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**A Snapshot of the
Implementation of
California's Mental
Health Parity Law**

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*Timothy Lake
Alicia Sasser
Cheryl Young
Brian Quinn*

Submitted to:

California HealthCare Foundation
476 Ninth Street
Oakland, California 94607

Submitted by:

Mathematica Policy Research, Inc.
50 Church Street, 4th Floor
Cambridge, MA 02138
(617) 491-7900

Project Officer:
Jan Eldred

Project Director:
Timothy Lake

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EXECUTIVE SUMMARY

In 1999, California passed a mental health parity law—referred to as Assembly Bill 88 (AB88)—that requires private health insurance plans to provide equal coverage for physical health and selected mental health conditions, including serious mental illnesses (SMI) in adults and serious emotional disturbances (SED) in children. The law requires health plans to eliminate the benefit limits and reduce the cost-sharing requirements that have traditionally made mental health benefits less comprehensive than physical health benefits. These include higher copayments and deductibles and limits on the number of outpatient visits or inpatient days covered.¹

Ultimately, the expansion of mental health benefits under AB88 is intended to improve access to and quality of mental health services for people with SMI and SED. Other goals of the law are decreasing the financial burden on California’s public sector in providing mental health services, ending discriminatory practices in the provision of mental health benefits, and reducing the stigma associated with mental illness and the delivery of mental health services (California Senate Rules Committee 2001).

In summer 2001, the California HealthCare Foundation commissioned Mathematica Policy Research, Inc. (MPR) to conduct an early “snapshot” study of the implementation of California’s mental health parity law. The study’s purpose was to assess the perceived objectives, initial experiences, and anticipated outcomes of the new law after its first year of implementation. Results from the study are intended to help identify the early successes, as well as the remaining challenges, in implementing the parity law. MPR interviewed more than 60 individuals representing more than three dozen stakeholder organizations at the state and local levels, including representatives from state and county governments, health plans, providers, employers, and consumer advocates.

¹Self-insured health plans are exempted from state mental health parity laws under the Employee Retirement Income Security Act (ERISA).

Stakeholders reported that most aspects of the implementation of AB88 during the first year have gone smoothly. They agreed that health insurance benefits for mental health services have been expanded in compliance with the law's mandate. In addition, the law does not appear to have had any adverse consequences on the health insurance market to date, such as large increases in premiums or decreases in health insurance offerings by employers.

Nevertheless, stakeholders identified several issues and remaining challenges related to the implementation of AB88 during the first year:

- The transition to managed behavioral health organizations (MBHOs) by some health plans in response to the law caused initial disruptions in care for some consumers. These disruptions appear to have been exacerbated by inadequate communication efforts and a short lead time for implementing these changes.
- The implementation of “partial parity” for a limited set of SMI and SED diagnoses, rather than all mental health diagnoses, has created administrative challenges and caused confusion for some stakeholders.
- The role of the private sector in delivering services to children with SED needs further clarification, especially given the traditional role of the public sector in providing children's services.
- Consumer education about expanded benefits needs to be improved in order to facilitate increased access to care under AB88.

In summary, an important goal of AB88 appears to have been achieved during the first year of implementation; but much work remains to be done to make the parity law a success in future years. In particular, mental health benefits have been expanded to conform with the parity mandate, but it will take time and additional effort to address such goals as reducing stigma and improving access to care for people with mental illness. The law has prompted discussions among stakeholders about such issues as the responsibility for additional education efforts, the availability of mental health providers in health plan networks, the delivery and management of mental health services in a managed care environment, and the delivery and coordination of mental health services for children by both the private and public sectors. Finally, there is a broad consensus that the full impact of parity may not be known for several years, until consumers become more aware of the expanded benefits.

CHAPTER I

INTRODUCTION

In 1999, California passed a mental health parity law—referred to as Assembly Bill 88 (AB88)—that requires private health insurance plans to provide equal coverage for physical health and the following selected mental health conditions:

- Severe mental illnesses (SMI), including schizophrenia, schizoaffective disorder, bipolar disorder (manic depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, and bulimia nervosa
- Serious emotional disturbances (SED) of a child, other than a primary substance abuse disorder or developmental disorder, that result in behavior inappropriate to the child’s age, according to expected developmental norms¹

Governor Gray Davis signed the bill into law in September 1999, and it became effective in July 2000. The law requires health plans to eliminate the benefit limits and cost-sharing requirements that have traditionally made mental health benefits less comprehensive than

¹To qualify for parity-level coverage, children must meet one or more of the following functional criteria: substantial functional impairments; risk of removal from the home; a mental disorder or impairment that has been present for more than six months; psychosis, risk of suicide or violence due to a mental disorder; or eligibility for special education. They also must be diagnosed with a mental health condition listed in Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).

physical health benefits. These include higher copayments and deductibles, and limits on the number of outpatient visits or inpatient days covered.²

The expansion of mental health benefits under AB88 ultimately is intended to improve access to, and the quality of, mental health services for people with SMI or SED. Other goals of the law include decreasing the financial burden on California's public sector in providing mental health services, ending discriminatory practices in the provision of mental health benefits, and reducing the stigma associated with mental illness and the delivery of mental health services (California Senate Rules Committee 2001).

Thirty-three other states currently have mental health parity laws. California's law is similar to those of 18 states that have restricted their parity laws to either SMI or "biologically based" conditions. The law is more narrowly defined than 15 other state parity laws that cover all mental health diagnoses. It also excludes coverage for substance abuse treatment. Currently, 13 states have extended parity to include treatment of substance abuse (Gitterman et al. 2000; and Rosenbach et al. 2001).

California is one of the few states with a mental health parity law that focuses specifically on children's conditions such as SED and autism. Only Vermont, Tennessee, Arkansas, and Maryland have specific provisions in their parity laws that mandate broader children's coverage than California; these states cover any diagnoses in the DSM-IV or ICD-10, regardless of the child's functioning. In April 2000, Massachusetts became the second state to enact a separate children's provision for the treatment of children with SED (Peck 2001).

