



CALIFORNIA
HEALTH BENEFITS REVIEW PROGRAM

August 13, 2010

The Honorable William Monning
Chair, California Assembly Committee on Health
State Capitol, Room 6005
10th and L Streets
Sacramento, CA 95814

The Honorable Elaine Alquist
Chair, California Senate Committee on Health
State Capitol, Room 5108
10th and L Streets
Sacramento, CA 95814

Via E-mail only

Dear Assembly Member Monning and Senator Alquist:

I am writing in response to the July 15, 2010 inquiry from Assembly Member William Monning, Chair of the Assembly Health Committee, regarding Assembly Bill (AB) 1600 Mental Health Services.

The California Health Benefits Review Program (CHBRP) submitted *Analysis of Assembly Bill 1600 Mental Health Services* on March 19, 2010. The full report is available at: <http://www.chbrp.org/analyses.html>. That report considered the version of the bill as introduced on January 4, 2010.

This letter responds to the request of the Assembly Health Committee Chair to re-examine the findings of CHBRP's original analysis based on the following considerations:

- The provisions of the federal Patient Protection and Affordable Care Act which was further amended by the Health Care and Education Reconciliation Act and collectively referred to as the "Affordable Care Act" (ACA) of 2010;
- The provisions of the federal Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 and its effects on mental health and substance use (MH/SA)¹ benefits for the Healthy Families Program;
- The provisions of the federal Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 and its effects on MH/SA benefits for California Public Employees' Retirement System (CalPERS) health plan enrollees;
- The potential administrative savings AB 1600 may provide to the state and the insurance industry due to potential simplification of MH/SA benefit requirements; and,
- Expected amendments to AB 1600 that would eliminate "V code" conditions and nicotine dependence from among the conditions required to be covered.

¹ MH/SA stands for "mental health and substance abuse." "Substance use" and "substance abuse" are both used interchangeably, and the acronym "SA" is used for both terms throughout this letter as well as CHBRP's March 19th analysis.

A detailed discussion of each consideration follows. A brief summary of CHBRP's re-examination of its analysis, given these considerations, is presented on the final page.

Potential Implications of the ACA

On March 23, 2010, the federal government enacted the federal Patient Protection and Affordable Care Act (P.L.111-148), which was further amended by the Health Care and Education Reconciliation Act (H.R.4872) signed into law on March 30, 2010. These laws (referred to as “the Affordable Care Act” or “ACA”) were enacted after CHBRP's analysis of AB 1600 was submitted.

ACA provisions that go into effect prior to January 1, 2011

CHBRP's analysis of state-level benefit mandate bills typically address the marginal effects in the year following implementation—specifically, how the mandate would impact benefit coverage, utilization, costs and public health, holding all other factors constant.

Some provisions in the ACA went into effect upon enactment, or will go into effect before the effective date of AB 1600 (which would be January 1, 2011). The ACA provisions discussed below would affect CHBRP's “baseline” estimates of health care expenditures, premiums, the number of persons who are insured, and their sources of insurance. Effects on these estimates would depend on a number of factors, including pending federal and state-level actions to implement the ACA, as well as market forces. However, these effects should not be attributed to the marginal or incremental effects of a particular state mandate bill.

The following provisions are examples of ACA provisions that may affect the baseline population and cost estimates for 2011:

- The ACA would allow children and young adults up to 26 years of age to have coverage under his/her parent's health plan.² According to the California Health Interview Survey approximately 28% of Californians aged 19-25 (959,000) were estimated to be uninsured at some point in 2007. As a result of the ACA, many of these young adults will likely gain access to group health insurance through a parent. This dynamic may diminish the number of uninsured and may shift some young adults from the individually-purchased health insurance market into the group market. The Departments of Treasury, Labor, and Health and Human Services estimate, for 2011, the number of young adults newly covered by his/her parent's plan would be about 0.78 to 2.12 million (using high and low take-up rate assumptions respectively). Of these young adults about 0.2 to 1.64 million would have previously been uninsured. The corresponding incremental cost impact to group insurance policies is estimated to be a premium increase of 0.5% to 1.2%.³
- The ACA makes funds available for the establishment of interim high-risk pools in 2010 and allows those to be run at the state level until 2014, when enrollees are expected to be transitioned into the

² “Grandfathered” plans may exclude adult children as dependants if they have access to employer sponsored insurance until 2014. See Department of the Treasury, Department of Labor, and Department of Health and Human Services. *Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act; Interim Final Rule and Proposed Rule*, Federal Register: 75: 116: pages 34538-34570, June 17, 2010.

³ Department of the Treasury, Department of Labor, and Department of Health and Human Services. *Group Health Plans and Health Insurance Issuers Relating to Dependent Coverage of Children to Age 26 Under the Patient Protection and Affordable Care Act; Interim Final Rule and Proposed Rule*, Federal Register: 75: 92: pages 27122- 27140, May 13, 2010.

