

INFORMATIONAL HEARING
Thursday, October 18, 2001
1:30 p.m. – Room 4202

Implementation of AB 88 (Mental Health Parity)

Introduction

The Assembly Health Committee hearing will review the status of the implementation of AB 88 (Thomson), Chapter 534, Statutes of 1999, which requires health care service plans and health insurers (health plans) to provide coverage for the medically necessary treatment of severe mental illnesses of a person of any age, and serious emotional disturbances of children under the same terms and conditions as is provided for any other illness. AB 88 applies to contracts or policies issued, amended, or renewed on or after July 1, 2000.

Panels of state regulators, purchasers, health plans, health care providers and consumer representatives will present their experiences with implementation of AB 88, answer questions of the Assembly Health Committee members, and help identify the successes and problems with implementation of this legislation.

Background

In 1996, Congress passed and then-President Clinton signed into law a limited version of nondiscriminatory mental health insurance coverage – or parity insurance – in the Mental Health Parity Act (MHPA) of 1996 (H.R. 3666). MHPA, however, only applied to group health plans that provide medical, surgical and mental health benefits, and required that health plans have, at minimum, the same lifetime limits and annual dollar limits for mental health benefits as the plan does for medical and surgical benefits. MHPA did not require health plans to provide mental health coverage and did not prohibit the practice of placing arbitrary caps on inpatient stays and outpatient visits or higher copayments and deductibles for mental health services. It also exempted small employers and individual plan contracts and contained other limitations that allowed most health plans to continue making meaningful coverage for mental health services unaffordable for most Americans. MHPA took effect January 1, 1998, and sunset September 30, 2001. The

federal law, however, acted as a catalyst to states' enacting stronger mental health parity laws.

During the 1990s, the use of managed care increased in the health care delivery system nationwide. By using managed care techniques such as preauthorization of services, provider networks, and utilization review, managed care caused a continuing reduction in hospital stays nationwide, containing the cost of health care. Continued discriminatory insurance practices against the mentally ill were coming under increasing scrutiny by the public with the advances of medical science producing breakthrough medications for the treatment of severe mental illnesses, particularly schizophrenia. Empirical data from the RAND Corporation in 1997 and again in 1998, along with reports to Congress from the National Institute of Mental Health reviewed the actual cost experience in several states which passed parity laws that showed that lifting the limits for mental health benefits caused only nominal increases in costs. In 1998, then-President Clinton signed an executive order providing equitable treatment for mental illness and substance abuse for all federal employees. The experience and research data on mental health parity weakened the rationale for limiting the coverage for the equitable treatment of mental illnesses.

California was the 28th state to enact a mental health parity law. AB 88, signed by Governor Gray Davis on September 27, 1999, reflected a fifteen-year legislative and grass roots battle against insurance discrimination that imposed arbitrary limits on inpatient days and outpatient visits, and high co-payments and deductibles on mental health benefits.

Assembly Bill 88

AB 88 requires health plans to provide coverage for the medically necessary treatment of severe mental illnesses of a person of any age, and the serious emotional disturbances of children under the same terms and conditions as is provided for any other illness.

Severe mental illnesses includes:

- (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. [see attachment 2 for a fact sheet on eating disorders.]

Serious emotional disturbances of children are 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 [see attachment 1] of the Welfare and Institutions Code.

Applicable benefits include:

- (1) Outpatient services.
- (2) Inpatient hospital services.
- (3) Partial hospital services.
- (4) Prescription drugs, if the plan contract includes coverage for prescription drugs.

Terms and conditions include, but are not limited to:

- (1) Maximum lifetime benefits.
- (2) Copayments.
- (3) Individual and family deductibles.

AB 88 was signed along with several other managed care reform bills including legislation that created a new Department of Managed Health Care (DMHC) to oversee health care service plans and implement managed health care legislation. DMHC has been working with the author's office to interpret and oversee the implementation of the bill consistent with the intent of the law as health plans geared up and started providing parity benefits as required by AB 88.

Implementation

It has been more than a year since AB 88 took effect. Some of the challenges in implementation have been:

- How to educate health plan enrollees of what to expect in mental health benefits.
- How to educate health plan personnel in order to provide accurate information on mental health parity benefits to callers.
- How to update health plan data banks to ensure effective communication on coverage between providers, enrollees, and the health plan.
- How to ensure enough providers are on HMO panels to cover the demand by new enrollees.
- How to ensure that health plans are making all reasonable efforts to comply with the new law.

