SENATE COMMITTEE ON HEALTH
Senator Dr. Richard Pan, Chair

BILL NO: AB 1859
AUTHOR: Levine
VERSION: February 8, 2022
HEARING DATE: June 22, 2022
CONSULTANT: Teri Boughton

SUBJECT: Mental health services

SUMMARY: Requires a health plan contract or health insurance policy that covers mental health services to approve services for a 72-hour hold for treatment and evaluation, schedule an initial outpatient appointment within 48 hours of release, ensure services are within a reasonable proximity to the enrollee or insured, and limit cost-sharing to in-network amounts when services are provided out-of-network.

Existing law:

1) Establishes the Department of Managed Health Care (DMHC) to regulate health plans under the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act); California Department of Insurance (CDI) to regulate health and other insurance; and, the Department of Health Care Services (DHCS) to administer the Medi-Cal program. [HSC §1340, et seq., INS §106, et seq., and WIC §14000, et seq.]

2) Requires every health plan contract and insurance policy that provides hospital, medical, or surgical coverage to provide coverage for medically necessary treatment of mental health and substance use disorders under the same terms and conditions applied to other medical conditions, as specified. [HSC §1374.72 and INS §10144.5]

3) Requires the health plan or insurer, if services for the medically necessary treatment of a mental health or substance use disorder are not available in network within the geographic and timely access standards set by law or regulation, to arrange coverage to ensure the delivery of medically necessary out-of-network services and any medically necessary follow-up services that, to the maximum extent possible, meet those geographic and timely access standards. This includes, but is not limited to, providing services to secure medically necessary out-of-network options that are available to the enrollee within geographic and timely access standards, and requires the enrollee or insured to pay no more than the same cost sharing that would be paid for the same covered services received from an in-network provider. [HSC §1374.72 and INS §10144.5]

4) Requires a health plan to provide 24-hour access for enrollees and providers, including, but not limited to noncontracting hospitals, to obtain timely authorization for medically necessary care, for circumstances where the enrollee has received emergency service, care is stabilized, and the treating provider believes that the enrollee may not be discharged safely. Includes additional screening, examination, and evaluation by a physician, or other provider to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the condition. Psychiatric emergency medical condition means a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient an immediate danger to self or others, or immediately unable to provide for, utilize, food, shelter, or clothing, due to the mental disorder. [HSC §1371.4, 1317.1]

5) Prohibits a noncontracting hospital from billing a patient who is an enrollee of a health plan for poststabilization care, except for applicable copayments, coinsurance, and deductibles, unless certain conditions exist. Requires a plan or contracting provider, to within 30 minutes from the time the noncontracting hospital makes the initial contact, as specified, and either assume management of the patient's care or provide authorization for treatment. [HSC §1262.8]

6) Requires a health plan or health insurer to ensure that its contracted provider network has adequate capacity and availability of licensed health care providers to offer enrollees or insureds appointments that meet the following timeframes:

   a) Urgent care appointments for services that do not require prior authorization: within 48 hours of the request for appointment;
   b) Urgent care appointments for services that require prior authorization: within 96 hours of the request for appointment;
   c) Nonurgent appointments for primary care: within ten business days of the request for appointment;
   d) Nonurgent appointments with specialist physicians: within 15 business days of the request for appointment;
   e) Nonurgent appointments with a nonphysician mental health care or substance use disorder provider: within ten business days of the request for appointment;
   f) Requires beginning July 1, 2022, nonurgent follow-up appointments with a nonphysician mental health care or substance use disorder provider: within ten business days of the prior appointment for those undergoing a course of treatment for an ongoing mental health or substance use disorder condition; and,
   g) Allows waiting times described above to be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, has determined and noted in the relevant record no detrimental impact on the health of the enrollee or insured. [HSC §1367.03 and INS §10133.54]

7) Establishes the Lanterman-Petris-Short (LPS) Act to end the inappropriate, indefinite, and involuntary commitment of persons with mental health disorders, developmental disabilities, and chronic alcoholism, as well as to safeguard a person's rights, provide prompt evaluation and treatment, and provide services in the least restrictive setting appropriate to the needs of each person. Permits the involuntary detention of a person who is found to be a danger to self or others, or gravely disabled, for various periods of time for evaluation and treatment. [WIC §5000, et seq.]

8) Permits when a person, as a result of a mental health disorder, is a danger to others, or to himself or herself, or gravely disabled, a peace officer, professional person in charge of a facility designated by the county for evaluation and treatment, member of the attending staff, as defined by regulation, of a facility designated by the county for evaluation and treatment, designated members of a mobile crisis team, or professional person designated by the county to, upon probable cause, take, or cause to be taken, the person into custody for a period of up to 72 hours for assessment, evaluation, and crisis intervention, or placement for evaluation and treatment in a facility designated by the county for evaluation and treatment and approved by DHCS. [WIC §5150]

This bill:

1) Requires a health plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2023, that includes coverage for mental health services, to do all of the following:

    a) Approve the provision of mental health services for enrollees or insureds under the plan who are detained for 72-hour treatment and evaluation pursuant to existing law;
    b) Schedule an initial outpatient appointment for the enrollee or insured with a licensed mental health professional. Require the appointment to be scheduled for a date that is within 48 hours of the enrollee's or insured's release from detention;
    c) Ensure that the location of facilities providing the covered mental health services for the enrollee or insured pursuant to 1a) above are within reasonable proximity of the business or personal residences of the enrollee or insured, and so located as to not result in unreasonable barriers to accessibility; and,
    d) Provide that if an enrollee or insured receives covered mental health services from a noncontracting provider, the enrollee or insured pays no more than the same cost-sharing amount that the enrollee or insured would pay for the same covered services received from a contracting provider. Requires this amount to be referred to as the "in-network cost-sharing amount."