Exchange (which will not be limited to high-risk populations).⁴ The California Legislature has passed, and the Governor signed, AB 1887 and SB 227. The resulting statutes provide for the establishment of the California Pre-existing Conditions Insurance Plan (PCIP), which will be administered by the Managed Risk Medical Insurance Board (MRMIB) and federally funded per the ACA's interim high-risk pool provisions. California submitted its application detailing its plans to implement the PCIP under these provisions to the U.S. Department of Health and Human Services (HHS) on July 6, 2010. The creation of the PCIP and subsequent enrollment into the program could increase the number of insured in 2011 since the program is designed to enroll those who did not have continuous health insurance coverage for 6 months and did not have credible health insurance coverage at the point of passage of the ACA. California's application states that expected costs are estimated to be \$761 million for the period of 2010-2013 for a monthly enrollment of 24,150 individuals.⁵

- The ACA would prohibit plans and policies from using lifetime benefit limits or unreasonable annual benefit limits for all group plans effective September 23, 2010.⁶ The U.S. Departments of Treasury, Labor, and Health and Human Services are to promulgate regulations clarifying what constitutes "unreasonable" annual benefit limits. Those Interim Final Rules are expected to be forthcoming in the very near future.

Provisions that go into effect by 2014 and beyond

Some ACA provisions that go into effect by 2014 or beyond would dramatically affect California's health insurance markets and their regulatory environment. Examples of such provisions follow:

- ACA provisions would require most U.S. citizens and qualified legal residents to have health insurance and would require large employers to offer health insurance or a tax-free credit to their employees to purchase health insurance.
- ACA provisions would establish state-based health insurance Exchanges. Qualified health plans (QHPs) offering plans in the small group and individual markets would be required to have minimum benefit standards. Subsidies for low-income individuals would be available to purchase health insurance through the Exchanges.
- ACA provisions would expand eligibility for Medicaid (Medi-Cal in California).

How these provisions are implemented in California would largely depend on regulations yet to be promulgated by federal agencies and statutory and/or regulatory actions yet to be undertaken by the California state government. Provisions that seek to expand Medicaid eligibility are an example. Effective 2014, the ACA expands Medicaid to cover adults with incomes up to 133% of the federal poverty level (FPL). On June 4, 2010, California submitted its Section 1115 waiver application to expand Medi-Cal eligibility for adults aged 19-64. According to the waiver application, "California plans to build on its current county-based coverage initiative so that in 2014, this population can become fully enrolled statewide and receive the federally required benchmark benefit package." The waiver application also seeks to phase in coverage for adults with incomes above the ACA benchmark (including those with incomes between 133%-200% of the FPL) either through county operated initiatives or through the Exchange.⁷ California is

⁴ Affordable Care Act, Section 1101. This section was effective 90 days after enactment.

⁵ *Solicitation for State Proposals to Operate Qualified High Risk Pools: Application for the State of California*. Submitted July 6, 2010. Available at: http://www.mrmib.ca.gov/MRMIB/High_Risk_Pool/Solicitation_for_State_Proposals_to_Operate_Qualified_HRPs.pdf. Accessed on August 5, 2010.

⁶ Affordable Care Act, Section 2711.

⁷ Correspondence from Toby Douglas, Chief Deputy Director, Health Care Programs, Department of Health Care Services, to Cindy Mann, Director, Center for Medicaid and State Operations, Department of Health and Human Services, Centers for Medicare & Medicaid Services, June 4, 2010. Available at:

currently in negotiations with the Centers for Medicare and Medicaid Services (CMS) and will submit a final waiver application by September 1, 2010. California's ability to enroll those who are newly eligible will depend on the success of the Section 1115 waiver application.⁸

More directly pertinent to AB 1600, ACA provisions related to the Exchange are another example of provisions that would interact with current and future state mandates that require coverage of mental health and substance use benefits. Only plans that meet certain requirements will be certified as QHPs eligible for sale through the Exchange in the small-group and individual markets. QHPs will be required to cover an "essential health benefits package," which specifically includes "[m]ental health and substance use disorder services, including behavioral health treatment."⁹ These provisions also require that the scope of the essential health benefits be equal to the scope of benefits provided under a typical employer plan. Furthermore, the parity requirements of the federal MHPAEA will also apply to QHPs "in the same manner and to the same extent" as they apply to health insurance issuers and group health plans.^{10, 11} Therefore, it is possible that any impacts of AB 1600 in the longer term (or beyond 2014), would be mitigated by these ACA requirements following the establishment of the Exchange. However, as noted, the effects are dependent upon the details of pending federal regulations and state legislative and regulatory actions.¹²

Potential Implications of CHIPRA

Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) requires States' Children's Health Insurance Programs (S-CHIP) to comply with the federal (MHPAEA).^{13, 14} Currently, California's S-CHIP program, Healthy Families, covers mental illnesses but limits inpatient care to a 30-day annual limit and limits outpatient visits to 20 visits with a higher copayment than for medical services. These benefit limits are for those conditions that are not already mandated under current law, such as "severe mental illness" (SMI)¹⁵ and "serious emotional disturbances" (SED) of a child. In California, the Managed Risk Medical Insurance Board (MRMIB) administers the Healthy Families Program, the Major Risk Medical Insurance Program (MRMIP), and the Access for Infants and Mothers program (AIM). According to MRMIB, Healthy Families will become compliant with CHIPRA (and, therefore with the MHPAEA) before AB 1600 would take effect.¹⁶ In addition, MRMIB indicates that the Healthy Families Program would continue to provide coverage for non-SMI/SED mental health services and substance use services. Taking

<http://www.dhcs.ca.gov/provgovpart/Documents/CMS%20Waiver%20Submission%20Ltr%20206-3-10.pdf>. Accessed on August 3, 2010.