Like most other states with parity laws, AB88 mandates that mental health services be covered as part of the overall health benefit package offered by health plans. That is, mental health benefits cannot be offered as an option to purchasers. Unlike some state parity laws, and the federal parity law, AB88 provides no exemption for benefits offered to either individuals or small groups, or on the basis of actual or expected cost increases (Gitterman et al. 2000; and GAO 2000).³ The law also includes specific provisions allowing health plans to pursue managed care or other cost-containment strategies—including the use of specialized mental health plans, or managed behavioral health organizations (MBHOs) and managed care arrangements, such as utilization review, case management, and networks of mental health providers.

AB88 was enacted concurrently with a number of consumer protection and managed care-related laws. The Department of Managed Health Care (DMHC) was created to provide regulatory oversight for these new laws. DMHC has responsibility for monitoring

²Self-insured health plans are exempted from state mental health parity laws under the Employee Retirement Income Security Act (ERISA).

³The federal parity law, which expired in September 2001, requires congressional legislation for renewal.

the implementation of AB88 and ensuring compliance with it for managed care plans.⁴ To date, DMHC's primary concerns have been to ensure that health plans fully disclose information about benefit changes to their enrollees, and that enrollees have appropriate access to care under AB88. The agency has also taken steps to clarify how health plans and employers may subcontract to managed behavioral health organizations, while continuing to ensure compliance with the law. The agency has not promulgated state regulations regarding AB88.

STUDY OVERVIEW

In summer 2001, the California HealthCare Foundation commissioned Mathematica Policy Research, Inc. (MPR) to conduct an early "snapshot" study of the implementation of California's mental health parity law. The study's purpose was to assess the perceived objectives, initial experiences, and anticipated outcomes of the new law after its first year of implementation. Results from the study are intended to help identify the early successes, as well as the remaining challenges, in implementing the parity law.

From September to November 2001, MPR interviewed more than 60 individuals representing more than three dozen stakeholder organizations at the state and local levels. These individuals represented the following stakeholder groups:

- ***State and county government officials.*** Representatives from the Department of Managed Health Care, the Department of Mental Health, county mental health departments, and the office of Assembly Member Helen Thomson, the bill's sponsor
- ***Health plans.*** Medical directors and other staff from eight major health plans (including the seven largest plans in the state) as well as medical directors of the managed behavioral health organizations associated with some of these plans
- ***Employers.*** At the state level, several employer purchasing groups, an insurance underwriter, and a statewide union; at the local level, both public and private employers representing large and small firms in the high technology, telecommunications, and education sectors

⁴DMHC also has responsibility for regulating Blue Cross and Blue Shield plans in California. The Department of Insurance regulates traditional indemnity health insurance plans, and is responsible for ensuring that these insurers comply with AB88.

- **Providers.** At the state level, state associations representing hospitals, psychiatrists, psychologists, social workers, and marriage and family therapists; at the local level, the behavioral health and administrative directors of two multi-specialty medical groups, two behavioral health independent practice associations (IPAs), and one hospital system, as well as two psychiatrists in private practice
- **Consumers.** Statewide and local consumer advocacy groups representing adults, families, and parents of children with SED or other conditions

Most interviews were completed in about an hour and were conducted as open-ended discussions guided by a structured interview protocol created specifically for each stakeholder group. The interviews addressed the following topics:

- Perceived objectives of the parity law and anticipated effects on access to care for people with mental illness
- Education and communication efforts related to implementation of AB88, and the level of awareness and understanding of its provisions by stakeholders
- Changes in the organization and financing of mental health services, including the use of mental health “carve-out” organizations and efforts to manage utilization of mental health services
- Implementation challenges or other implications related to: (1) the limited set of mental health diagnoses addressed by the law; (2) the inclusion of autism, developmental disorders, and all serious emotional disturbances for children; and (3) the exclusion of substance abuse services from the parity mandate

This report presents the findings of these stakeholder interviews. Chapter II describes the changes that have occurred during the first year of implementation. Chapter III discusses stakeholder perceptions of the first year of implementation. Chapter IV presents the study’s conclusions.

CHAPTER II

BASIC CHANGES DURING THE FIRST YEAR OF IMPLEMENTATION

This chapter describes the key changes that occurred in the California health care market during the first year of implementation of AB88, discussing both expectations about these changes and stakeholders' actual experiences during this period.

First, we discuss the changes in mental health benefits that occurred as a result of the law. Although health plans were expected to expand benefits in compliance with the law, the extent of these expansions varied, given the differences across health plans in the level of mental and physical health benefits prior to AB88.

Second, we identify the changes that health plans have made in their mental health delivery systems for managing and delivering services covered under the expanded benefits. A key question for the study was how health plans would decide to contain costs and manage financial risk under the expansion of mental health benefits, and what new services, if any, they would provide under AB88.

Finally, we describe how benefit and system changes were communicated to consumers during the first year. All stakeholders—health plans, providers, employers, consumer advocates, and the state—had the potential to be involved in notification efforts; but it was not certain what role each of these groups would play in consumer education during the first year.

EXPANSION OF MENTAL HEALTH BENEFITS

All the health plans that we interviewed expanded coverage of mental health services in order to be compliant with AB88, typically as purchaser contracts came up for renewal on or after July 1, 2000. However, the extent of benefit changes for consumers varied because of

preexisting differences in the level of physical and mental health benefits prior to the parity law. Our interviews identified two important areas of variation: (1) whether consumers were enrolled in an HMO or PPO product, and (2) whether coverage was provided through large or small employers.

Prior to the parity law, typical HMO benefit packages were limited to coverage of 20 to 50 outpatient or office-based mental health visits and 30 to 60 inpatient days per year. Under AB88, these limits were eliminated for the diagnoses specified in the law. With passage of AB88, both inpatient and outpatient mental health copayments were reduced to be equal to physical health copayments. Typical outpatient mental health copayments prior to the parity law often were \$25 or more per visit, with some higher than \$50. These have now typically been reduced to \$10 or \$20 per visit.

