage, both PPO and HMO enrollees in California rely partially on out-of-network services for MH/SUD either due to choice of provider or limited access to in-network providers. The impact of SB 855 on out-of-network service use and spending is unknown, but likely marginal. According to actuarial analysis of both Milliman's 2017 Consolidated Health Cost Guidelines Sources Database (CHSD) and 2017 MarketScan® Commercial Claims and Encounters Database (see Appendix C), 3% of HMO enrollees currently obtain out-of-network services that were paid for by the plan. These data sources do not include denied claims and CHBRP does not know the reasons enrollees received services from out-of-network providers.

SB 855 requires plans to pay for out-of-network claims at full billed charges for enrollees who are unable to access care if providers are not available according to the existing timeliness and geographic access to care regulations. However, it is unknown how frequently out-of-network care due to these reasons will occur and if that care will be paid for by the plan due to DMHC and CDI enforcing existing standards related to timeliness and geographic access to needed care.

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

CHBRP does not project any cost offsets or savings in health care that would result because of the enactment of provisions in SB 855. Based upon the evidence presented in the *Medical Effectiveness* section of this analysis, mental health parity does not appear to result in substantial changes in utilization of MH/SUD services or related services. In addition, due to the baseline 99.8% benefit coverage and the unknown impact of new medical necessity requirements and out-of-network coverage, CHBRP does not estimate any cost offsets or savings.

Postmandate Administrative Expenses and Other Expenses

CHBRP estimates that the increase in administrative costs of DMHC-regulated plans and/or CDI-regulated policies will be the main reason for an increase in premiums for SB 855 for 99.8% of enrollees with health insurance subject to SB 855. CHBRP assumes that despite insurance carriers already reporting 99.8% benefit coverage of MH/SUD, all plans would need to purchase and administer trainings for their staff and potentially staff/physicians in participating medical groups, which would cost \$1,062,000 total to comply in year 1.

Because CHBRP does not have information on staffing models and the exact cost of training employees within specific insurance carriers across market segments, CHBRP assumed a uniform implementation of the training and dissemination requirements based on a ratio of 1 health plan staffer per 5,000 enrollees and 1 medical office staff member or physician per 714 MH/SUD enrollee covered by the plan. CHBRP estimated that approximately 1 health insurance carrier staff member per 5,000 enrollees would need to be trained via webinar as required by SB 855. In addition, CHBRP estimated that staff members or providers in private practices, medical groups, or other contracted organizations would need to undergo training as well in delegated arrangements (1 staff/physician trained per 714 patients), (Morrison, 1998).⁵⁵ Based on external benchmarks, CHBRP set the cost of these webinars at \$100 for a three-hour session. To comply with the information dissemination requirements of SB 855, CHBRP estimated that limited staff time would be necessary to disseminate guideline information to participating network providers and enrollees via e-mail or other virtual methods.

In future years, due to turnover and changes in guidelines and training materials, CHBRP estimates a similar impact.

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 13, and Table 14, CHBRP would expect no measurable change in the number of uninsured persons due to the enactment of SB 855.

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 SB 855. The change in premiums due to benefit

⁵⁵ The carrier survey indicated that in some cases, plans defer to medical groups to make medical necessity determinations based on clinical guidelines determined by the group. SB 855 would require participating providers to comply with specific guidelines for MH/SUD, such that staff and/or providers would need to be familiar with the new requirements, guidelines and criteria.

coverage and the cost of compliance with the Education and Monitoring components of SB 855 are marginal and will not result in enrollees losing coverage.

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

Due to 99.8% enrollees having baseline coverage for the services required to be covered by SB 855, and 0.2% lacking coverage for SUD services only in the grandfathered individual market, CHBRP estimates that no cost shifts to other payers will occur.

Summary of Benefit Coverage, Utilization and Cost Findings

CHBRP reached the following conclusions regarding the impacts of SB 855 on 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.

Table 13. Baseline Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2021

	DMHC-Regulated						CDI-Regulated			Total
	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	
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 SB 855	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 14. Postmandate Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2021

	DMHC-Regulated						CDI-Regulated			Total
	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	
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 SB 855	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	\$0.0030	\$0.0028	\$0.0000	\$0.0032	\$0.0000	\$0.0000	\$0.0030	\$0.0027	\$0.0000	\$401,000
Average portion of premium paid by employee	\$0.0008	\$0.0010	\$0.0107	\$0.0006	\$0.0000	\$0.0000	\$0.0008	\$0.0011	\$1.1029	\$2,478,000
Total premium	\$0.0038	\$0.0038	\$0.0107	\$0.0038	\$0.0000	\$0.0000	\$0.0038	\$0.0038	\$1.1029	\$2,879,000
Enrollee expenses										
For covered benefits (deductibles, copays, etc.)	\$0.0000	\$0.0000	\$0.0007	\$0.0000	\$0.0000	\$0.0000	\$0.0000	\$0.0000	\$0.1226	\$251,000
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	\$0.0038	\$0.0038	\$0.0114	\$0.0038	\$0.0000	\$0.0000	\$0.0038	\$0.0038	\$1.2255	\$3,130,000
Percent change										
Premiums	0.0007%	0.0007%	0.0017%	0.0006%	0.0000%	0.0000%	0.0006%	0.0006%	0.2165%	0.0024%
Total expenditures	0.0007%	0.0006%	0.0014%	0.0006%	0.0000%	0.0000%	0.0005%	0.0005%	0.1826%	0.0024%

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

The individual and societal burden of mental health/substance use disorders (MH/SUD) is significant in California. There are a number of important physical and mental health outcomes associated with MH/SUD such as premature death (e.g., suicide, drug overdose, or eating disorders) and quality of life, as well as social outcomes (educational attainment, family stability, employment/income, incarceration, stable housing, etc.). Over a 20-year span, three major (federal and state) mental health parity laws have taken effect, along with the ACA, with the intent to expand health insurance coverage and improve access to care and health outcomes for the approximately 5 million Californians diagnosed with MH/SUD.

Estimated Public Health Outcomes

As described in the *Medical Effectiveness* section, the evidence of effectiveness of mental health parity laws show mixed results in terms of increasing access to care and improving health outcomes as compared with no parity. Briefly, there is inconclusive evidence of effectiveness of mental health parity on reducing enrollee out-of-pocket costs, receipt of recommended care, or the probability of receiving of MH/SUD care, and insufficient evidence to evaluate the effect of parity on admissions for SUD treatment or on health outcomes (which is not evidence of no effect). However, as compared with no parity, there is a preponderance of evidence that parity increased the number of insured people using MH/SUD services and the number of MH/SUD treatment encounters.

As discussed in the *Benefit Coverage, Utilization, and Cost Impacts* section, 99.8% of the 13.4 million enrollees with insurance subject to SB 855 currently have coverage for all DSM-5 and ICD-10 MH/SUD diagnoses and medically necessary treatments. This is due to existing federal and state mental health parity laws, and current industry practice according to carrier survey responses. The remaining 0.2% of Californians (26,726 enrollees), represented in a subset of grandfathered individual market DMHC-regulated plans and CDI-regulated policies, would receive full coverage of MH/SUD if SB 855 became law.

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. (See below for a more robust discussion of the unknown impact associated with SB 855.)

However, for the almost 27,000 (of 13.4 million) 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.

Discussion of SB 855-related Factors Contributing to an Unknown Impact

Despite the seemingly expansive language in SB 855, there are important underlying reasons for an unknown public health impact. The following describes major provisions of SB 855 and associated, supporting rationales for CHBRP's conclusion.