⁸ Insure the Uninsured Project, *California's §1115 Medicaid Waiver Renewal Summary, Thoughts, and Analysis on Coverage Expansion*, July 22, 2010 Available at: <http://www.itup.org/blog/media/users/cliff/ITUP%20Waiver%20Thoughts%207-22-10%20Final.pdf>. Accessed on August 3, 2010.

⁹ Affordable Care Act, Section 1302(b)(1)(E).

¹⁰ There remains some ambiguity as to how this provision interacts with the MHPAEA's exemption for small employer groups.

¹¹ Affordable Care Act, Section 1311(j).

¹² Currently, at least two active bills in the California Legislature – AB 1602 and SB 900 – directly seek to implement, in different manners, provisions of the ACA relating to the establishment of a state-level Exchange.

¹³ CHIPRA, Section 502.

¹⁴ Correspondence from Cindy Mann, Director, Center for Medicaid and State Operations, Department of Health and Human Services, Centers for Medicare & Medicaid Services, to State Health Official, November 4, 2009 (SHO 09-014) available at <https://www.cms.gov/SMDL/downloads/SHO110409.pdf>, Accessed on August 3, 2010

¹⁵ Section 1374.72 to California's Health and Safety Code and Section 10144.5 to the Insurance Code defines "serious mental illness" as nine specific diagnoses: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, panic disorder, obsessive compulsive disorder, pervasive developmental disorders or autism, anorexia nervosa, and bulimia nervosa.

¹⁶ Personal correspondence with John Symkowick, Legislative Coordinator, Managed Risk Medical Insurance Board, August 11, 2010.



this into consideration, CHBRP's utilization and cost estimates for Healthy Families as presented in the March 19th analysis of AB 1600 would be reduced to about a zero impact.

Currently, AIM has mental health and substance use benefits that are similar to Healthy Families—but with inpatient day limits and outpatient visit limits for non-SMI and SED mental health conditions. There remains some legal ambiguity as to whether the AIM program is subject to the provision of CHIPRA requiring compliance with MHPAEA.¹⁷ If subject, then AIM would also need to make adjustments to current benefits to comply with federal laws and, therefore, the program would be in compliance with AB 1600 when it goes into effect. CHBRP estimated a small utilization and cost impact associated with AIM in its March 19th Analysis. These estimates would be reduced to about a zero impact if AIM is deemed to be subject to the relevant CHIPRA provision.

Potential Implications of MHPAEA on CalPERS and Medi-Cal Managed Care

AB 1600 explicitly exempts plans contracting with CalPERS and also explicitly exempts Medi-Cal Managed Care plans. Therefore CHBRP's March 19th *Analysis of AB 1600 (Mental Health Services)* estimates no impact of the mandate on these publicly-funded plans.

This section responds to the question posed in the July 15th Letter regarding the potential impacts of the MHPAEA on coverage requirements of CalPERS health maintenance organization (HMO) plans. We also include information regarding requirements on Medi-Cal Managed Care plans since such information is available.

The MHPAEA applies to non-federal government plans that are fully insured. This includes CalPERS HMO plans.¹⁸ To achieve compliance with MHPAEA, CalPERS HMOs made changes to their mental health and substance use benefits, effective January 1, 2010 and have coverage at parity for mental health and substance use services.¹⁹ Therefore, it would appear that CalPERS HMO plans are already in compliance with AB 1600's provisions to cover those services to treat non-SMI/SED mental health conditions and substance use services at parity.

According to the Centers for Medicare & Medicaid Services, the MHPAEA would apply to those managed care plans that contract with state agencies to cover Medicaid beneficiaries.²⁰ Therefore, it would appear that Medi-Cal Managed Care Plans that contract with the California Department for Health Care Services should

¹⁷ Ibid.

¹⁸ "State-sponsored group health plans are subject to MHPAEA requirements to the same extent as other employer-sponsored plans that cover active employees, or both active employees and retirees, when an employer that sponsors the plan employs at least 51 employees...if CalPERS covers both active employees and retirees, it is subject to MHPAEA requirements by virtue of the fact that the plan is 'established or maintained for its employees by the Government . . . of any State or political subdivision thereof, or by any agency or instrumentality of any of the foregoing.' [T]he sponsor of a self-funded, nonfederal governmental plan may elect to exempt its self-funded plan(s) from certain requirements of title XXVII of the PHS Act." Personal correspondence with David Holstein, Health Insurance Specialist, Division of Private Health Insurance, Medicare Enrollment & Appeals Group, Centers for Medicare & Medicaid Services, July 27, 2010.

¹⁹ Kaiser Permanente, *CalPERS: Health Maintenance Organization: Combined Evidence of Coverage and Disclosure Form for the Basic Plan and the Managed Medicare Health Plans*, Effective January 1, 2010. Blue Shield of California, *CalPERS: Health Maintenance Organization: NetValue HMO: Combined Evidence of Coverage and Disclosure Form for the Basic Plan and the HMO Supplement to Original Medicare*, Effective January 1, 2010; Blue Shield of California, *CalPERS: Health Maintenance Organization: Access+ HMO: Combined Evidence of Coverage and Disclosure Form for the Basic Plan and the HMO Supplement to Original Medicare*, Effective January 1, 2010.

²⁰ Correspondence from Cindy Mann, Director, Center for Medicaid and State Operations, Department of Health and Human Services, Centers for Medicare & Medicaid Services, to State Health Official, November 4, 2009 (SHO 09-014). Available at <https://www.cms.gov/SMDL/downloads/SHO110409.pdf>. Accessed on August 3, 2010.



already be in compliance with AB 1600's provisions to cover those services to treat non-SMI/SED mental health conditions and substance use services at parity.