Prior to the parity law, PPOs tended to provide less comprehensive mental health benefits than HMOs, although this is difficult to generalize, since benefit packages offered by PPOs tend to be less standardized than HMOs. Two health plans in California account for the vast majority of enrollees covered under PPO products subject to the parity law. In one plan, PPO coverage of mental health services was virtually nonexistent prior to parity. Some large employers, however, purchased separate benefit riders from this plan, in order to expand mental health coverage for their employees. In the other plan, there was wide variation in the level of PPO coverage across purchaser contracts, ranging from extremely limited benefit packages—with very high out-of-pocket cost-sharing provisions for enrollees—to more comprehensive packages that were already near parity with physical health benefits. Thus, the extent of benefit expansions under AB88 for consumers covered by PPO products varied widely.

Coverage also varied for consumers depending on the size of their employer. Small employers typically offered a “barebones” mental health benefit, or no benefit at all, prior to implementation of AB88. In contrast, some of the larger employers in the state offered mental health benefits that were on par with or even more comprehensive than what AB88 requires. For example, one large employer with approximately 300,000 employees moved toward a parity model in the year prior to AB88’s passage by expanding visit limits (to 50 visits per year) and by setting copayments for all mental health services equal to those for physical health services.

As a result, consumers working in small companies, and many of those covered by PPOs, tended to experience the largest increases in mental health benefits under AB88. Nonetheless, many stakeholders report that it is challenging to characterize a typical change in benefits for consumers, because of the variation in preexisting mental health and physical health benefit levels.

CHANGES IN MENTAL HEALTH DELIVERY SYSTEMS

Prior to AB88, health plans used a variety of approaches for delivering mental health services. Some plans in California delivered mental health services through large medical

II. Basic Changes During the First Year of Implementation

groups and IPAs for their HMO products. Based on data from Interstudy (2000), we estimate that about half of all HMO enrollees in California received mental health services through these groups. Under these arrangements, health plans delegated financial risk and responsibility for health care services (including mental health) to these provider organizations. Other plans “carved out” mental health services to MBHOs that specialize in delivery of these services.¹ A few plans used both an MBHO and medical groups for delivering mental health services.

Following passage of AB88, four of the eight health plans we interviewed made no major changes to their mental health delivery systems—continuing to use an MBHO, at-risk medical groups or IPAs, or a mix of both approaches. Together, these four plans represent a little less than half of HMO enrollment in California, but account for only a small percentage (7 percent) of PPO coverage:

- Two plans continued to contract with at-risk medical groups for their HMO products, either delegating responsibility for mental health services to these groups or providing services from within an integrated delivery system.
- One plan maintained its practice of delivering services through an MBHO or a delegated medical group, depending on the geographic location of its enrollees.
- One plan continued to rely exclusively on a subsidiary MBHO for providing mental health services.

The other four plans we interviewed (including two with substantial PPO enrollment) have shifted to, or increased their use of, MBHOs for delivering mental health services following implementation of AB88.

- One plan carved out mental health services from at-risk medical groups to a subsidiary MBHO for its HMO product, but has allowed selected medical groups to become members of the MBHO’s provider network.
- One plan using both at-risk medical groups and an MBHO has given all additional service responsibility (and financial risk) for expanded benefits under AB88 to the MBHO, including services exceeding the outpatient visit

¹MBHOs specialize in the delivery of mental health services through a network of contracted providers. Consumers typically access services by calling a toll-free telephone number and obtaining a list of network providers available in the local geographic area. Under these arrangements, primary care physicians and other providers who make an initial diagnosis of a mental health problem are also required to refer patients to the MBHO. Once a consumer begins seeking treatment from an MBHO provider, care is monitored by the MBHO.

or inpatient day limits that existed prior to the law. This plan continues to use at-risk medical groups to provide short-term “crisis” benefits.

- Two plans completely changed their mental health provider networks, shifting from at-risk medical groups to the exclusive use of MBHOs for mental health service delivery.

Health plans that made few changes in their approach tended to have relatively comprehensive mental health benefits prior to passage of AB88. Among these plans, few changes were also reported in the overall size and composition of existing provider networks (that is, the number or types of providers) or in the approaches to managing care.

In contrast, plans that shifted to an MBHO tended to have somewhat less comprehensive benefits prior to the parity law. One of these plans, in particular, had very limited mental health benefits prior to parity. Plans cited the ability of MBHOs to manage expanded mental health benefits and contain costs as their main rationale for making changes in their provider networks. They also cited the ease of contracting with a single entity, rather than multiple organizations, in responding to the parity law.

Some providers expressed concerns about the increased use of MBHOs by health plans—including the potential loss of coordination of care between primary care physicians and mental health specialists. Under carve-out arrangements, a primary care physician and the selected mental health provider in the MBHO may be less likely to have an established relationship with or pattern of communication for referred patients.² Depending on how stringently MBHOs manage mental health care, some are also concerned that these arrangements may reduce access to care. MBHOs typically allow for greater management of mental health services through the use of medical necessity criteria, utilization management, and prior authorization of treatment. Regardless of whether plans changed their overall delivery systems, many have also taken incremental steps during the first year to fill some of the gaps in provider networks and to ensure adequate access to AB88 services. Some plans have asked mental health providers within medical groups in underserved areas to apply for recertification since the July 1, 2000 implementation date. Others have contracted with mental health providers to provide crisis intervention services in areas where they have gaps in their network. One provider reported that health plans have negotiated single-case agreements in which a patient needing treatment will be sent to an out-of-network specialist who will be paid a higher fee for that case only.

NOTIFICATION ABOUT BENEFIT AND SYSTEM CHANGES

Consumers received notification about benefit changes under AB88 through several sources. Health plans usually sent a letter to employers or enrollees announcing changes in

²Other respondents noted, however, that there is little evidence documenting the quality of referral relationships in non-MBHO settings.

mental health benefits. Some employers also communicated the change in benefits to their employees, usually through brochures describing the basic list of benefits each plan offered during the open enrollment period. A major mental health consumer advocacy group in the state notified its members of the passage of AB88 and benefit changes related to the law. Stakeholders generally characterized media coverage regarding AB88 as uneven. The bill was covered extensively when it was being debated in the legislature, but there was little media coverage of the law following its passage.