Mandating coverage of mental health/substance use disorders (MH/SUD) that are listed in the International Classification of Diseases (ICD) or the DSM of Mental Disorders

The intersection of current law and current industry practice (federal mental health parity laws; state mental health laws [including parity and coverage for autism spectrum disorder]; California's essential health benefits through the ACA; and carrier survey responses) means that health plans and policies already cover the MH/SUD identified in SB 855 at parity for 99.8% of enrollees.

Mandating scope of services (including intermediate care sites such as residential treatment facilities)

Under the interim and final Mental Health Parity and Addiction Equity Act (MHPAEA) rules, MH/SUD coverage is also subject to the parity standard for non-quantitative treatment limits (e.g., prior authorization, medical necessity review, step therapy, formularies, provider reimbursement rate, etc.) (Berry et al., 2017). This means that plans/policies must apply the same standards when evaluating coverage for facilities that treat medical conditions as well as MH/SUD. For example, health care coverage for a residential facility for MH/SUD would have to be equivalent to the coverage for a skilled nursing facility for a medical condition. MHPAEA currently requires health plans and policies to cover the care settings specified in SB 855, including intermediate care (residential facilities, partial hospitalization, and intensive outpatient services).

Defining medical necessity

SB 855 would define medical necessity in law; currently, there is no definition in California law. Carrier survey responses indicated that some insurers used similar definitions of medical necessity, while others included broader or narrower definitions. Carrier survey responses also reported inconsistent use of guidelines, as specified by SB 855, to inform their medical necessity determinations. It is unclear the degree to which SB 855 will change carriers' current definition and application of medical necessity, and therefore, unclear whether public health impacts will occur. As mentioned in the *Policy Context* section, CHBRP assumes plans and policies fully implement current law, however, recent court decisions indicate some enrollees may not be receiving services they are entitled to under current law. The changes due to SB 855 could result in some enrollees receiving care they are currently entitled to, although CHBRP is unable to estimate this impact. Should a change occur, CHBRP estimates the overall cost and utilization effects would be marginal. CHBRP recognizes that this change could be quite significant for an individual, if the treatment or service was effective; however, CHBRP is unable to estimate an impact at the population-level.

Utilization management

SB 855 does not change current provisions outlining utilization management by carriers (such as concurrent review, prior authorization, case management, step therapy, network providers, etc.). Utilization management permits carriers to review treatment and services for appropriateness of care, helps them ensure patient safety, and manage costs. Retaining such tools permits plans and policies some measure of control, thus CHBRP's analysis concludes with an unknown marginal impact.

Requiring coverage of out-of-network services at in-network cost to enrollees

If no in-network services are immediately available (meeting state-mandated timeliness and geographic standards for access to care), plans would have to cover enrollee costs under in-network provisions and reimburse out-of-network providers at the full billed charge. As reported in the *Benefit Coverage, Utilization, and Cost Impacts* section, approximately one-third of enrollees with PPOs and 3% of enrollees with HMOs currently use out-of-network services for MH/SUD treatment. A Milliman study estimated the ratio of MH/SUD to medical/surgical out-of-network outpatient claims as a proxy for carrier network adequacy, and found that California enrollee use of MH/SUD out-of-network services fluctuated between 2013 and 2017 with the largest difference being eight times greater (2016) than out-of-network use for medical/surgical care (Melek et al., 2019). In 2017, the California rate fell to four times greater for MH/SUD out-of-network use than medical/surgical. Inpatient utilization ratio was seven times greater for MH/SUD out-of-network claims as compared with medical/surgical out-of-network claims.

Based on paid claims data, 3% of HMO enrollees and almost one-third of PPO enrollees use out-of-network services; however, it is unclear what share of enrollees use these services due to personal choice or due to lack of available providers according to the timeliness and geographic standards established in current law. It is also unclear what proportion have part or all of the claim paid by their

health insurance. Therefore, CHBRP is unable to estimate the financial impact on enrollee expenses for medically necessary out-of-network care. While there may be an impact on utilization and costs, the public health impact on access to care and enrollee financial burden is unknown.

Additional Factors Contributing to an Unknown Impact

Following implementation of parity laws, anticipated increases in MH/SUD treatment utilization (or spending) have not appeared, especially for expensive treatments such as inpatient hospitalizations or residential treatment stays (Barry et al., 2106). Based on litigation across the U.S., including California, there is frustration with unequal compliance with and enforcement of mental health parity laws among and between insurance carriers. Court findings in favor of patient plaintiffs are one indicator of this disparate application of parity law. State and federal leaders acknowledge this problem as well (Anderson, 2020; Mental Health and Substance Use Disorder Parity Task Force, 2016). The Obama Administration formed a MH/SUD Parity Task Force in 2016 that recommended a series of actions to improve implementation, oversight and enforcement of parity protections. The Task Force Committee members, other stakeholders, as well as researchers note that parity law-related issues remain regarding unspecified or unregulated practices (such as non-quantitative treatment limits, which includes utilization management) and the need for consistent transparent criteria (Bankowitz, 2017; Berry et al., 2015; Kirkner, 2018; Peterson and Busch, 2018). Such ambiguity leaves insurers, enrollees, independent medical reviewers, and eventually the courts to interpret language; and these interpretations can be applied inconsistently within and among insurance carriers. Finally, others assert that the fundamental differences between medical conditions and MH/SUD cannot be bridged by parity laws (Berry et al., 2015). This presumably unequal, but unknown difference in the application and enforcement of mental health parity laws further complicates CHBRP's assessment of the impact of SB 855 on MH/SUD access and health outcomes.

Structural Challenges to Accessing Care

Mental health provider shortages (as described in the *Background* section) and provider willingness to accept insurance are challenges that patients and insurance carriers face (Peterson and Busch, 2018). America's Health Insurance Plans cited several other challenges to health plans in trying to meet parity laws including: federal laws that limit sharing SUD information among providers and with plans (inhibiting care coordination and patient safety); lack of robust quality measurement infrastructure; and lack of validated, standardized accreditation standards and definitions for facilities (Bankowitz, 2017).

In addition to a shortage of mental health providers, the California Hospital Association reports a shortage in facilities. Specifically, the psychiatric inpatient bed inventory has declined 23% (per capita) since 1995. In 2017, California had 17 beds/100,000 residents, or a deficit of approximately 4,000 beds. CHA recommends a minimum of 50 public psychiatric beds/100,000 residents to meet the needs of Californians (CHA, 2019). These shortages affect both patient access and carriers' ability to meet network adequacy.

Moreover, the number of California facilities offering SUD treatment also declined between 2013 and 2015. According to a 2015 survey of public and private California SUD treatment facilities, there were 1,004 outpatient facilities (152 fewer facilities), 521 residential (37 fewer facilities), and 30 hospital inpatient facilities (16 fewer facilities; responding organizations may report more than one type of facility) (Holt, 2018).

These shortages contribute to CHBRP's unknown marginal impact conclusion. If there is insufficient provider/facility supply, regardless of in- or out-of-network, patients who are seeking treatment will still confront access-to-care barriers. However, the significance of this barrier is unknown, in part because the duplication of providers contracted with multiple plans is unknown.

Patient Attitudinal Challenges to Accessing Care

Finally, enrollee concern about stigma, readiness for treatment, fear of discrimination and adherence to treatment are factors unrelated to parity laws that may affect rates of change in MH/SUD treatment. Stigma and lack of readiness for treatment are well-documented reasons for low uptake of services regardless of insurance coverage (CDC, 2010; Han et al., 2017). The patient attitudinal challenge contributes to CHBRP's unknown marginal impact conclusion; if SB 855 did produce a change in utilization in MH/SUD treatment services, it may not be as large as some would assume due to this barrier.

LONG-TERM IMPACTS

In this section, CHBRP estimates the long-term impact of SB 855, 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

No long-term impact is expected due to the current baseline coverage of benefits in SB 855. However, CHBRP concludes that the long-term impacts due to the changes in medical necessity criteria will likely result 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 due to the requirement that out-of-network services should be covered at the full billed charges if delivered to a patient due to a lack of provider availability in their current insurance network due to geographic access, timeliness, and network standards.