Potential Implications of the MHPAEA on California's High Risk Pools

As discussed above, California is in the process of implementing the ACA provisions to establish the state's PCIP. In addition, California has a state-funded high risk pool, MRMIP, with enrollment of approximately 7,000 people. According to MRMIB, which administers MRMIP and will administer the PCIP, the federal MHPAEA would not be applicable to these programs because the MHPAEA places requirements on group health plans which are defined as an employer-sponsored plan.^{21,22} MRMIP currently provides less than full-parity coverage for non-SMI/SED mental health services (limited to 10 days inpatient and 15 visits outpatient per year) and limits substance use benefits to medically-necessary inpatient detoxification.²³ Given that MRMIP plans would have to make some changes to its MH/SA benefits to comply with AB 1600 after enactment, a relatively small utilization and cost impact would continue to remain.²⁴

CHBRP's March 19th analysis did not consider the potential impact of AB 1600 on the PCIP since that program has yet to be established. The California PCIP preliminary summary of benefits appears to match MRMIP coverage, applying the same day/visit limits on non-SMI/SED mental health service coverage and does not explicitly specify the benefits for substance use treatment.²⁵ Whether the PCIP is subject to state benefit mandates would depend on how the program is ultimately administered and implemented. However, federal interim final regulations appear to exempt the PCIP from the requirements of both the MHPAEA and state-level mandates.^{26,27} If this is the case, then AB 1600 would have no impact on the PCIP program.

²¹ Personal correspondence with John Symkowick, Legislative Coordinator, Managed Risk Medical Insurance Board, August 11, 2010.

²² Personal correspondence with David Holstein, Health Insurance Specialist, Division of Private Health Insurance, Medicare Enrollment & Appeals Group, Centers for Medicare & Medicaid Services, July 27, 2010.

²³ Anthem Blue Cross, *Major Risk Medical Insurance Program (MRMIP) Preferred Provider Organization (PPO) Service Agreement and Combined Evidence of Coverage and Disclosure Form*, Effective January 1, 2010. Kaiser Foundation Health Plan, Inc. Southern California Region, *Major Risk Medical Insurance Program Disclosure Form and Evidence of Coverage*, Effective January 1, 2010. Kaiser Foundation Health Plan, Inc. Northern California Region, *Major Risk Medical Insurance Program Disclosure Form and Evidence of Coverage*, Effective January 1, 2010.

²⁴ CHBRP reports typically include the cost impact estimates related to MRMIP and AIM along with the estimates provided for the Healthy Families program because those programs total about 14,000 enrollees while Healthy Families enrollment totals approximately 800,000. Given the relative size of the MRMIP population, the relative cost estimates would be on the order of about 1% of the projections presented in the March 19th analysis.

²⁵ *Solicitation for State Proposals to Operate Qualified High Risk Pools: Application for the State of California*. Submitted July 6, 2010.

Available at:

http://www.mrmib.ca.gov/MRMIB/High_Risk_Pool/Solicitation_for_State_Proposals_to_Operate_Qualified_HRPs.pdf

Accessed on August 5, 2010.

²⁶ Department of the Treasury, Department of Labor, and Department of Health and Human Services. *Pre-Existing Condition Insurance Plan Program; Interim Final Rule*, Federal Register: 75: 146: pages 45014-45033, July 30, 2010.

²⁷ The *Pre-Existing Condition Insurance Plan Program; Interim Final Rule*, Section II.G states that "the high risk pools do not meet the definition of a group health plan or a health insurance issuer pursuant to sections 2791(a)(1) and 2791(b)(2) of the PHS Act" and Section 152.40 states that "[t]he standards established under this section shall supersede any State law or regulation, other than State licensing laws or State laws relating to plan solvency, with respect to PCIPs which are established in accordance with this section."



Potential Administrative Cost Impacts as a Result of AB 1600

The July 15th Letter asks CHBRP to consider whether there may be potential administrative savings given that AB 1600 may provide a single coverage standard that simplifies and clarifies coverage issues related to mental health and substance abuse benefits.

CHBRP's method for determining the administrative costs or "administrative load" associated with a mandate is based on a proportion of the total premium associated with the benefit. Depending on the market segment (e.g. individual market versus the large group market) the administrative load may vary from 15%-33%.

Each type of plan or policy is subject to its own requirements and these must be considered in addressing the administrative cost question. Some complexities in coverage requirements would remain since there are portions of the market that are not subject to AB 1600. As discussed above, AB 1600 contain provisions that explicitly exempt Medi-Cal Managed Care and CalPERS HMOs from the bill. In addition, it is important to note that there are portions of the California market that are generally not subject to state benefit mandate laws: these include Medi-Cal fee-for-service, Medicare Advantage plans, Medicare fee-for-service, plans for state and local government employees which are self-insured such as CalPERS PPOs, and the self-insured market that is governed under the **Employee Retirement Income Security Act (ERISA)**.

Potential Impacts of the Expected Amendments

Amendments that the bill author, Assembly Member Jim Beall expects to take were attached to the July 15th letter submitted to CHBRP. CHBRP was asked to assess how those amendments would impact the findings presented in the March 19th *Analysis of AB 1600 Mental Health Services*. The expected amendments are included in Attachment A.