Consumer education efforts on the part of the state have centered around more general patient advocacy efforts undertaken during the first year of implementation. The DMHC published a brochure through its Office of the Patient Advocate describing consumers' basic rights as HMO members, what the mental health parity law was, and what organizations to contact if consumers encountered problems with coverage or access. The brochures are distributed in response to consumers' specific questions or complaints about AB88. DMHC also collaborated with a large consumer advocacy group to provide a series of briefings for legislative district office staff responsible for addressing consumer concerns in their districts.

During the first year of implementation, mental health providers emerged as the primary educators of mental health consumers about the provisions of AB88, largely because providers usually are the first to be asked about changes in benefits. For example, in the department of psychiatry of one large multi-specialty group, patient questions have become so routine that department staff created a one-page handout for patients, informing them of the basic expansion in benefits, as well as their options for accessing mental health services following passage of AB88.

Providers expressed concern about the limited availability of staff resources for continuing education of consumers about changes related to AB88. As a result, providers often directed their patients to other resources—health plans, advocacy groups, or the state—that are designed to respond to individual consumer questions and complaints. Health plans indicate that they routinely answer questions from consumers regarding the change in benefits and how to access services. Consumer advocates note that some consumers have difficulty navigating the dispute-resolution process, and engage advocacy groups or caretakers to help them. Consumers were also advised by providers to call DMHC's toll-free hotline, known as the HMO Help Center, if there was a problem with their coverage or they were unable to gain access to care.

CHAPTER III

EARLY PERCEPTIONS OF THE IMPLEMENTATION OF MENTAL HEALTH PARITY IN CALIFORNIA

The transition to mental health parity was perceived as fairly smooth for most stakeholders. In fact, a basic expansion of mental health benefits was the most notable change for many of those we interviewed. The transition was especially uneventful for providers, purchasers, and consumers who were affiliated with health plans that made few changes to their delivery systems or that already offered fairly comprehensive mental health benefits. However, some stakeholders reported that they experienced complications due to delivery system or benefit design changes that were made during the first year.

This chapter presents the key findings from our interviews with stakeholders regarding their perceptions of the implementation of California's mental health parity law. First, we discuss some initial communication issues related to system changes regarding the delivery of mental health services. Second, we describe the key implementation challenges related to design aspects of AB88, including the law's coverage of a limited list of diagnoses, the exclusion of parity for substance abuse coverage, and its particular focus on children's conditions. Finally, we discuss stakeholder perceptions of initial effects of the law on delivery of mental health services and on the broader health insurance market.

COMPLICATIONS DURING THE INITIAL TRANSITION

Stakeholders identified two areas in which complications arose during the initial transition to parity-level coverage. These included confusion about how employers' direct contracts with MBHOs should be handled under AB88 and disruptions in care for some consumers as the result of increased use of MBHOs by health plans. Complications arising during the first year of implementation appear to be caused by, or at least exacerbated by, the lack of lead time in preparing for system changes and inadequate communication about

these changes. Some respondents in our interviews noted that there was less than a year in which to pursue options for changes in their delivery system, given that the law was signed in September 1999. However, one respondent noted that California state laws are usually implemented at the beginning of the next year (January), so that the mental health parity legislation provided six additional months of lead-time. Many also believe that some stakeholders could have been more proactive in their responses to the law, and more comprehensive in their communication efforts.

Confusion About Employer Contracts with Health Plans

Prior to the parity law, many large employers provided mental health benefits through a separate, carve-out arrangement with an MBHO, and offered physical health services through one or more full-service health plans. However, employer representatives report that one provision of AB88 caused initial confusion and ultimately forced some large employers to abandon their carve-out arrangements. In particular, full-service health plans were deemed ultimately responsible for ensuring mental health parity coverage under AB88, including coverage provided by separate carve-out companies that contracted directly with employers (DMHC 2000).

In response, full-service health plans have added “wraparound coverage” to ensure that enrollees’ mental health benefits (including those provided through the preexisting carve-out arrangement) were equal to the health plans’ physical health benefits under AB88. These plans have charged an additional premium to employers for the wraparound coverage, which is intended to ensure that enrollees have parity-level coverage in the cases where coverage offered in the carve-out arrangement is not equal to physical health benefits offered by the plans. However, employers believe that plans have overestimated the additional premium required to cover these services. Rather than pay twice to cover mental health benefits for employees in these full-service health plans, large employers typically dropped their preexisting coverage with the MBHO and bought the HMO mental health coverage for their employees. These large employers believe that an unintended consequence of the law is that they can no longer offer a uniform benefit to all of their employees, despite having provided a benefit that was sometimes richer than what was required under AB88.

Employers also expressed concern about inadequate notification about these issues from both health plans and the state. For example, one large employer reported that it was not informed of any potential contractual issues by health plans until June 2000—one month before the law became effective. The delayed notification left little time for employers to negotiate new contracts with health plans to cover AB88 diagnoses. In addition, DMHC did not issue an advisory addressing the coordination of mental health benefits for large employer groups until September 2000—after many of these contracts, which were to begin in January, had been negotiated.¹ Moreover, employers do not believe that the advisory fully

¹The advisory was issued two months after DMHC was created in July 2000.

resolved the underlying contract issues that they face, since health plans still require employers to purchase wraparound coverage.

Disruptions in Care For Consumers

Provider representatives and consumer advocates expressed concerns about disruptions in care for enrollees in the health plans that carved out mental health services to MBHOs for the first time under AB88. Some consumers had difficulty obtaining new sources of mental health care during this transition, and thus sought the assistance of their current providers. Plan representatives noted that many providers had declined the opportunity to participate in new MBHO networks, on either a transitional or permanent basis, because they felt that MBHO fees were too low. Thus, patients were given the choice of seeking care on a self-pay basis with their existing provider or changing to a new provider in the MBHO network. Providers in medical groups not participating in MBHO provider networks often needed to act as intermediaries for patients, helping them obtain appointments during the first six to eight months of implementation within new MBHO networks, even though patients were allowed to self-refer through use of a toll-free number.

Our interviews provide some evidence of the magnitude of consumer difficulties in accessing care during the transition to new systems of care under AB88. Several medical groups documented a surge in telephone calls during the first six months of implementation of AB88 from consumers who did not know how to access their care or obtain a referral through their health plans' new MBHO. One medical group documented a 250 percent increase in telephone volume to its psychiatry department—accompanied by a 9 percent decrease in the number of patient visits to the medical group—during the first six months after AB88 was implemented, compared to the previous six months. Providers also reported that patients often experienced waits of up to two hours when trying to schedule an appointment because MBHO toll-free telephone lines were inundated with calls. In response, one large medical group provided scheduling assistance for patients needing urgent or crisis care during the transition period to help them obtain care through the MBHOs.