Cost Impacts

CHBRP assumes that the long-term costs for training and dissemination to comply with the medical necessity requirements on SB 855 will be the same in Year 1 as in future years, due to the need to train new employees, address staff turnover, and retrain staff and providers when changes to the guidelines are made. Cost impacts around benefits and coverage will be small due to the compliance of 0.2% of the enrollees (in grandfathered individual market plans). Cost impacts are unknown related to out-of-network coverage, but could incentivize current network providers to avoid future contracting with health plans if they perceive that network adequacy, geographic access, and timeliness standards enforcement by DMHC and CDI could expand their ability to be paid full billed charges by plans for out-of-network patients. Because psychiatrists and other mental health providers may be less likely to be part of larger medical groups and independent practice associations that will continue contracting with health plans, they may have more flexibility in responding to SB 855 by avoiding negotiations with insurance carriers and health plans due to the incentive to provide out-of-network services at a higher price. If MH/SUD providers systematically decide not to negotiate with health plans to become participating providers, those networks of providers for HMO, EPO, and PPO products could become “narrower” resulting in a higher likelihood of plans needing to reimburse non-participating providers due to an inability to create networks that meet the geographic access, timeliness and network standards overseen by DMHC and CDI.

Long-Term Public Health Impacts

The long-term public health impact is unknown due to aforementioned reasons in this section and in the *Public Health* section. Note that because CHBRP projects a change in coverage for almost 27,000 people, there could be a reduction in out-of-pocket costs, a primary barrier to MH/SUD treatment, for the portion of people who seek treatment, resulting in improved quality of life, increased productivity and perhaps reductions in premature mortality.

APPENDIX A TEXT OF BILL ANALYZED

On January 15, 2020 the California Senate Committee on Health requested that CHBRP analyze SB 855.

SENATE BILL

NO. 855

**Introduced by Senator Wiener
(Principal coauthor: Senator Beall)
(Principal coauthors: Assembly Members Aguiar-Curry and Chiu)
(Coauthors: Senators Glazer and Hill)
(Coauthors: Assembly Members Maienschein and Wicks)**

January 14, 2020

An act to add Section 1367.045 to, and to repeal and add Section 1374.72 of, the Health and Safety Code, and to repeal and add Section 10144.5 of the Insurance Code, relating to health coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 855, as introduced, Wiener. Health coverage: mental health or substance abuse disorders.

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, known as the California Mental Health Parity Act, requires every health care service plan contract or health insurance policy issued, amended, or renewed on or after July 1, 2000, that provides hospital, medical, or surgical coverage to provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses of a person of any age, and of serious emotional disturbances of a child under the same terms and conditions applied to other medical conditions, as specified. Existing law requires those benefits to include, among other things, outpatient services, inpatient hospital services, partial hospital services, and prescription drugs, if the plan contract or policy includes coverage for prescription drugs.

This bill would revise and recast those provisions, and would instead require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2021, that provides hospital, medical, or surgical coverage to provide coverage for the diagnosis and medically necessary treatment of mental health and substance use

disorders, as defined, under the same terms and conditions applied to other medical conditions. The bill would prohibit a health care service plan or health insurer from limiting benefits or coverage for chronic or pervasive mental health and substance use disorders to short-term or acute treatment.

This bill would authorize certain individuals or entities to pursue a civil action against a health care service plan or health insurer for a violation of the above-described provisions either independently or through a class action lawsuit, and would authorize the imposition of penalties in a civil action under these provisions, including attorney's fees. The bill would declare that its provisions are severable.

Because a willful violation of these requirements with respect to health care service plans would be a crime, this 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.

DIGEST KEY

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

BILL TEXT

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

SECTION 1.

The Legislature finds and declares all of the following:

(a) The California Mental Health Parity Act (Section 1374.72 of the Health and Safety Code and Section 10144.5 of the Insurance Code) was enacted in 1999 to require coverage of all diagnosis and medically necessary treatment of nine listed severe mental illnesses, as well as serious emotional disturbances of a child. However, this list of nine severe mental illnesses is not only incomplete and out-of-date, but also fails to encompass the range of mental health and substance use disorders whose complex interactions are contributing to overdose deaths from opioids and methamphetamines, the increase in suicides, and other so-called deaths of despair.

(b) Following the California Mental Health Parity Act, the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 put in place even more robust mental health parity protections, which also applied to substance use disorders,

making the most important provision of the California Mental Health Parity Act its coverage requirement for medically necessary treatment for severe mental illnesses and serious emotional disturbances of a child.

(c) The federal Affordable Care Act (ACA) includes mental health and addiction coverage as one of its 10 essential health benefits, but it does not contain a definition for medical necessity, and despite the ACA, needed mental health and addiction coverage can be denied through overly restrictive medical necessity determinations.

(d) With one in five adults in the United States experiencing a mental health disorder and 1 in 13 individuals 12 years of age or older experiencing a substance use disorder, it is critical for the California Mental Health Parity Act to be expanded to apply to all mental health and substance use disorders, as defined by the preeminent national and international bodies.

(e) The conditions currently listed in the California Mental Health Parity Act, including autism, are all included in the broader definition of mental health and substance use disorders.

(f) If the California Mental Health Parity Act is so expanded, coverage of medically necessary treatment would increase for the fewer than one-half of adults with a mental health disorder who now receive treatment and the fewer than 1 in 10 individuals 12 years of age or older with a substance use disorder who now receive treatment.

(g) When medically necessary mental health and substance use disorder care is not covered, individuals with mental health and substance use disorders often have their conditions worsen, ending up on Medicaid, in the criminal justice system, or on the streets, resulting in harm to individuals and communities, and higher costs to taxpayers.

(h) In 2016, approximately 6,000,000 veterans in the United States had private health care coverage, making it critical to ensure that the veterans' private health plans cover all medically necessary treatment for the invisible wounds of war.

(i) Expansion of the California Mental Health Parity Act will help address the following manifestations of the ongoing mental health and addiction crises in California:

(1) Between 2012 and 2017, California's rate of fatal overdoses for all opioids increased 22 percent, while fatal overdose rates increased 85 percent for heroin and 425 percent for fentanyl.

(2) Suicide rates in California increased by 14.8 percent between 1999 and 2016, with the suicide rate from 1991 to 2017, inclusive, for children 10 to 14 years of age, inclusive, increasing by 225 percent.

(3) Thirty-seven percent of students with a mental health condition 14 years of age and older drop out of school, and mental illness has the highest dropout rate of any disability group.

(4) The correlation between untreated mental illness, substance use disorders, and incarceration is substantial, as three in four individuals in jail have been diagnosed with both a mental illness and a substance use disorder.

(5) Untreated mental health and substance use disorders are an enormous problem with incarcerated youth, with 70 percent of youth arrested each year having a mental health disorder.

(6) As many as one-third of the 130,000 individuals who are homeless living on the streets in California have a mental health condition.

(j) In two court decisions, *Harlick v. Blue Shield of California*, 686 F.3d 699 (9th Cir. 2011), cert. denied, 133 S.Ct. 1492 (2013), and *Rea v. Blue Shield of California*, 226 Cal.App.4th 1209, 1227 (2014), the California Mental Health Parity Act was interpreted to require coverage of medically necessary residential treatment.

(k) Coverage of intermediate levels of care such as residential treatment, which are essential components of the level of care continuum called for by nonprofit, and clinical specialty associations such as the American Society of Addiction Medicine (ASAM), are often denied through overly restrictive medical necessity determinations.