Elimination of "V Codes"

The expected amendments would allow DMHC-regulated plans and CDI-regulated policies to explicitly exclude those "V codes" as specified in the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM IV). V codes are a subset of the non-SMI mental health diagnoses that are not mandated under current California law and include a broad range of diagnoses including adult antisocial behavior and bereavement. In general, the V codes included in the expected amendment mirrors the list included in the DSM-IV but a few discrepancies are worth noting:

- The amendment lists "V61.1" as the V code for physical/sexual abuse of adults, whereas the DSM-IV lists "V61.12." According to the DSM-IV this code is used only "if focus of clinical attention is on the perpetrator and abuse is by partner." If the focus of clinical attention is on an adult victim, code 995.81 should be used for physical abuse and code 995.83 for sexual abuse. This may be interpreted to require coverage for mental health services for the victim of the abuse (i.e., the adults whose partners physically or sexually abuse them) because the amendment does not exclude coverage for codes 995.81 and 995.83. However, the amendment would not require coverage for mental health services for the partner perpetrating the abuse on his/her partner.
- The amendment lists "V62.2" as the V code for an occupational problem, whereas the DSM-IV lists "V62.29." as the corresponding code for an occupational problem.
- The amendment does not list the V code "V62.83." This code is used for physical or sexual abuse of an adult "if focus of clinical attention is on the perpetrator and abuse is by person other than partner." In other words, this V code is used as a diagnosis for an individual perpetrating abuse on

someone other than his/her partner. If the focus of clinical attention is on an adult victim, code 995.81 should be used for physical abuse and code 995.83 for sexual abuse.

The elimination of the V codes as a required benefit coverage under AB 1600 would affect CHBRP's March 19th analysis in the following manner:

Medical Effectiveness: The medical effectiveness analysis would largely remain unchanged as a result of the amendments related to the V code conditions. CHBRP's medical effectiveness analysis focused on studies of the impact of parity in coverage for mental health and substance use services (MH/SA) on use of services. None of these studies specifically examined the diagnoses associated with the V codes. Therefore the conclusions regarding the effects of parity coverage on utilization of MH/SA services would continue to be relevant.

Cost, Coverage and Utilization Impacts: CHBRP estimates of the marginal or "post-mandate" costs following implementation of AB 1600 was modeled on all plans and policies moving to broad and comprehensive coverage of MH/SA benefits. Those who currently have broad coverage for non-SMI mental health benefits at full parity or have limited (or non-parity) coverage for non-SMI mental health benefits are likely to have some coverage for V code conditions. The remaining proportion of the population with no coverage for non-SMI mental health benefits (approximately 1.41%) is not likely to have coverage for "V code" conditions.

If AB 1600 were to be enacted with the expected amendments, it is unclear whether those plans and policies that currently include broad coverage for non-SMI mental health benefits would explicitly exclude the V code conditions from coverage. It is also unclear whether those plans and policies that do not cover or provide limited coverage for non-SMI mental health benefits would explicitly exclude coverage for V code conditions post-mandate. In order to estimate the impact of this amendment, CHBRP would need to conduct a survey of coverage and research what proportion of non-SMI mental health diagnosis and associated utilization can be attributed to V-codes. Such data may or may not be available. In addition, diagnoses associated with V-codes may also be captured through use of other codes (e.g. due to comorbidity with other MH/SA conditions). Based on a preliminary analysis, CHBRP estimates that this amendment may result in a lower estimate of cost and utilization by a small to an immaterial amount.

Public Health Impacts: The overall conclusion provided in the public health impacts analysis would largely remain unchanged as a result of the amendments related to the V code conditions. It is likely that AB 1600 would still have positive health outcomes for those enrollees who are newly covered for mental health or substance use disorder services. Additionally, it is likely that AB 1600 would have positive health outcomes for some enrollees whose coverage is expanded from limited MH/SA benefits to full parity.

Elimination of Nicotine Dependence

The expected amendment would eliminate nicotine dependence as one of the conditions to be covered under the substance use benefit under AB 1600. This amendment would affect CHBRP's March 19th Analysis in the following manner:

Medical Effectiveness: The medical effectiveness analysis would largely remain unchanged as a result of the amendments related to nicotine dependence. There is strong evidence that smoking cessation counseling and pharmacotherapy are effective.²⁸ However, as CHBRP's medical effectiveness analysis focused on studies of the impact of parity in coverage for mental health and substance abuse services (MH/SA) on use

²⁸ See CHBRP, *Analysis of Senate Bill 220: Health Care Coverage: Tobacco Cessation Services* (2010).

Available at: http://www.chbrp.org/docs/index.php?action=read&bill_id=107&doc_type=3. Accessed on August 10, 2010.

of services rather than on the effectiveness of treatments for any specific disorder, such as nicotine dependence, the conclusions regarding the effects of parity coverage on utilization of MH/SA services would continue to be relevant.

Cost, Coverage and Utilization Impacts: The cost and utilization projections that were presented in the March 19th report would be lower as a result of the expected amendments. This is because eliminating the requirement to cover nicotine dependence would likely lower the post-mandate utilization rates, and the post-mandate costs (premiums, expenditures, out of pocket costs).