Providers' role as the primary educators of consumers was complicated by the lack of timely communication from health plans about these system changes. They commented that written notifications from health plans were either cursory or confusing. In addition, providers noted that several health plans did not release their new provider panel lists until several weeks before the July 1 date. This further hindered the ability of providers to obtain referrals for their patients during the law's implementation.

One health plan in particular was widely criticized by providers for delays in communicating changes due to their late decision to carve out mental health services. A large medical group contracting with this health plan reported that they did not receive any notification until May 2000, regarding changes to be implemented by July 1, 2000. An administrator of a behavioral health group reported that, as late as September 2000—three months into implementation—neither the health plan nor the MBHO could give her clear operational guidance regarding AB88.

Ongoing contract renewals also complicated communication between health plans and providers as employers renewed their contracts with plans during the renegotiation process. Whereas renewals under the parity law occurred once for employers, it was an ongoing process for providers as patients' coverage changed at different times during the year. Providers had difficulty keeping track of individual changes in coverage and had to contact health plans in many cases to determine whether the patient was covered under AB88, and, if so, which providers the patient could see within the plan network.

ONGOING CHALLENGES RELATED TO THE DESIGN OF AB88

Most stakeholders believe that AB88's coverage of a limited set of SMI and SED diagnoses was appropriate in its focus on the most severe illnesses for adults and children, and in its concern for limiting cost increases. However, the focus on specific mental health diagnoses has also introduced some special challenges for the stakeholders we interviewed. These include the complexity associated with a partial list of mental health diagnoses covered under AB88, the effects of excluding parity-level coverage for substance abuse, and the challenges related to coverage of children's mental health conditions.

“Partial Parity” Adds Complexity to Delivery Systems

All of the health plan representatives we interviewed noted that AB88's focus on selected SMI and SED diagnoses (sometimes referred to as “partial parity”) has introduced new administrative challenges, including modifying claims adjudication systems to account for varying benefit structures for different diagnoses, developing policies for different copayment arrangements, notifying providers about these policies, and clarifying the definition of specific diagnoses in terms of DSM codes.

To avoid administrative difficulties and possible confusion on the part of consumers and providers, two plans decided to extend parity beyond the selected diagnoses in AB88. Other health plans have chosen to limit parity primarily to AB88 diagnoses to reduce their financial risk, but have made exceptions in certain areas. For example:

- One plan reduced copayment levels for all mental health diagnoses to simplify its cost-sharing approach, while maintaining outpatient visit and inpatient day coverage limits for non-AB88 diagnoses.
- One plan applied parity-level benefits (reduced cost-sharing and elimination of benefit limits) for all inpatient mental health diagnoses, since the vast majority of patients treated on an inpatient basis have AB88 diagnoses anyway. However, this plan still distinguishes between AB88 and non-AB88 diagnoses in changes made in the coverage of outpatient services.

- One plan has decided to apply parity-level copayments for new patients making initial outpatient visits, until a more permanent diagnosis (either covered or not covered by AB88) is made.

Providers also reported several challenges related to implementation of “partial parity.” For example, provider representatives said that variation in plans’ approaches has caused confusion among providers. Varying copayment policies for AB88 and non-AB88 diagnoses have also led to billing difficulties during the initial visits, when a diagnosis had not yet been established. Provider information systems do not distinguish copayment amounts based on diagnosis, thus making the new benefits difficult to administer.

Effects of Excluding Substance Abuse Coverage

Many stakeholders believe that parity coverage for substance abuse services, in addition to mental health services, would be helpful in improving clinicians’ ability to treat problems experienced by patients with co-occurring or “dual” diagnoses, including both mental illness and substance abuse.² Because private health plan coverage for substance abuse treatment typically emphasizes inpatient detoxification, with more limited coverage for rehabilitation and counseling, patients’ underlying chemical dependency disorders often receive relatively little treatment. Without coverage for these services, many providers believe that patients often fall into a cycle of detoxification and relapse, decreasing their chances for long-term recovery. In essence, the exclusion of substance abuse coverage leads to a “revolving door” where detoxification is covered under medical services, but subsequent rehabilitation is not, creating a break in treatment. Providers reported that this discontinuity of care can greatly complicate mental health providers’ ability to treat patients with “dual” diagnoses.

Some plan and employer representatives, however, expressed concerns about the impact that parity for substance abuse coverage would have on health care costs. They do not believe that the added costs associated with expanded substance abuse coverage would be offset by savings in other health care services, although there is no empirical evidence to support or dispute this argument. In September 2001, a California Senate bill mandating parity for substance abuse (SB 59) failed to gain passage in the legislature.

Uncertain Role for the Private Sector in Covering Children’s Services Under AB88

Most stakeholders identified mental health services for children as the most complex area in implementing California’s mental health parity law. Health plans and providers remain uncertain about what services they are required to provide under AB88—especially given the traditional role of the public sector in providing these services to children (see box on the next page).

²Approximately 15 percent of persons with severe mental illnesses are estimated to have a substance abuse problem (Kessler et al. 1996).

**PUBLIC PROVISION OF SERVICES FOR CHILDREN
WITH SED AND AUTISM IN CALIFORNIA**

During the 1970s and 1980s, federal and state laws were passed to allow children who were severely disabled or who had physical, learning, or communication disabilities, to obtain comprehensive special education instruction and services specific to their needs through the public school system. Since then, California has developed a complex infrastructure involving public schools, regional centers, and state and county mental health providers to serve the educational, medical, mental health, and social support service needs of these children.

Under the existing system, most children with SED are first identified through the school system. If an educational assessment indicates that a child needs special education, a school-based team works with the parents to develop an individualized education plan (IEP) that outlines what special education services will be provided, subject to approval and funding by the school district. This may include a range of health and social services, such as language and speech development, audio and vision services, physical and occupational therapy, psychological services, as well as vocational education and career development counseling. Service delivery is coordinated by a regional Special Education Local Plan Area (SELPA) that administers funds and ensures that each child receives the appropriate services. Each SELPA works closely with its local school districts to coordinate the services its students receive between the regular and special education programs.