(l) In March 2019, the United States District Court of the Northern District of California ruled in *Wit v. United Behavioral Health*, 2019 WL 1033730 (Wit; N.D.CA Mar. 5, 2019), that United Behavioral Health created flawed level of care placement criteria that were inconsistent with generally accepted standards of mental health and substance use disorder care in order to “mitigate” the requirements of the federal Mental Health Parity and Addiction Equity Act of 2008.

(m) As described by the federal court in *Wit*, the eight generally accepted standards of mental health and substance use disorder care require all of the following:

(1) Effective treatment of underlying conditions, rather than mere amelioration of current symptoms, such as suicidality or psychosis.

(2) Treatment of cooccurring behavioral health disorders or medical conditions in a coordinated manner.

(3) Treatment at the least intensive and restrictive level of care that is safe and effective; a lower level or less intensive care is appropriate only if it safe and just as effective as treatment at a higher level or service intensity.

(4) Erring on the side of caution, by placing patients in higher levels of care when there is ambiguity as to the appropriate level of care, or when the recommended level of care is not available.

(5) Treatment to maintain functioning or prevent deterioration.

(6) Treatment of mental health and substance use disorders for an appropriate duration based on individual patient needs rather than on specific time limits.

(7) Accounting for the unique needs of children and adolescents when making level of care decisions.

(8) Applying multidimensional assessments of patient needs when making determinations regarding the appropriate level of care.

(n) The court in *Wit* found that all parties' expert witnesses regarded the ASAM criteria for substance use disorders and Level of Care Utilization System, Child and Adolescent Level of Care Utilization System, Child and Adolescent Service Intensity Instrument, and Early Childhood Service Intensity Instrument (LOCUS/CALOCUS and CASII/ECSII) criteria for mental health disorders as prime examples of level of care criteria that are fully consistent with generally accepted standards of mental health and substance use care.

SEC. 2.

Section 1367.045 is added to the Health and Safety Code, to read:

(a) If a health care service plan contract offered, issued, delivered, or renewed on or after January 1, 2021, whether or not in California, that provides health care coverage for a California resident contains a provision that reserves discretionary authority to the plan, or an agent of the plan, to determine eligibility for benefits or coverage, to interpret the terms of the contract, or to provide standards of interpretation or review that are inconsistent with the laws of this state, that provision is void and unenforceable.

(b) For purposes of this section, "renewed" means continued in force on or after the contract's anniversary date.

(c) For purposes of this section, the term "discretionary authority" means a contract provision that has the effect of conferring discretion on a health care service plan or other claims administrator to determine entitlement to benefits or interpret contract language that, in turn, could lead to a deferential standard of review by a reviewing court.

(d) This section does not prohibit a health care service plan from including a provision in a contract that informs an enrollee that, as part of its routine operations, the plan applies the terms of its contracts for making decisions, including making determinations regarding eligibility, receipt of benefits and claims, or explaining policies, procedures, and processes,

so long as the provision could not give rise to a deferential standard of review by a reviewing court.

(e) This section applies to both group and individual health care service plan contracts.

(f) The director may adopt regulations reasonably necessary to implement this section.

(g) This section is self-executing. If a health care service plan contract contains a provision rendered void and unenforceable by this section, the parties to the contract and the courts shall treat that provision as void and unenforceable.

SEC. 3.

Section 1374.72 of the Health and Safety Code is repealed.

~~1374.72.~~

~~(a) Every health care service plan contract issued, amended, or renewed on or after July 1, 2000, that provides hospital, medical, or surgical coverage shall provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses of a person of any age, and of serious emotional disturbances of a child, as specified in subdivisions (d) and (e), under the same terms and conditions applied to other medical conditions as specified in subdivision (c).~~

~~(b) These benefits shall include the following:~~

~~(1) Outpatient services.~~

~~(2) Inpatient hospital services.~~

~~(3) Partial hospital services.~~

~~(4) Prescription drugs, if the plan contract includes coverage for prescription drugs.~~

~~(c) The terms and conditions applied to the benefits required by this section, that shall be applied equally to all benefits under the plan contract, shall include, but not be limited to, the following:~~

~~(1) Maximum lifetime benefits.~~

~~(2) Copayments.~~

~~(3) Individual and family deductibles.~~

~~(d) For the purposes of this section, "severe mental illnesses" shall include:~~

~~(1) Schizophrenia.~~

~~(2) Schizoaffective disorder.~~

~~(3) Bipolar disorder (manic-depressive illness).~~

~~(4) Major depressive disorders.~~

~~(5) Panic disorder.~~

~~(6) Obsessive-compulsive disorder.~~

~~(7) Pervasive developmental disorder or autism.~~

~~(8) Anorexia nervosa.~~

~~(9) Bulimia nervosa.~~

~~(e) For the purposes of this section, a child suffering from, "serious emotional disturbances of a child" shall be defined as a child who (1) has one or more mental disorders as~~

~~identified in the most recent edition of the Diagnostic and Statistical Manual 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) who meets the criteria in paragraph (2) of subdivision (a) of Section 5600.3 of the Welfare and Institutions Code.~~

~~(f) This section shall not apply to contracts entered into pursuant to Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Division 9 of Part 3 of the Welfare and Institutions Code, between the State Department of Health Services and a health care service plan for enrolled Medi-Cal beneficiaries.~~

~~(g) (1) For the purpose of compliance with this section, a plan may provide coverage for all or part of the mental health services required by this section through a separate specialized health care service plan or mental health plan, and shall not be required to obtain an additional or specialized license for this purpose.~~

~~(2) A plan shall provide the mental health coverage required by this section in its entire service area and in emergency situations as may be required by applicable laws and regulations. For purposes of this section, health care service plan contracts that provide benefits to enrollees through preferred provider contracting arrangements are not precluded from requiring enrollees who reside or work in geographic areas served by specialized health care service plans or mental health plans to secure all or part of their mental health services within those geographic areas served by specialized health care service plans or mental health plans.~~

~~(3) Notwithstanding any other provision of law, in the provision of benefits required by this section, a health care service plan may utilize case management, network providers, utilization review techniques, prior authorization, copayments, or other cost sharing.~~

~~(h) Nothing in this section shall be construed to deny or restrict in any way the department's authority to ensure plan compliance with this chapter when a plan provides coverage for prescription drugs.~~

SEC. 4.

Section 1374.72 is added to the Health and Safety Code, to read:

(a) (1) Every health care service plan contract issued, amended, or renewed on or after January 1, 2021, that provides hospital, medical, or surgical coverage shall provide coverage for the diagnosis and medically necessary treatment of mental health and substance use disorders, including, but not limited to, severe mental illnesses of a person of any age, and serious emotional disturbances of a child, under the same terms and conditions applied to other medical conditions as specified in subdivision (c).

(2) Mental health and substance use disorders shall mean a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

(3) Medically necessary treatment of a mental health or substance use disorder shall be a covered service that is all of the following:

(A) Recommended by the patient's treatment provider.

(B) Furnished in the manner and setting that can most effectively and comprehensively address the patient's conditions, including, but not limited to, functional impairments, lack of coping skills, symptoms, and the underlying biopsychosocial determinants of mental health, substance use, and medical disorders, and any combination thereof.

(C) Provided in sufficient amount, duration, and scope to do any of the following:

- (i) Prevent, diagnose, or treat a disorder.
- (ii) Minimize the progression of a disorder or its symptoms.
- (iii) Achieve age-appropriate growth and development.
- (iv) Minimize the progression of disability.
- (v) Attain, maintain, regain, or maximize full functional capacity.

(D) Consistent with generally accepted standards of practice, which shall be based on either of the following:

- (i) Scientific evidence published in peer-reviewed medical literature generally recognized by the relevant clinical community.
- (ii) Clinical specialty society recommendations, professional standards, and consensus statements.