Discussion Questions

All panelists were provided with the following questions from which they could organize their presentations for the hearing. They were advised to choose the questions that they feel they have experience to answer.

1. Explain the steps your organization/group has taken to implement AB 88.
2. Did you "gear up" to prepare for AB 88 taking effect on July 1, 2000? If so, how?
3. Do you consider the implementation process over? Why or why not? What is left to be done?
4. What is working well in the process of implementation? (e.g., what are you doing differently that you believe has improved access to mental health services?)
5. Approximately how many complaints has your organization received regarding implementation? Who complained? Family members? Enrollees? Providers? What were the most common complaints? How have you attempted to resolve them?
6. Examples of complaints Assemblymember Thomson has received since AB 88 took effect are the following:
 - Family members calling on behalf of their minor child with autism. The health plan has told the family that AB 88 means they will cover behavioral therapy but has denied coverage for speech and occupational therapy -- services which are often necessary to treat autistic children.
 - Enrollees calling because they can not find a provider on a health plan panel that will take new patients.
 - Enrollees calling because the health plan had denied outpatient visits beyond a certain number.
 - Enrollees calling because they have to switch mental health providers because the health plan has carved out the mental health benefit and their current provider is not on the health plan provider panel.
 - Enrollees being advised by health plan personnel who say the health plan cannot contract with an individual provider for the purpose of allowing an enrollee to stay with their current provider, even if there is good reason to allow it.
 - Enrollees being denied mental health parity benefits because they are receiving their benefits from an out-of-state company, which is being governed by a weaker parity law.

What suggestions can you offer to resolve these complaints?

7. Has there been any experience in California showing that lifting the limits on benefits for the treatment of severe mental illnesses and serious emotional disturbances of children resulted in significant cost increases to health plans?
8. What does data show on the experience of California employers on access, utilization, and the mix of available mental health services?
9. Does empirical data show an increase or decrease in utilization of mental health services? Does that data include information regarding an increase or decrease in the

quality of those services?

10. One of the major behavioral health companies has chosen to drop the pre-authorization of services requirement for psychiatrists. Has there been any significant impact on costs due to that action? If not, are other carve out companies interested in following suit?
11. Are health plan provider panels providing sufficient numbers of available mental health providers to cover the demand for equitable mental health services?
12. Are there any requirements established by health plans that health care providers on health plan panels be available to new patients? What oversight is provided by health plans to ensure that enrollees have access to mental health services?
13. Are health plans meeting the requirement in Section 1367 of the Health and Safety Code that the plan is required to furnish services in a manner providing continuity of care and ready referral of patients to other providers at times as may be appropriate consistent with good professional practice? Are health plans meeting the requirement in that section that all services are required to be readily available at reasonable times to all enrollees, and to the extent feasible, the plan is required to make all services readily accessible to all enrollees?
14. What is the percentage of HMO patients compared to non-HMO patients for providers who are part of an HMO provider panel?
15. How frequently are provider lists updated?
16. What steps have been taken by health plans to educate their employees of the requirements of AB 88? Have employees who answer consumer hot lines been instructed how to handle calls involving AB 88 issues?
17. AB 88 did not include equitable coverage for substance abuse services. Have there been any significant problems providing effective mental health services to enrollees with a dual diagnosis who do not have access to equitable substance abuse services?
18. Since AB 88 took effect, have there been any complaints that enrollees are unable to access affordable mental health services because their diagnosis did not meet the criteria in AB 88? If so, how many complaints have there been? Do you see any evidence of "diagnostic drift"? Should the diagnostic categories be expanded or eliminated?

ATTACHMENT 1:
California Welfare and Institutions Code Section 5600.03

5600.3. To the extent resources are available, the primary goal of use of funds deposited in the mental health account of the local health and welfare trust fund should be to serve the target populations identified in the following categories, which shall not be construed as establishing an order of priority:

(a) (1) Seriously emotionally disturbed children or adolescents.

(2) For the purposes of this part, "seriously emotionally disturbed children or adolescents" means minors under the age of 18 years who have a mental disorder 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, which results in behavior inappropriate to the child's age according to expected developmental norms. Members of this target population shall meet one or more of the following criteria:

(A) As a result of the mental disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following occur:

(i) The child is at risk of removal from home or has already been removed from the home.