Children with SED may also receive services through California's county mental health departments. The Department of Mental Health provides state-wide leadership to the county mental health system, and also provides inpatient services to children through its state mental health facilities. The department also provides oversight for the Children's System of Care initiative, which is intended to enhance coordination among many local agencies that are involved in providing services to children with SED in California.

Children with autism receive services through the public school system, as well as the state's regional centers. The regional centers operate as private, non-profit organizations funded primarily by the state Department of Developmental Services to provide and coordinate medical and non-medical support services, including in-home services for autistic and developmentally disabled children and adults.

The need for clarification about the private sector's role in providing *diagnostic* services stems in part from the definition of SED and autism. For example, SED is based on functional criteria defined in the state's Welfare and Institutions code, in addition to DSM-based diagnoses. Some respondents believe that local school systems currently are the most experienced and best equipped to apply these functional criteria to children. Autism, on the other hand, is a developmental disorder that health plans typically cover as a physical health condition. Providers also were uncertain about whether higher-functioning disorders closely related to autism, such as Asperger's syndrome, are eligible for parity-level coverage, although these conditions are covered under the broader category "pervasive developmental disorders" as defined in the law.

In general, we were told that private health plans and mental health providers in their networks currently lack the assessment tools and the expertise to make appropriate diagnoses and develop treatment plans for SED or autism. One health plan noted that, because of the lack of resources for determining functional criteria, it currently is providing parity-level coverage for mental health services to all enrollees under age 18 with any DSM diagnosis.

Stakeholders also identified a need for greater clarification about what *treatment* services health plans should cover for children under AB88. For example, many children with autism receive up to 40 hours a week of in-home behavioral intervention from educational specialists funded by California's school districts. Stakeholders raised the issue of whether health plans should pay for additional services, or cover parents' out-of-pocket costs for these or other autism services. Providers also noted that the treatment of autism has traditionally been the domain of pediatricians, rather than mental health specialists, given the developmental nature of the condition. Providers are unsure about how services will be coordinated between the physical and mental health domains, especially given the fact that AB88 benefits have been carved out to MHBOs that specialize in mental health service delivery.

Stakeholders report that there have been no significant changes in approaches for delivering services to children with SED and autism. The public sector continues to play a large role in the provision of services to children. Health plans have generally not recruited new providers or developed new services for treating these conditions. They continue to provide such services as hospitalization, pharmacy benefits, and office-based psychotherapy for children. Other services, however, such as educational psychology assessments and in-home services for children with autism, continue to be provided primarily by the public sector. At least one plan, though, has started working with specialists at well-recognized centers in assessing enrollees' needs and coordinating with providers and case managers to get patients and families the resources they need through schools and regional centers.

Representatives of DMHC, the California Psychiatric Association, the California Association of Health Plans, and others have begun working together to develop clarification about provisions in AB88 related to children. These efforts led to a statewide

meeting in November 2001. Issues addressed by these collaborative efforts and the recent meeting include:

- How should children with private insurance be screened and diagnosed for conditions covered by the law?
- What types of services should be delivered to children with different conditions?
- How should services and information be coordinated and communicated among health plans, providers, and public agencies?

The stakeholders we interviewed have mixed opinions about the need for state regulation in the area of children's services under AB88. Some respondents believe that the state should take steps to formally specify the services that are required of health plans under AB88 through the publication of regulations. Others suggest that these issues can be resolved through more informal processes, including greater communication and clarification among stakeholders about their current and future roles in providing children's services.

STAKEHOLDERS' PERCEPTIONS OF THE EARLY EFFECTS OF AB88

Although it is too soon to quantify the effects of AB88, stakeholders provided some early assessments of the likely impact of the law in a few key areas. First, stakeholders believe that AB88 has the potential to expand access, but better consumer education is needed to achieve this goal. Many stakeholders also expressed concerns that shortages of mental health providers could limit potential increases in access to care under AB88. Finally, stakeholders identified few adverse effects on the overall health insurance market so far.

Expanded Benefits Can Improve Access, But Further Education Is Needed

Many stakeholders believe that expanded benefits under AB88 have the potential to increase access to care for consumers of mental health services in California, especially for those with severe mental illness. Consumers are likely to find mental health services more affordable under the parity law, given the elimination of outpatient visit limits and inpatient day limits and the reduction of copayment levels. Some consumer advocates believe that these changes may also enable or encourage consumers to seek care in the private sector, rather than the public sector. Advocates predict that increased private sector use will be most common among consumers with new onset of severe mental illness, rather than those with long-standing illness who are already accustomed to obtaining services from the public sector.

Despite education efforts undertaken during the first year of implementation, most interview respondents believe that consumers in California remain largely unaware of the

benefit expansions under AB88. In the view of these stakeholders, it appears that initial notification efforts were not effective in increasing awareness of expanded mental health benefits among the general population. Many respondents questioned whether initial notifications were read and well understood by consumers. A respondent in the state legislature reported receiving numerous telephone calls from consumers who expressed difficulty getting clarification about benefit or delivery system changes from their customer service representatives at health plans. Providers reported that patients appeared to know very little about the law or the change in benefits when making appointments for mental health services, and that they were confused about changes in provider networks. As a result, most stakeholders anticipate that use of mental health services will not increase until consumers learn more about the benefit and until they better understand how to navigate changes in the mental health delivery system.

Most stakeholders believe that improved education efforts are essential for increasing access to mental health services that were previously unavailable or unaffordable for consumers. Providers and consumer advocates, as well as some employer representatives, suggested that additional notifications about AB88 should be sent to consumers following the first year of implementation because of the general lack of awareness. However, health plan representatives questioned the effectiveness of broad outreach efforts, believing that most consumers will not attempt to understand these benefits until they need them.