(4) A health care service plan shall not limit benefits or coverage for chronic or pervasive mental health and substance use disorders to short-term or acute treatment.

(5) (A) Consistent with paragraph (3), for all medical necessity determinations concerning level of care placement, continued stay, and transfer or discharge, a health care service plan shall exclusively rely on the most recent editions of the following:

- (i) The American Society of Addiction Medicine (ASAM) criteria developed by the American Society of Addiction Medicine for substance use disorders for patients of any age.
- (ii) The Level of Care Utilization System (LOCUS) criteria developed by the American Association of Community Psychiatrists for mental health disorders for patients 18 years of age and over.
- (iii) The Child and Adolescent Level of Care Utilization System (CALOCUS) developed by the American Association of Community Psychiatrists or the Child and Adolescent Service Intensity Instrument (CASII) developed by the American Academy of Child and Adolescent Psychiatry for mental health disorders for patients 6 to 17 years of age, inclusive.
- (iv) The Early Childhood Service Intensity Instrument (ECSII) developed by the American Academy of Child and Adolescent Psychiatry for mental health disorders for patients zero to five years of age, inclusive.
- (v) The American Psychiatric Association criteria for eating disorders for a primary diagnosis of an eating disorder for patients any of age.

(vi) “Clarifications Regarding Applied Behavior Analysis Treatment of Autism Spectrum Disorder: Practice Guidelines for Healthcare Funders and Managers” or subsequent guidelines developed by the Behavior Analyst Certification Board or the Association of Professional Behavior Analysts for individuals with autistic spectrum disorders undergoing behavior therapy.

(B) As specified in clauses (i) to (vi), inclusive, of subparagraph (A), reviewers shall err on the side of caution and safety in making medical necessity determinations by placing patients in higher levels of care when there is ambiguity as to the appropriate level of care.

(6) To ensure the proper use of the criteria described in paragraph (5), every health care service plan shall do all of the following:

(A) Sponsor a formal education program by nonprofit clinical specialty associations to educate plan staff, including any third parties contracted with the health plan to review claims, conduct utilization reviews, or make medical necessity determinations, and other stakeholders, including the plan’s participating providers and covered lives, about the guidelines, and provide the guidelines and any training material or resources to providers and insured patients.

(B) Track, identify, and analyze how the clinical guidelines are used to certify care, deny care, and support the appeals process.

(C) Run inter-rater reliability reports about how the clinical guidelines are used in conjunction with the utilization management process and parity compliance activities.

(D) Achieve inter-rater reliability pass rates of at least 90 percent and, if this threshold is not met, immediately provide for the remediation of poor inter-rater reliability and inter-rater reliability testing for all new staff before they can conduct utilization review without supervision.

(E) Report the activities in this paragraph to the plan’s quality assurance committee.

(b) These benefits shall include, but not be limited to, the following:

(1) Outpatient services.

(2) Inpatient services.

(3) Intermediate services, including the full range of levels of care in the most recent edition of the ASAM criteria, LOCUS, CALOCUS, ECSII, and CASII, including, but not limited to, residential treatment, partial hospitalization, and intensive outpatient treatment.

(4) Prescription drugs, if the plan contract includes coverage for prescription drugs.

(c) The terms and conditions applied to the benefits required by this section, that shall be applied equally to all benefits under the plan contract, shall include, but not be limited to, all of the following patient financial responsibilities:

(1) Maximum lifetime benefits.

(2) Copayments.

(3) Individual and family deductibles.

(d) If any of the medically necessary mental health services enumerated in subdivision (b) are not available in network within the geographic and timeliness standards set by law or regulation, the health care service plan shall immediately cover out-of-network services, whether secured by the patient or the health care service plan, at an in-network benefit level and reimburse out-of-network providers for those services at full billed charges. A health care service plan may not interrupt a course of treatment initiated out of network due to network inadequacy if in-network services subsequently become available.

(e) This section shall not apply to contracts entered into pursuant to Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code, between the State Department of Health Care Services and a health care service plan for enrolled Medi-Cal beneficiaries.

(f) (1) For the purpose of compliance with this section, a health care service plan may provide coverage for all or part of the mental health and substance use disorder services required by this section through a separate specialized health care service plan or mental health plan, and shall not be required to obtain an additional or specialized license for this purpose.

(2) A health care service plan shall provide the mental health and substance use disorder coverage required by this section in its entire service area and in emergency situations as may be required by applicable laws and regulations. For purposes of this section, health care service plan contracts that provide benefits to enrollees through preferred provider contracting arrangements are not precluded from requiring enrollees who reside or work in geographic areas served by specialized health care service plans or mental health plans to secure all or part of their mental health services within those geographic areas served by specialized health care service plans or mental health plans, provided that all appropriate mental health or substance use disorder services are actually available within those geographic service areas within timeliness standards.

(3) Notwithstanding any other law, in the provision of benefits required by this section, a health care service plan may utilize case management, network providers, utilization review techniques, prior authorization, copayments, or other cost sharing, provided that these practices are consistent with Section 2052 of the Business and Professions Code.

(g) This section shall not be construed to deny or restrict in any way the department's authority to ensure plan compliance with this chapter when a health care service plan provides coverage for prescription drugs.

(h) A health care service plan shall not limit benefits or coverage for medically necessary services on the basis that those services should be or could be covered by a public entitlement program, including, but not limited to, special education or an individualized education program, Medicaid, Medicare, Supplemental Security Income, or Social Security Disability Insurance, and shall not include or enforce a contract term that excludes otherwise covered benefits on the basis that those services should be or could be covered by a public entitlement program.

(i) A health care service plan shall not adopt, impose, or enforce additional terms in its policies or provider agreements, in writing or in operation, that undermine or alter the requirements of this section.

(j) (1) An enrollee, subscriber, or in-network or out-of-network provider on behalf of an enrollee or subscriber may bring a civil action in a court of competent jurisdiction individually or on behalf of a class against a health care service plan for a violation of this section or Section 1374.73 or 1374.76.

(2) The remedies in a civil action brought pursuant to this section include, independent of causation or damages, a five-thousand-dollar (\$5,000) statutory penalty per act or offense, general and special damages, which may be trebled for knowing conduct, injunctive relief, restitution of premium, and attorney's fees and costs, including expert expenses.

(3) If a claim is litigated on a class basis, the same act or offense shall be counted with respect to each class member.

(4) An administrative action taken or not taken by the department with regard to the health care service plan's conduct shall not provide an affirmative defense in the court's consideration of the claim. A claimant shall be promptly notified in writing by the health care service plan and by the department of any administrative action, including the final outcome, against a health care service plan as a result of the claimant's complaint.

SEC. 5.

Section 10144.5 of the Insurance Code is repealed.