Based on a preliminary analysis the expected amended version of AB 1600 would likely have the following cost impacts as compared to CHBRP's March 19th analysis:²⁹

- Estimates for **total annual expenditures** would decrease from \$44,917,000 (0.06%) to \$43,453,000 (0.06%)
- Estimates for **premium expenditures by private employers for group insurance** would decrease from \$25,386,000 (0.06%) to \$24,482,000 (0.06%)
- Estimates for **premium expenditures for individually purchased insurance** would decrease from \$28,792,000 (0.48%) to \$28,623,000 (0.48%), and
- Estimates for **individual out-of-pocket expenditures for covered benefits** (deductibles, copayments, etc.) would decrease from -\$18,212,000 (-0.31%) to -17,715,000 (-0.30%).

Public Health Impacts: The overall conclusion provided in the public health impacts analysis would largely remain unchanged, as it is likely that AB 1600 would still have positive health outcomes for those enrollees who are newly covered for mental health or substance use disorder services and have positive health outcomes for some of those enrollees whose coverage is expanded from limited MH/SA benefits to full parity.

The public health discussion notes that tobacco use is a leading cause of premature death, resulting in about 36,687 deaths in California each year. It stands to reason that eliminating the requirement to cover treatment for nicotine dependence would decrease the public health benefits of AB 1600. However, the ACA includes provisions requiring coverage of tobacco cessation, potentially mitigating the effects of any related California requirement. Specifically, effective September 23, 2010, the ACA requires coverage of preventive services that are rated "A" or "B" by the U.S. Preventive Services Task Force (USPSTF).³⁰ Providing tobacco cessation interventions to those who use tobacco products is rated at Grade A. Combination therapy with counseling and medications is considered more effective than either component alone.

In addition, tobacco cessation will be considered part of the essential health benefits package to be provided by QHPs providing coverage in the small-group and individual markets through the state-based insurance Exchanges, effective in 2014. Therefore, any effects a state-level requirement to cover nicotine dependence treatment might be diminished by these ACA requirements.

Summary

The following summarizes the key points of this letter:

²⁹ This estimate also includes the elimination of costs associated with the Healthy Families Program as discussed on page 4.

³⁰ This requirement does not apply to "grandfathered" plans. Department of the Treasury, Department of Labor, and Department of Health and Human Services. *Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services under the Patient Protection and Affordable Care Act*, Federal Register: 75: 137: pages 41726-41760, June 19, 2010.



- The expected amendment's provisions to eliminate the requirement to cover nicotine dependence would have a dampening effect on the cost impact estimates (as originally presented in CHBRP's March 19th analysis). While it stands to reason this provision would decrease the public health benefits of AB 1600, it may be that the ACA's requirement to cover tobacco cessation interventions may counteract that effect.
- The expected amendment's provisions to eliminate the requirement to cover diagnoses associated with the "V" codes may have a slight dampening effect on the cost impacts, however, given the lack of data on utilization of services associated with these V codes, and lack of information on the use of these codes in general, it is not possible to quantify how slight those effects may be. The medical effectiveness analysis as presented in CHBRP's March 19th analysis would continue to be relevant as it focused on studies of the impact of parity in coverage for MH/SA benefits on use of services.
- The CHIPRA provision that requires compliance with MHPAEA would appear to eliminate the impacts of AB 1600 on Healthy Families, as confirmed by MRMIB.
- Finally, after 2014, the ACA's provisions related to the Exchange may dampen any impacts of AB 1600 on the small group and individual markets, depending on the details of pending federal regulations and state legislative and regulatory actions.

My colleagues and I appreciate the opportunity to respond to your questions, and we are happy to respond to any additional questions you may have. Please feel free to contact me at your convenience.

Thank you.

Sincerely,



Susan Philip, MPP
 Director, CHBRP
 Division of Health Sciences and Services
 University of California, Office of the President

cc: Assembly Member Jim Beall, Author of Assembly Bill 1600
 Assembly Member John Pérez, Speaker of the Assembly
 Senator Darrell Steinberg, President Pro Tem of the Senate
 Assembly Member Nathan Fletcher, Vice Chair, Assembly Committee on Health
 Assembly Member Felipe Fuentes, Chair, Assembly Committee on Appropriations
 Assembly Member Connie Conway, Vice Chair, Assembly Committee on Appropriations
 Senator Tony Strickland, Vice Chair, Senate Committee on Health
 Senator Christine Kehoe, Chair, Senate Committee on Appropriations
 Senator Roy Ashburn, Vice Chair, Senate Committee on Appropriations
 Senator Ron Calderon, Chair, Senate Committee on Banking, Finance, and Insurance
 Senator Dave Cogdill, Vice Chair, Senate Committee on Banking, Finance, and Insurance
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Agnes Lee, Director, Senate Office of Research
Jennifer Kent, Deputy Legislative Secretary, Office of Governor Arnold Schwarzenegger
Steve Poizner, Insurance Commissioner, California Department of Insurance
David Link, Deputy Commissioner, California Department of Insurance
Cindy Ehnes, Director, California Department of Managed Health Care (DMHC)
Sherrie Lowenstein, Senior Supervising Counsel/Legislative Coordinator, California DMHC
Mark Yudof, President, University of California, Office of the President (UCOP)
Dan Dooley, Senior Vice President, External Relations, UCOP
Steve Juarez, Associate Vice President and Director, State Governmental Relations, UCOP
Angela Gilliard, Legislative Director, State Governmental Relations, UCOP
John Stobo, Senior Vice President, Health Sciences and Services, UCOP
Lauren LeRoy, President and CEO, Grantmakers In Health and CHBRP,
National Advisory Council Chair

SP/kw



Attachment A: Text of Expected Amendments to AB 1600

This version revises the text to incorporate the amendments submitted to CHBRP on July 15, 2010. The text of the amendments, as submitted to CHBRP, can be located below the amended language.