Concerns About Shortages of Mental Health Providers

Provider and consumer representatives expressed concerns about the availability of providers in health plans' mental health provider networks. These stakeholders noted that the reported size of plans' current mental health provider networks may not represent the true availability of providers, given that some providers in these networks may not be accepting new patients because their practices are full. Providers cited anecdotes of patients' difficulties in obtaining referrals to providers within the MBHO network who were willing to take new patients. Employers also noted that during the first few months of implementation, network provider information was often outdated.

In our interviews, respondents frequently cited the generally short supply of psychiatrists in California, noting an especially severe shortage of child psychiatrists.³ One provider representative asserted that the number of current psychiatric residency training positions is currently too low to meet demand for services. Some also noted shortages among other professionals, such as psychiatric nurses, who treat the severely mentally ill. Given the law's focus on people with biologically based conditions, many stakeholders believe that the current shortage in psychiatry may ultimately constrain the ability of the law to increase access to care for some services. Respondents also noted a significant shortage of hospital-

³These perceptions may reflect a growing nationwide shortage of psychiatrists. Only about three percent of U.S.-trained medical residents now choose psychiatry—the lowest percentage since 1929 (Clay 1998).

based eating disorder treatment programs, which may inhibit the law's goal of expanding access to care for patients with anorexia or bulimia.

According to some stakeholders we spoke with, payment reductions in some health plan networks may have compounded these provider supply problems. We learned that discussions were held between state officials, health plans, MBHOs, and provider associations over the past year to address the problem of provider availability and payment issues. At least one health plan has since increased its fees by 15 to 30 percent, in an effort to entice more psychiatrists to their network. However, health plans say that there are significant challenges to enticing psychiatrists into their networks. Health plan and provider representatives note that psychiatrists are in such high demand by patients that many psychiatrists do not need to participate in MBHO networks in order to maintain viable practices.

Few Adverse Effects on the Health Insurance Market, Thus Far

Initial perceptions indicate that utilization changes have been small during the first year of implementation. However, since most contracts had been renewed under AB88 within the last 12 months at the time of our interviews, health plans indicated that they have had relatively little experience or actual data with which to make judgments about the impact of the law on utilization patterns. Thus, respondents were not yet able to quantify these initial perceptions.

Premium increases associated with mental health parity have also been small. Although employers faced premium increases of 10 to 20 percent in 2001, little of the increase was attributed to parity. Rather, health plans cited a variety of factors contributing to the increases, such as inpatient hospital use, prescription drug costs, and other state benefit mandates passed in 1999. Health plan representatives noted that it was difficult to determine the extent to which each of these factors contributed to the premium increases, but generally noted that the parity was a minor factor. One health plan cited a three percentage point increase in the overall premium in 2001 due to the parity law, but acknowledged, in retrospect, that this figure probably was an overestimate of the effect on its costs. Other plans gave smaller estimates of premium increases, or were unable to give an average estimate across benefit packages. One plan said that none of the premium increase for their benefit packages in 2000 was attributed to AB88.

Thus far, there is no evidence that employers—large or small—were dropping health care coverage because of AB88, as some had feared prior to the bill's passage. One employer purchasing group noted that, to the contrary, an increasing number of employers were offering health insurance in recent years. However, the same group cautioned that some firms—particularly, small businesses—could still decide to drop their existing health coverage if parity ultimately led to large increases in premiums in the future.

As of fall 2001, health insurance purchasers said that they have not seen “earth-shattering” changes in premium costs related to the mental health parity law. One employer

representative referred to the parity law as a “non-event.” Given AB88’s potential to increase costs, employers were most concerned about the law immediately prior to its passage in the legislature, as well as during the renewal of their health insurance contracts during the first year of implementation. Since then, employer interest in the parity law has waned, as they have shifted their attention to other issues. Because of the small changes in premiums, mental health parity is perceived to be a “small blip” on employers’ radar screens compared with other human resources issues, such as increasing costs for workers’ compensation, unemployment insurance, general liability insurance, and especially general medical coverage.

We also were told that mental health parity is likely to remain low on the list of employer concerns so long as utilization and premium costs remain a small part of future premium increases. Yet, most employers report that it is “too early to tell” whether their health care costs will increase in the future as a result of the benefit expansions under AB88.

Indeed, the recent experience of one large employer we interviewed suggests that mental health costs could rise in the future, as consumers become more aware of the expansion of benefits under AB88. This employer, which moved toward a mental health parity model in its health insurance benefit package in the year prior to implementation of AB88, has observed the impact on utilization and costs for the past two years. Consistent with early experience under AB88, there was little increase in either the use or the cost of mental health services during the first year. However, after the second year, the mental health carve-out they were using to provide benefits to their employees increased premiums substantially, in part because of increased utilization. This employer speculates that few people knew about the benefit initially, accounting for the low utilization during the first year. It expects that utilization increased during the second year as knowledge of the benefit became more widespread.

Employers noted that any future increases in premiums due to AB88 could result in one of several responses from employers. Employers may decide to purchase less-generous combinations of physical and mental health benefits; decide to increase cost-sharing with employees; or, at the extreme, possibly drop health coverage altogether. Interview respondents also noted that broader market trends unrelated to AB88, such as increases in general medical costs, could trigger this type of employer response.

CHAPTER IV

CONCLUSIONS

This chapter presents the conclusions from our snapshot study of the implementation of California's mental health parity law. First, we provide an overall assessment of the first year of implementation of AB88, based on the perceived objectives and expectations of the major stakeholders in California. We then discuss the remaining challenges faced by stakeholders in the implementation of California's parity law in future years, as well potential lessons from our study for other states.

ASSESSMENT OF THE FIRST YEAR OF IMPLEMENTATION

An assessment of the success of the first year of implementation depends in part on expectations about what can reasonably be accomplished during this period. At a minimum, there is widespread agreement that health insurance benefits for mental health services have been expanded in compliance with the law's mandate. In addition, the law does not appear to have had any adverse consequences on the health insurance market to date, such as large increases in premiums or decreases in health insurance offerings by employers.