~~10144.5.~~

~~(a) Every policy of disability insurance that covers hospital, medical, or surgical expenses in this state that is issued, amended, or renewed on or after July 1, 2000, shall provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses of a person of any age, and of serious emotional disturbances of a child, as specified in subdivisions (d) and (e), under the same terms and conditions applied to other medical conditions, as specified in subdivision (c).~~

~~(b) These benefits shall include the following:~~

~~(1) Outpatient services.~~

~~(2) Inpatient hospital services.~~

~~(3) Partial hospital services.~~

~~(4) Prescription drugs, if the policy or contract includes coverage for prescription drugs.~~

~~(c) The terms and conditions applied to the benefits required by this section that shall be applied equally to all benefits under the disability insurance policy shall include, but not be limited to, the following:~~

~~(1) Maximum lifetime benefits.~~

~~(2) Copayments and coinsurance.~~

~~(3) Individual and family deductibles.~~

~~(d) For the purposes of this section, "severe mental illnesses" shall include:~~

~~(1) Schizophrenia.~~

~~(2) Schizoaffective disorder.~~

~~(3) Bipolar disorder (manic-depressive illness).~~

~~(4) Major depressive disorders.~~

~~(5) Panic disorder.~~

~~(6) Obsessive-compulsive disorder.~~

~~(7) Pervasive developmental disorder or autism.~~

~~(8) Anorexia nervosa.~~

~~(9) Bulimia nervosa.~~

~~(e) For the purposes of this section, a child suffering from, "serious emotional disturbances of a child" shall be defined as a child who (1) has one or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual 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) who meets the criteria in paragraph (2) of subdivision (a) of Section 5600.3 of the Welfare and Institutions Code.~~

~~(f)(1) For the purpose of compliance with this section, a disability insurer may provide coverage for all or part of the mental health services required by this section through a separate specialized health care service plan or mental health plan, and shall not be required to obtain an additional or specialized license for this purpose.~~

~~(2) A disability insurer shall provide the mental health coverage required by this section in its entire in-state service area and in emergency situations as may be required by applicable laws and regulations. For purposes of this section, disability insurers are not precluded from requiring insureds who reside or work in geographic areas served by specialized health care service plans or mental health plans to secure all or part of their mental health services within those geographic areas served by specialized health care service plans or mental health plans.~~

~~(3) Notwithstanding any other provision of law, in the provision of benefits required by this section, a disability insurer may utilize case management, managed care, or utilization review.~~

~~(4) Any action that a disability insurer takes to implement this section, including, but not limited to, contracting with preferred provider organizations, shall not be deemed to be an action that would otherwise require licensure as a health care service plan under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code.~~

~~(g) This section shall not apply to accident only, specified disease, hospital indemnity, Medicare supplement, dental only, or vision only insurance policies.~~

SEC. 6.

Section 10144.5 is added to the Insurance Code, to read:

(a) (1) Every health insurance policy issued, amended, or renewed on or after January 1, 2021, that provides hospital, medical, or surgical coverage shall provide coverage for the diagnosis and medically necessary treatment of mental health and substance use disorders, including, but not limited to, severe mental illnesses of a person of any age, and serious emotional disturbances of a child, under the same terms and conditions applied to other medical conditions as specified in subdivision (c).

(2) Mental health and substance use disorders shall mean a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

(3) Medically necessary treatment of a mental health or substance use disorder shall be a covered service that is all of the following:

(A) Recommended by the patient's treatment provider.

(B) Furnished in the manner and setting that can most effectively and comprehensively address the patient's conditions, including, but not limited to, functional impairments, lack of coping skills, symptoms, and the underlying biopsychosocial determinants of mental health, substance use, and medical disorders, and any combination thereof.

(C) Provided in sufficient amount, duration, and scope to do any of the following:

(i) Prevent, diagnose, or treat a disorder.

(ii) Minimize the progression of a disorder or its symptoms.

(iii) Achieve age-appropriate growth and development.

(iv) Minimize the progression of disability.

(v) Attain, maintain, regain, or maximize full functional capacity.

(D) Consistent with generally accepted standards of practice, which shall be based on either of the following:

(i) Scientific evidence published in peer-reviewed medical literature generally recognized by the relevant clinical community.

(ii) Clinical specialty society recommendations, professional standards, and consensus statements.

(4) A health insurer shall not limit benefits or coverage for chronic or pervasive mental health and substance use disorders to short-term or acute treatment.

(5) (A) Consistent with paragraph (3), for all medical necessity determinations concerning level of care placement, continued stay, and transfer or discharge, a health insurer shall exclusively rely on the most recent editions of the following:

(i) The American Society of Addiction Medicine (ASAM) criteria developed by the American Society of Addiction Medicine for substance use disorders for patients of any age.

(ii) The Level of Care Utilization System (LOCUS) criteria developed by the American Association of Community Psychiatrists for mental health disorders for patients 18 years of age and over.

(iii) The Child and Adolescent Level of Care Utilization System (CALOCUS) developed by the American Association of Community Psychiatrists or the Child and Adolescent Service Intensity Instrument (CASII) developed by the American Academy of Child and Adolescent Psychiatry for mental health disorders for patients 6 to 17 years of age, inclusive.

(iv) The Early Childhood Service Intensity Instrument (ECSII) developed by the American Academy of Child and Adolescent Psychiatry for mental health disorders for patients zero to five years of age, inclusive.

(v) The American Psychiatric Association criteria for eating disorders for a primary diagnosis of an eating disorder for patients any of age.

(vi) “Clarifications Regarding Applied Behavior Analysis Treatment of Autism Spectrum Disorder: Practice Guidelines for Healthcare Funders and Managers” or subsequent guidelines developed by the Behavior Analyst Certification Board or the Association of Professional Behavior Analysts for individuals with autistic spectrum disorders undergoing behavior therapy.

(B) As specified in clauses (i) to (vi), inclusive, of subparagraph (A), reviewers shall err on the side of caution and safety in making medical necessity determinations by placing patients in higher levels of care when there is ambiguity as to the appropriate level of care.

(6) To ensure the proper use of the criteria described in paragraph (5), every health insurer shall do all of the following:

(A) Sponsor a formal education program by nonprofit clinical specialty associations to educate the health insurer’s staff, including any third parties contracted with the health insurer to review claims, conduct utilization reviews, or make medical necessity determinations, and other stakeholders, including the insurer’s participating providers and covered lives, about the guidelines, and provide the guidelines and any training material or resources to providers and insured patients.

(B) Track, identify, and analyze how the clinical guidelines are used to certify care, deny care, and support the appeals process.

(C) Run inter-rater reliability reports about how the clinical guidelines are used in conjunction with the utilization management process and parity compliance activities.

(D) Achieve inter-rater reliability pass rates of at least 90 percent and, if this threshold is not met, immediately provide for the remediation of poor inter-rater reliability and inter-rater reliability testing for all new staff before they can conduct utilization review without supervision.

(E) Report the activities in this paragraph to the plan's quality assurance committee.

(b) These benefits shall include, but not be limited to, the following:

(1) Outpatient services.

(2) Inpatient services.

(3) Intermediate services, including the full range of levels of care in the most recent edition of the ASAM criteria, LOCUS, CALOCUS, ECSII, and CASII, including, but not limited to, residential treatment, partial hospitalization, and intensive outpatient treatment.

(4) Prescription drugs, if the plan contract includes coverage for prescription drugs.

(c) The terms and conditions applied to the benefits required by this section, that shall be applied equally to all benefits under the plan contract, shall include, but not be limited to, all of the following patient financial responsibilities:

(1) Maximum lifetime benefits.

(2) Copayments.

(3) Individual and family deductibles.

(d) If any of the medically necessary mental health services enumerated in subdivision (b) are not available in network within the geographic and timeliness standards set by law or regulation, the health insurer shall immediately cover out-of-network services, whether secured by the patient or the health insurer, at an in-network benefit level and reimburse out-of-network providers for those services at full billed charges. A health insurer may not interrupt a course of treatment initiated out of network due to network inadequacy if in-network services subsequently become available.

(e) This section shall not apply to accident-only, specified disease, hospital indemnity, Medicare supplement, dental-only, or vision-only insurance policies.

(f) (1) For the purpose of compliance with this section, a health insurer may provide coverage for all or part of the mental health and substance use disorder services required

by this section through a separate specialized health insurance policy or mental health insurance policy, and shall not be required to obtain an additional or specialized license for this purpose.

(2) A health insurer shall provide the mental health and substance use disorder coverage required by this section in its entire service area and in emergency situations as may be required by applicable laws and regulations. For purposes of this section, health insurance policies that provide benefits to insureds through preferred provider contracting arrangements are not precluded from requiring enrollees who reside or work in geographic areas served by specialized health insurance policies or mental health insurance policies to secure all or part of their mental health services within those geographic areas served by specialized health insurance policies or mental health insurance policies, provided that all appropriate mental health or substance use disorder services are actually available within those geographic service areas within timeliness standards.