ASSEMBLY BILL No. 1600

Introduced by Assembly Member Beall

January 4, 2010

An act to add Section 22856 to the Government Code, to add Section 1374.74 to the Health and Safety Code, and to add Section 10144.8 to the Insurance Code, relating to health care coverage.

Legislative Counsel's Digest

AB 1600, as introduced, Beall. Health care coverage: mental health services.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Under existing law, a health care service plan contract and a health insurance policy are required to provide coverage for the diagnosis and treatment of severe mental illnesses of a person of any age. Existing law does not define "severe mental illnesses" for this purpose but describes it as including several conditions.

This bill would expand this coverage requirement for certain health care service plan contracts and health insurance policies issued, amended, or renewed on or after January 1, 2011, to include the diagnosis and treatment of a mental illness of a person of any age and would define mental illness for this purpose as a mental disorder defined in the Diagnostic and Statistical Manual IV, subject to regulatory revision, as specified. The bill would specify that this requirement does not apply to a health care benefit plan, contract, or health insurance policy with the Board of Administration of the Public Employees' Retirement System unless the board elects to purchase a plan, contract, or policy that provides mental health coverage.

Because this bill would expand coverage requirements for health care service plans, the willful violation of which would be a crime, it would impose a state-mandated local program.

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



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

Vote: majority. Appropriation: no. Fiscal committee: yes.

State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 22856 is added to the Government Code, to read:

22856. The board may purchase a health care benefit plan or contract or a health insurance policy that includes mental health coverage as described in Section 1374.74 of the Health and Safety Code or Section 10144.8 of the Insurance Code.

SEC. 2. Section 1374.74 is added to the Health and Safety Code, to read:

1374.74. (a) A health care service plan contract issued, amended, or renewed on or after January 1, 2011, that provides hospital, medical, or surgical coverage shall provide coverage for the diagnosis and medically necessary treatment of a mental illness of a person of any age, including a child, under the same terms and conditions applied to other medical conditions as specified in subdivision (c) of Section 1374.72. The benefits provided under this section shall include all those set forth in subdivision (b) of Section 1374.72.

(b) (1) "Mental illness" for the purposes of this section means a mental disorder defined in the Diagnostic and Statistical Manual of *Mental Disorders* IV, published by the American Psychiatric Association, and includes substance abuse, *but excludes treatment of the following diagnoses, all as defined in the manual:*

(A) Noncompliance With Treatment (V15.81).

(B) Partner Relational Problem (V61.1).

(C) Physical/Sexual Abuse of an Adult (V61.1).

(D) Parent-Child Relational Problem (V61.20).

(E) Child Neglect (V61.21).

(F) Physical/Sexual Abuse Of a Child (V61.21).

(G) Sibling Relational Problem (V61.8).

(H) Relational Problem Related to a Mental Disorder or General Medical Condition (V61.9).

(I) Occupational Problem (V62.2).

(J) Academic Problem (V62.3).

(K) Acculturation Problem (V62.4).

(L) Relational Problems (V62.81).

(M) Bereavement (V62.82).

(N) Borderline Intellectual Functioning (V62.89).

(O) Phase of Life Problem (V62.89).

(P) Religious or Spiritual Problem (V62.89).

(Q) Malingering (V65.2).

(R) Adult Antisocial Behavior (V71.01).

(S) Child or Adolescent Antisocial Behavior (V71.02).

(T) There is not a Diagnosis or a Condition on Axis I (V71.09).



(U) There is not a Diagnosis on Axis II (V71.09).

(V) Nicotine Dependence (305.10).

(2) Following publication of each subsequent volume of the manual, the definition of “mental illness” shall be subject to revision to conform to, in whole or in part, the list of mental disorders defined in the then-current volume of the manual.

(3) Any revision to the definition of “mental illness” pursuant to paragraph (2) shall be established by regulation promulgated jointly by the department and the Department of Insurance.

(c) (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) 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 to the extent permitted by law or regulation.

(d) 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.

(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) This section shall not apply to a health care benefit plan or contract entered into with the Board of Administration of the Public Employees’ Retirement System pursuant to the Public Employees’ Medical and Hospital Care Act (Part 5 (commencing with Section 22750) of Division 5 of Title 2 of the Government Code) unless the board elects, pursuant to Section 22856 of the Government Code, to purchase a health care benefit plan or contract that provides mental health coverage as described in this section.

(g) This section shall not apply to accident-only, specified disease, hospital indemnity, Medicare supplement, dental-only, or vision-only health care service plan contracts.



SEC. 3. Section 10144.8 is added to the Insurance Code, to read:

10144.8. (a) A policy of health insurance that covers hospital, medical, or surgical expenses in this state that is issued, amended, or renewed on or after January 1, 2011, shall provide coverage for the diagnosis and medically necessary treatment of a mental illness of a person of any age, including a child, under the same terms and conditions applied to other medical conditions as specified in subdivision (c) of Section 10144.5. The benefits provided under this section shall include all those set forth in subdivision (b) of Section 10144.5.

(b) (1) “Mental illness” for the purposes of this section means a mental disorder defined in the Diagnostic and Statistical Manual *of Mental Disorders* IV, published by the American Psychiatric Association, and includes substance abuse, *but excludes treatment of the following diagnoses, all as defined in the manual:*

(A) Noncompliance With Treatment (V15.81).