(ii) The mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment.

(B) The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.

(C) The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.

(b) (1) Adults and older adults who have a serious mental disorder.

(2) For the purposes of this part "serious mental disorder" means a mental disorder which is severe in degree and persistent in duration, which may cause behavioral functioning which interferes substantially with the primary activities of daily living, and which may result in an inability to maintain stable adjustment and independent functioning without treatment, support, and rehabilitation for a long or indefinite period of time. Serious mental disorders include, but are not limited to, schizophrenia, as well as major affective disorders or other severely disabling mental disorders. This section shall not be construed to exclude persons with a serious mental disorder and a diagnosis of substance abuse, developmental disability, or other physical or mental disorder.

(3) Members of this target population shall meet all of the following criteria:

(A) The person has a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a substance use disorder or developmental disorder or acquired traumatic brain injury pursuant to subdivision (a) of Section 4354 unless that person also has a serious mental disorder as defined in paragraph (2).

(B) (i) As a result of the mental disorder the person has substantial functional impairments or symptoms, or a psychiatric history demonstrating that without treatment there is an imminent risk of decompensation to having substantial impairments or symptoms.

(ii) For the purposes of this part, "functional impairment" means being substantially impaired as the result of a mental disorder in independent living, social relationships, vocational skills, or physical condition.

(C) As a result of a mental functional impairment and circumstances the person is likely to become so disabled as to require public assistance, services, or entitlements.

(4) For the purpose of organizing outreach and treatment options, to the extent resources are available, this target population includes, but is not limited to, persons who are any of the following:

(A) Homeless persons who are mentally ill.

(B) Persons evaluated by appropriately licensed persons as requiring care in acute treatment facilities including state hospitals, acute inpatient facilities, institutes for mental disease, and crisis residential programs.

(C) Persons arrested or convicted of crimes.

(D) Persons who require acute treatment as a result of a first episode of mental illness with psychotic features.

(c) Adults or older adults who require or are at risk of requiring acute psychiatric inpatient care, residential treatment, or outpatient crisis intervention because of a mental disorder with symptoms of psychosis, suicidality, or violence.

(d) Persons who need brief treatment as a result of a natural disaster or severe local emergency.

ATTACHMENT 2: BULIMIA AND ANOREXIA

FACTS

Anorexia (A): 10% of sufferers die from this disease.

Bulimia (B): The most common serious illness, second only to suicide, among teen and young adult women.

- Nearly equal numbers of boys and girls affected by eating disorders up to age 12 and after age 32. Between 12 and 32, more girls than boys affected (ratio 90% - 10%). After age 45 and with increasing age, more men than women may be affected.
- Essential treatment components (A&B):
 - Nutrition evaluation and counseling to patients and family.
 - Medication.
 - Psychotherapeutic intervention.
 - Medical and dental evaluation and monitoring.

Note: All of the above are necessary for effective treatment and clinical outcome.

- Symptoms (A&B):
 - Rapid weight loss (15lbs in less than 4 weeks);
 - Russell's Sign (B) -- hand calluses from 8 to 9 episodes of bingeing and vomiting in a day)
 - Fatigue, swelling of salivary glands, sensitivity to cold, changes in skin, hair, and nails.
- If untreated (A&B):
 - Death -- Ten year follow-up reveals 10% death rate and increased rate of suicide (A).
 - Malnutrition (A.).
 - Cardiac arrest (B).
 - Growth retardation -- children and teenagers.
 - Infertility -- young adults; Osteoporosis (decalcification) of bones from absent menstruation.
 - Teeth casualties – enamel destruction.
 - Cardiac problems from upset of electrolytes, potassium and other mineral defects.
- Frequently accompanied by other severe illnesses (A&B): Obsessive Compulsive Disorder, Depression, Anxiety, and Substance Abuse (B).
- Prevention – As health insurance benefits improve, eating disorders are destigmatized; early recognition, active multi-modal treatment, prevention of relapse, education in schools, colleges, public media.

Source: Barton J. Blinder, M.D., Ph.D., Clinical Professor

Director of Eating Disorders Research
Department of Psychiatry and Human Behavior
College of Medicine
University of California, Irvine