(3) Notwithstanding any other law, in the provision of benefits required by this section, a health insurer may utilize case management, network providers, utilization review techniques, prior authorization, copayments, or other cost sharing, provided that these practices are consistent with Section 2052 of the Business and Professions Code.

(g) This section shall not be construed to deny or restrict in any way the department's authority to ensure a health insurer's compliance with this chapter when a health insurer provides coverage for prescription drugs.

(h) A health insurer shall not limit benefits or coverage for medically necessary services on the basis that those services should be or could be covered by a public entitlement program, including, but not limited to, special education or an individualized education program, Medicaid, Medicare, Supplemental Security Income, or Social Security Disability Insurance, and shall not include or enforce a contract term that excludes otherwise covered benefits on the basis that those services should be or could be covered by a public entitlement program.

(i) A health insurer shall not adopt, impose, or enforce additional terms in its policies or provider agreements, in writing or in operation, that undermine or alter the requirements of this section.

(j) (1) An insured, policyholder, or in-network or out-of-network provider on behalf of an insured or policyholder may bring a civil action in a court of competent jurisdiction individually or on behalf of a class against a health insurer for a violation of this section.

(2) The remedies in a civil action brought pursuant to this section include, independent of causation or damages, a five-thousand-dollar (\$5,000) statutory penalty per act or offense, general and special damages, which may be trebled for knowing conduct, injunctive relief, restitution of premium, and attorney's fees and costs, including expert expenses.

(3) If a claim is litigated on a class basis, the same act or offense shall be counted with respect to each class member.

(4) An administrative action taken or not taken by the department with regard to the health insurer's conduct shall not provide an affirmative defense in the court's consideration of the claim. A claimant shall be promptly notified in writing by the health insurer and by the department of any administrative action, including the final outcome, against a health insurer as a result of the claimant's complaint.

SEC. 7.

The provisions of this act are severable. If any provision of this act or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

SEC. 8.

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 MH/SUD parity policies were identified through searches of PubMed, the Cochrane Library, Web of Science, Embase, Scopus, and PsycINFO. Websites maintained by the following organizations were also searched: Agency for Healthcare Research and Quality; the National Institute for Health and Care Excellence (NICE); Scottish Intercollegiate Guideline Network (SIGN); NHS Centre for Reviews and Dissemination; PubMed Health; Substance Abuse and Mental Health Services Administration (SAMHSA); American Association of Community Psychiatrists; American Psychiatric Association; American Association of Child and Adolescent Psychiatry; American Academy of Pediatrics; American Psychological Association; American Society of Addiction Medicine (ASAM); National Institute on Drug Abuse; and the National Institutes for Health (NIH).

The search was limited to abstracts of studies published in English. The medical effectiveness search was limited to studies published from 2011 to present because CHBRP had previously reviewed this literature using similar search terms in 2011 for the AB 154: Mental Health Services analysis. The literature on the effectiveness of MH/SUD laws did not include any randomized controlled trials; the majority of the papers returned were observational studies with comparison groups.

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 179 articles, of which 24 were reviewed for inclusion in this report. A total of 19 new studies since 2011 were included in the medical effectiveness review for SB 855. A grand total of 31 studies were included in the medical effectiveness review for SB 855.

Evidence Grading System

In making a "call" for each outcome measure, the medical effectiveness lead and the content expert consider 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*.⁵⁶ 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;*

⁵⁶ 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 (* indicates truncation of word stem)

The search terms used to locate studies relevant to SB 855 were as follows.

The following subject headings were used to search PubMed and PsycINFO:

- Child Health Services
- Continuity of Patient Care
- Continuum of Care
- Cost of Illness
- Costs and Cost Analysis
- Criminal Justice
- Cultural Diversity
- Drug Prescriptions
- Drug Utilization
- Emergency Service, Hospital
- Ethnic Groups
- Facilities and Services Utilization
- Financial Strain
- Health Benefit Plans, Employee
- Health Care Economics
- Health Disparities
- Health Insurance
- Health Status Disparities
- Healthcare Disparities
- Hospitalization
- Incarceration
- Insurance
- Insurance Benefits
- Insurance Claim Review
- Insurance Coverage
- Insurance, Health
- Insurance, Hospitalization
- Legislation and Jurisprudence
- Legislation as Topic
- Legislation, Medical
- Mental Disorders
- Mental Health Parity
- Morbidity
- Mortality Rate
- Mortality Risk
- Mortality, Premature
- Office Visits
- Patient Acceptance of Health Care
- Patients
- Posttreatment Followup
- Productivity
- Quality-Adjusted Life Years
- Quality of Life
- Recurrence
- Substance-Related Disorders
- Suicide

- Supply and Distribution
- Treatment Adherence and Compliance
- Treatment Barriers
- Treatment Compliance

The following keywords were used to search PubMed, Cochrane Library, PsycINFO, Web of Science, and Scopus:

- Addiction Parity
- Addiction*
- Adherence
- Alcohol*
- Anxiety
- Barrier*
- Burden*
- Compliant*
- Cost Analysis*
- Cost of Illness
- Cost to Society
- Cost*
- Criminal Justice
- Department*
- Depression
- Depressive
- Disorder*
- Disparity
- Drug Abuse
- Drug Adherence
- Drug Compliance
- Drug Dependence
- Drug Nonadherence
- Eating
- Economic Loss
- Emergency Department
- Emergency Room
- Emergency Service
- Emotional
- Ethnic
- Ethnicity
- Federal Parity
- Financial Barrier*
- Financial Burden*
- Follow-Up Care
- Gender
- Health Insurance
- Hospitali*
- HRQOL
- Illness*
- Incarcerat*
- Incidence
- Insurance
- Insurance Parity
- Insured
- Intermediate Stay*
- Law
- Legislation
- Level of Care
- Long Term Impact*
- Medical Insurance
- Medication Adherence
- Medication Compliance
- Medication* Non-adherence
- Medication* Nonadherence
- Mental Health Parity
- Mental Health Parity and Addiction Equity Act
- Mental Illness*
- MHPAEA
- Mood
- Morbidity
- Mortality
- Non-adherence
- Nonadherence
- Outpatient
- Parity*
- Pervasive Mental
- Prescribed
- Prescription*
- Prevalence
- Problem*
- Productivity
- Provider Supply
- Provider*
- Psychiatric
- Quality-Adjusted Life Year*
- Quality of Life
- Race
- Racial
- Receptivity
- Recurrence
- Relapse
- Risk
- Self-Injurious Behavior
- Self-Injury
- Serious Mental Illness
- Severe Emotional Disturbance
- Severe Mental Illness
- Severe Mental Illness Parity

- Severity
- Societal Cost
- State Parity
- Stigma*
- Stress
- Substance Abuse*
- Substance Dependence
- Substance Use Disorder
- Substance Use Disorder Parity
- SUD
- Suicide
- Suppl*
- Treatment Adherence
- Treatment Non-Adherence
- Treatment Nonadherence
- United States
- Usage
- Utilis*
- Utiliz*
- Visit
- Willingness

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.⁵⁷

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.⁵⁸

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 relevant to specifically to an analysis of SB 855:

- Relevant codes from the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) and National Drug Codes (NDCs) were used to extract data from Milliman's 2017 Consolidated Health Cost Guidelines Sources Database (CHSD) and 2017 MarketScan® Commercial Claims and Encounters Database. These data were used to develop baseline cost and utilization information for MH/SUD treatment. Baseline cost and utilization rates per 1,000 members were calculated and used to estimate the number of treatments and average cost per treatment.
- Baseline average cost was trended from 2017 to 2021 at annual rates of increase that vary from 6.1% to 8.5% depending on the type of service.
- Carrier surveys were administered to estimate the percentage of enrollees who have MH/SUD coverage premandate. The below is a summary of responses:
 - 100.0% of individuals subject to SB 855 have coverage for MH treatment premandate.
 - 100.0% of commercially insured enrollees and CalPERS plan enrollees, except for enrollees in individual grandfathered plans, have coverage for SUD treatment premandate.
 - 85.1% of enrollees in individual grandfathered plans have coverage for SUD treatment premandate.
 - In aggregate, 99.8% of individuals subject to SB 855 have coverage for SUD treatment premandate.