(B) Partner Relational Problem (V61.1).

(C) Physical/Sexual Abuse of an Adult (V61.1).

(D) Parent-Child Relational Problem (V61.20).

(E) Child Neglect (V61.21).

(F) Physical/Sexual Abuse Of a Child (V61.21).

(G) Sibling Relational Problem (V61.8).

(H) Relational Problem Related to a Mental Disorder or General Medical Condition (V61.9).

(I) Occupational Problem (V62.2).

(J) Academic Problem (V62.3).

(K) Acculturation Problem (V62.4).

(L) Relational Problems (V62.81).

(M) Bereavement (V62.82).

(N) Borderline Intellectual Functioning (V62.89).

(O) Phase of Life Problem (V62.89).

(P) Religious or Spiritual Problem (V62.89).

(Q) Malingering (V65.2).

(R) Adult Antisocial Behavior (V71.01).

(S) Child or Adolescent Antisocial Behavior (V71.02).

(T) There is not a Diagnosis or a Condition on Axis I (V71.09).

(U) There is not a Diagnosis on Axis II (V71.09).

(V) Nicotine Dependence (305.10).

(2) Following publication of each subsequent volume of the manual, the definition of “mental illness” shall be subject to revision to conform to, in whole or in part, the list of mental disorders defined in the then-current volume of the manual.

(3) Any revision to the definition of “mental illness” pursuant to paragraph (2) shall be established by regulation promulgated jointly by the department and the Department of Managed Health Care.

(c) (1) For the purpose of compliance with this section, a health 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 health 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, health 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) In the provision of benefits required by this section, a health insurer may utilize case management, managed care, or utilization review to the extent permitted by law or regulation.

(4) Any action that a health 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).

(d) This section shall not apply to accident-only, specified disease, hospital indemnity, or Medicare supplement insurance policies, or specialized health insurance policies, except behavioral health-only policies.

(e) This section shall not apply to a policy of health insurance purchased by the Board of Administration of the Public Employees' Retirement System pursuant to the Public Employees' Medical and Hospital Care Act (Part 5 (commencing with Section 22750) of Division 5 of Title 2 of the Government Code) unless the board elects, pursuant to Section 22856 of the Government Code, to purchase a policy of health insurance that covers mental health services as described in this section.

SEC. 4. 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.



Amendment text (submitted to CHBRP on July 15, 2010):

AMENDMENTS TO ASSEMBLY BILL NO. 1600

Amendment 1

On page 2, line 19, after "Manual" insert:

of Mental Disorders

Amendment 2

On page 2, line 21, after "abuse" insert:

, but excludes treatment of the following diagnoses, all as defined in the manual:

- (A) Noncompliance With Treatment (V15.81).
- (B) Partner Relational Problem (V61.1).
- (C) Physical/Sexual Abuse of an Adult (V61.1).
- (D) Parent-Child Relational Problem (V61.20).
- (E) Child Neglect (V61.21).
- (F) Physical/Sexual Abuse of a Child (V61.21).
- (G) Sibling Relational Problem (V61.8).
- (H) Relational Problem Related to a Mental Disorder or General Medical Condition (V61.9).
- (I) Occupational Problem (V62.2).
- (J) Academic Problem (V62.3).
- (K) Acculturation Problem (V62.4).
- (L) Relational Problems (V62.81).
- (M) Bereavement (V62.82).
- (N) Borderline Intellectual Functioning (V62.89).
- (O) Phase of Life Problem (V62.89).
- (P) Religious or Spiritual Problem (V62.89).
- (Q) Malingering (V65.2).
- (R) Adult Antisocial Behavior (V71.01).
- (S) Child or Adolescent Antisocial Behavior (V71.02).
- (T) There is not a Diagnosis or a Condition on Axis I (V71.09).
- (U) There is not a Diagnosis on Axis II (V71.09).
- (V) Nicotine Dependence (305.10)

Amendment 3

On page 4, line 18, after "Manual" insert:

of Mental Disorders

Amendment 4

On page 4, line 20, after "abuse" insert:

, but excludes treatment of the following diagnoses, all as defined in the manual:

- (A) Noncompliance With Treatment (V15.81).
- (B) Partner Relational Problem (V61.1).



- (C) Physical/Sexual Abuse of an Adult (V61.1).
- (D) Parent-Child Relational Problem (V61.20).
- (E) Child Neglect (V61.21).
- (F) Physical/Sexual Abuse of a Child (V61.21).
- (G) Sibling Relational Problem (V61.8).
- (H) Relational Problem Related to a Mental Disorder or General Medical Condition (V61.9).
- (I) Occupational Problem (V62.2).
- (J) Academic Problem (V62.3).
- (K) Acculturation Problem (V62.4).
- (L) Relational Problems (V62.81).
- (M) Bereavement (V62.82).
- (N) Borderline Intellectual Functioning (V62.89).
- (O) Phase of Life Problem (V62.89).
- (P) Religious or Spiritual Problem (V62.89).
- (Q) Malingering (V65.2).
- (R) Adult Antisocial Behavior (V71.01).
- (S) Child or Adolescent Antisocial Behavior (V71.02).
- (T) There is not a Diagnosis or a Condition on Axis I (V71.09).
- (D) There is not a Diagnosis on Axis II (V71.09).
- (V) Nicotine Dependence (305.10)