Early education and communication efforts about benefit and delivery system changes were not viewed as adequate by several stakeholders. Some attributed this to a relatively short lead time in which to respond to the law (signed in September 1999 and implemented in July 2000). The new state agency charged with overseeing managed care plans' implementation of the law had little time in which to clarify technical compliance issues, since it too was established in July 2000. Several respondents, especially those representing health plans, also noted the challenges of focusing on changes necessary to comply with the parity law, given the large number of other managed care reforms that were being implemented in California during this period. Yet, some stakeholders believe that health plans could have been more proactive in making decisions earlier and informing others about the changes they were planning to make. Earlier and more extensive communication

about system changes may have prevented some initial transition problems for providers, employers, and consumers.

Some stakeholders encountered challenges during the first year that were related to basic design features of the law. For example, stakeholders confronted administrative complexities associated with implementing the limited list of SMI and SED diagnoses under AB88. The law also introduced unanticipated regulatory challenges. Large employers expressed concern that the law's mandate on full-service health plans has unintentionally discouraged employers' use of separate carve-out arrangements with MBHOs.

Finally, some areas of implementation are considered to be at such an early stage of development that it is too soon to judge the degree of success at this point. For example, major changes in the delivery of children's services have not yet taken place, given the complexity of this area and the prominent and well-established role played by the public sector in providing services for children.

REMAINING CHALLENGES

We identified several remaining challenges faced by stakeholders as the implementation of AB88 proceeds in the future. First, continued efforts are needed to improve coordination and communication among health plans, providers, and employers in implementing or responding to system changes—particularly, given the complexity of implementing “partial parity” and the possible disruptions in service delivery because of the expanded use of MBHOs. These efforts should include more up-to-date network provider listings, improved communications about when and how referrals should be made for mental health services in new systems of care, clarification about which diagnoses are covered under parity-related benefit expansions, and clarification about how cost-sharing and benefit limits should be applied to mental health consumers with different diagnoses or at different stages of treatment.

Second, stakeholders should continue their discussions about the role of the private and public sectors in delivering services to children with SED and autism under AB88. Issues that remain to be addressed include whether the responsibility of the public sector for providing services will be reduced, what services should be covered by private health plans, who should be responsible for diagnosing AB88 conditions in children with private insurance coverage, and how needed services should be coordinated between the private and public sectors. Currently, most discussions appear to be among state-level leaders. Ultimately, statewide discussions and leadership efforts should be translated into specific efforts at the local level, to respond to the law's focus on children's conditions.

Third, stakeholders will need to develop appropriate strategies for improving consumer awareness about benefit expansions under AB88 to facilitate their access to mental health services. There is no consensus yet about how consumers should be further educated about their expanded benefits, which types of consumers should be targeted, and who should be

responsible for undertaking such efforts. A range of efforts could be considered, including a broad-based public education campaign, additional notifications sent by health plans to their enrollees, training of customer service representatives about mental health parity changes, or educational materials distributed by providers to their patients. The choice of strategies should consider which consumers would benefit most from further notification, and which stakeholders, including state agencies, health plans, providers, employers, or consumer advocates, are in the best position to undertake education efforts.

Finally, stakeholders should attempt to identify strategies for addressing shortages in certain provider specialties or programs viewed as important for meeting increased service demand under AB88, such as child psychiatry and eating-disorder programs. Longer-term policy changes may be required to address secular shortages in the overall number of licensed providers in California. However, strategies targeted to the current delivery system may help AB88 achieve its goals of expanding availability of services in the short term. Reassessment of current payment levels for services was the most important area noted by stakeholders in our interviews. Other strategies to consider include expanded provider recruitment and recredentialing efforts by health plans, reduction of administrative burdens for mental health providers, and development of partnerships between plans, providers, and other stakeholders to develop new treatment programs. At the same time, the effectiveness of these strategies will need to be balanced against the potential effects on costs.

LESSONS FOR OTHER STATES

The results from this study provide several early implementation lessons for other states that are implementing or considering passage of mental health parity laws. These lessons relate to how goals of the parity reforms may be most effectively pursued, what may be expected in terms of unintended consequences of the reforms, and how any adverse outcomes might be avoided or ameliorated.

The results highlight the regulatory complexity of what appears to be a relatively straightforward mandate to expand coverage for mental health services. For example, state officials may need to consider how parity laws will affect employers that contract directly with MBHOs. They may also need to anticipate the types of responses health plans have to a parity mandate during the initial transition, assess what types of disruptions in care this may cause, if any, and develop communication and other mechanisms for easing the transition and reducing confusion among stakeholders. Stakeholders may want to think proactively about what information should be conveyed to health plans, employers, providers or consumers, and when notifications should be made. In particular, the needs for consumer education should be addressed early on during the implementation process to facilitate access to care under a parity law. Stakeholders may want to consider such issues as who should be primarily responsible for educating consumers, what are likely to be the best methods for improving consumer awareness of reforms, and when education efforts should take place.

The initial diversity of responses by health plans in California to the limited list of diagnoses—and stakeholders’ mixed views about “partial parity” in California—may also be instructive to states that have either passed similar parity laws or that are considering doing so. States considering passage of a parity law will need to weigh the potential administrative costs of a limited parity law, versus the potentially increased health care costs associated with expanding parity to all mental health diagnoses. States in the early stage of implementation of a limited parity law may also want to ensure that early communication efforts specifically address the complexities of implementing partial parity, in order to reduce potential confusion about this issue.

Finally, states may need to assess how rapidly or effectively a parity law, on its own, can expand the role of private providers in delivering mental health services traditionally provided by the public sector. Our findings from early implementation in California indicate that additional, proactive efforts on the part of state leaders will be necessary to achieve this goal under the parity law.

MENTAL HEALTH PARITY IN THE FUTURE

In summary, an important goal of AB88 in California appears to have been achieved during the first year of implementation; but a great deal of work remains to be done to make the parity law a success in the future. In particular, mental health benefits have been expanded to conform with the parity mandate, but it will take time and additional effort to achieve goals such as reducing stigma and improving access to care for people with mental illness. The law has prompted discussions among stakeholders about such issues as responsibility for additional education efforts, availability of mental health providers in health plan networks, delivery and management of mental health services in a managed care environment, and delivery and coordination of mental health services for children by both the private and the public sector. There is a broad consensus, however, that the full impact of parity may not be known for several years, as longer-term implementation issues are addressed and as consumers become aware of expanded benefits and begin accessing newly covered services.

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