Determining Public Demand for the Proposed Mandate

This subsection discusses public demand for the benefits SB 855 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:

- Considers the bargaining history of organized labor; and

⁵⁷ 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.

⁵⁸ See method documents posted at http://chbrp.com/analysis_methodology/cost_impact_analysis.php; in particular, see *2019 Cost Analyses: Data Sources, Caveats, and Assumptions*.

- Compares the benefits provided by self-insured health 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 description treatment or service. 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 SB 855 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 content experts about the possibility of varied second year impacts and determined the second year's impacts of SB 855 would be substantially the same as the impacts in the first year (see Table 1). Minor changes to utilization and expenditures are due to population changes between the first year postmandate and the second year postmandate.

APPENDIX D PUBLIC HEALTH CALCULATIONS

Background

Classification of mental disorders in the DSM-5

Within the 20 classes, DSM-5 recognizes more than 300 mental disorder diagnoses.

1. Neurodevelopmental Disorders
2. Schizophrenia Spectrum and Other Psychotic Disorders
3. Bipolar and Related Disorders
4. Depressive Disorders
5. Anxiety Disorders
6. Obsessive-Compulsive and Related Disorders
7. Trauma- and Stressor-Related Disorders
8. Dissociative Disorders
9. Somatic Symptom Disorders
10. Feeding and Eating Disorders
11. Elimination Disorders
12. Sleep-Wake Disorders
13. Sexual Dysfunctions
14. Gender Dysphoria
15. Disruptive, Impulse Control and Conduct Disorders
16. Substance Use and Addictive Disorders
17. Neurocognitive Disorders
18. Personality Disorders
19. Paraphilic Disorders
20. Other Disorders

Symptoms of Substance Use Disorder

For each substance class, there are 10 possible symptoms of substance use disorder. The diagnosed severity ranges from mild (2 to 3 symptoms); moderate (4 to 5 symptoms); severe (6+ symptoms).

1. Wanting to cut down or stop using the substance but not managing to.
2. Spending a lot of time getting, using, or recovering from use of the substance.
3. Cravings and urges to use the substance.
4. Not managing to do what you should at work, home, or school because of substance use.
5. Continuing to use, even when it causes problems in relationships.
6. Giving up important social, occupational, or recreational activities because of substance use.

7. Using substances again and again, even when it puts you in danger.
8. Continuing to use, even when you know you have a physical or psychological problem that could have been caused or made worse by the substance.
9. Needing more of the substance to get the effect you want (tolerance).
10. Development of withdrawal symptoms, which can be relieved by taking more of the substance.

Common Mental Health Treatment Settings

Outpatient Treatment – individual and group therapy sessions occurring weekly or monthly for milder or well-managed mental health conditions (e.g., mild depression, anxiety, managed bipolar disorder). May also include monthly medication management visits.

Crisis Stabilization – Overnight residential services 24/7 for a limited time to stabilize acute symptoms, evaluate treatment needs, and develop plans to meet patient needs. Commonly used to deter unnecessary inpatient hospitalization. (CARF, 2020).

Intensive Outpatient Treatment - The intensive outpatient program consists of a scheduled series of sessions appropriate to the person-centered plans of the persons served. These may include services provided during evenings and on weekends and/or interventions delivered by a variety of service providers in the community. The program may function as a step-down program from partial hospitalization, detoxification, or residential services; may be used to prevent or minimize the need for a more intensive and restrictive level of treatment; and is considered to be more intensive and integrated than traditional outpatient services. (CARF, 2020).

Partial Hospitalization - time limited, medically supervised programs that offer comprehensive, therapeutically intensive, coordinated, and structured clinical services. Available at least five days per week, but may also offer half-day, weekend, or evening hours where series of structured, face-to-face therapeutic sessions occur at various levels of intensity and frequency. Used when a person is not a danger to themselves or others and used as an alternative to inpatient hospitalization. (CARF, 2020).

Residential - *Acute* care residential settings provide time-limited, 24/7 care depending on need for people with mental health conditions or co-occurring conditions. Crisis residential programs provide community-based short-term stays for those experiencing a psychiatric crisis. California established this system to reduce unnecessary ED visits and hospitalizations, and support jail diversion. (<https://www.dhcs.ca.gov/services/MH/Documents/CrisisResidentialProgramsMarch2010.pdf>).

Inpatient - There are several types of facilities for those with serious mental disorders requiring acute care and stabilization. California has 139 facilities with 6,777 beds providing inpatient care; 25 (primarily rural) counties have no psychiatric beds (CHA, 2019).

- General Acute Care Hospitals with psychiatric unit: 79 facilities with 3,504 beds;
- Psychiatric Health Facilities (PHF), which are limited to 16 beds; 28 facilities with 500 beds;
- Stand-alone psychiatric hospitals; 32 facilities with 2,773 beds; and
- 32 facilities with 746 inpatient beds accept children.

(Note: Emergency departments [EDs] have become a default treatment site for people experiencing untreated psychiatric emergencies. Though not usually a preferred setting for mental health care, EDs offer universal access to care for a crisis. As of 2016, California had 7,889 treatment stations (beds) in 334 EDs; 4.2% of ED visits were made for mental disorders.) (<https://www.chcf.org/wp-content/uploads/2018/08/CAEmergencyDepartments2018.pdf>).

APPENDIX E 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 The Kennedy Forum in February 2020.

American Society of Addiction Medicine (ASAM). State code references to ASAM criteria for medical necessity criteria used by insurers. Unknown date.

Bogner HR and McClintock HF. Costs of coexisting depression and diabetes. *Journal of General Internal Medicine* 31(6):594-5. March 23, 2016.

Ettner SL et al. Benefit-cost in the California treatment outcome project: Does substance abuse treatment “pay for itself”? *Health Services Research* 41:1. February 2006.

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Melek SP, et al. Potential economic impact of integrated medical-behavioral healthcare. *Milliman Research Project*. January 2018.

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Yohanan M. Mental Health Parity: Where have we come from? Where are we now? MCG. June 2017. Available at <https://www.ahip.org/wp-content/uploads/2017/06/MCG-White-Paper-Mental-Health-Parity.pdf>.

The following information was submitted by Ryan Hampton, Director and Advocate, the Voices Project, in February 2020.

Hamilton R. Personal communication regarding SB 855. Letter by e-mail. February 4, 2020.

The following information was submitted by Alice Hayes in February 2020.

Hayes A. Personal communication regarding SB 855. E-mail. February 4, 2020, which offered the following citations:

National Academies of Sciences, Engineering, and Medicine. Medications for Opioid Use Disorder Saves Lives, 2019. *The National Academies Press*.

National Quality Forum. Enhancing Access to Medication-Assisted Treatment, 2019. *The National Quality Forum*.

Elitzer J, Tatar M. Why Health Plans Should Go to the “MAT” in the Fight Against Opioid Addiction, 2017. *The California Health Care Foundation*.

United States Government Accountability Office. OPIOID USE DISORDER: Barriers to Medicaid Beneficiaries' Access to Treatment Medications, 2020. *United States Government Accountability Office*. GAO-20-233.

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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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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