2) Limits what an enrollee or insured owes the noncontracting provider to no more than the in-network cost-sharing amount for covered mental health services, and requires at the time of payment by the plan to the noncontracting provider, the plan or insurer to inform the enrollee or insured and the noncontracting provider of the in-network cost-sharing amount owed.

3) Prohibits a noncontracting provider billing or collecting any amount from the enrollee or insured for covered mental health services, except for the in-network cost-sharing amount.

4) Defines "covered mental health services" as mental health services that are urgently needed to prevent serious deterioration of the enrollee's health resulting from unforeseen illness or injury for which treatment cannot be delayed until the enrollee or insured can receive services from a contracting provider.

5) Exempts Medi-Cal managed care plans.

FISCAL EFFECT: According to the Assembly Appropriations Committee:

1) Costs of $2,000 in fiscal year (FY) 2022-23 and $12,000 in FY 2023-24 to the CDI, to review insurance policies for compliant language (Insurance Fund).

2) Costs of approximately $200,000 per year in FY 2022-23 and FY 2023-24, and in the low-to-mid hundreds of thousands of dollars annually thereafter, to the DMHC to review Evidence of Coverage documents, provider contracts and other health plan documents for compliance with the requirements of this bill and to address enrollee complaints (Managed Care Fund).

3) CHBRP estimates this bill will increase total net annual expenditures by approximately $1.6 million, or approximately 0.001%, for enrollees with health plans or health insurance policies. A very small, unknown percentage of this cost would be incurred by the state for its share of cost in Covered California plans.

PRIOR VOTES:

Assembly Floor:	59 - 12
Assembly Appropriations Committee:	12 - 4
Assembly Health Committee:	11 - 2

COMMENTS:

1) *Author's statement.* According to the author, a recent State Audit concluded that in California, thousands of individuals were subjected to repeated instances of involuntary treatment without being connected to ongoing care that could help them live safely in their communities. According to the California Health Benefits Review Program (CHBRP), 24% of enrollees who had a 72-hour hold have a follow-up visit within 48 hours of the hold, and 37% have no follow-up visit within 90 days. Prompt follow-up appointments with outpatient mental health providers after discharge from a psychiatric hospitalization are critical for maintaining continuity of treatment and preventing repeat hospitalizations. This bill will ensure timely access to care by requiring that a patient released from involuntary mental health hospitalization receive authorization and an appointment for care within 48 hours of their release. This bill will help create parity in the provision of mental health care services compared to physical health care services, provide urgent support to an individual suffering from a mental health emergency, and improve mental health outcomes of Californians.

2) *LPS Act involuntary detentions.* The LPS Act provides for involuntary detentions for varying lengths of time for the purpose of evaluation and treatment, provided certain requirements are met, such as that an individual is taken to a county-designated facility. Typically, one first interacts with the LPS Act through a 5150 hold initiated by a peace officer or other person authorized by a county, who must determine and document that the individual meets the standard for a 5150 hold. A county-designated facility is authorized to then involuntarily detain an individual for up to 72 hours for evaluation and treatment if they are determined to be, as a result of a mental health disorder, a danger to self or others, or gravely disabled. The professional person in charge of the county-designated facility is required to assess an individual to determine the appropriateness of the involuntary detention prior to admitting the individual. Subject to various conditions, a person who is found to be a danger to self or others, or gravely disabled, can be subsequently involuntarily detained for an initial up-to 14 days for intensive treatment, an additional 14 or 30 days in counties that have opted to provide this additional up-to 30-day intensive treatment episode, and ultimately a conservatorship, which is typically for up to a year and may be extended as appropriate. Throughout this process, existing law requires specified entities to notify family members or others identified by the detained individual of various hearings, where it is determined whether a person will be further detained or released, unless the detained person requests that this information is not provided. Also, a person cannot be found to be gravely disabled if they can survive safely without involuntary detention with the help of responsible family, friends, or others who indicate they are both willing and able to help. A person can also be released prior to the end of intensive treatment if they are found to no longer meet the criteria or are prepared to accept treatment voluntarily.

3) *CHBRP analysis.* AB 1996 (Thomson, Chapter 795, Statutes of 2002) requests the University of California to assess legislation proposing a mandated benefit or service and prepare a written analysis with relevant data on the medical, economic, and public health impacts of

proposed health plan and health insurance benefit mandate legislation. CHBRP was created in response to AB 1996, and reviewed this bill. Key findings include:

a) *Prevalence in California.* The total number of 72-hour involuntary detentions in FY 2018-2019 was 136,163, including 21,952 for children aged 17 years and younger and 114,211 for adults aged 18 years and older.

b) *Population affected.* 14,776,000 enrollees and insureds (38% of all Californians).

c) *Benefit coverage.* No change in benefit coverage because these enrollees and insureds already are covered for the benefits of this bill.

d) *Cost.* Increase in total net expenditures of $1,559,000, or about .001%, for enrollees with DMHC plans and insureds with CDI policies.

e) *Public health.* The number of people with commercial insurance who would receive an outpatient appointment within 48 hours of discharge would increase but the impacts of this on Emergency Department visits, hospital readmissions, or suicide are unknown due to insufficient, inconclusive, or limited evidence.

f) *Medical effectiveness.*
   i) There is inconclusive evidence of effects of timely access to mental health outpatient visits on hospital readmissions, although the most pertinent studies (i.e., those that assess people with commercial health insurance) suggest that receiving follow-up outpatient mental health services within 30 days of discharge is associated with a small reduction in hospital readmissions.
   ii) The impact of receiving follow-up outpatient care within two days of discharge is unknown because none of the studies assessed the impact of receiving follow-up care during this time interval. There is insufficient evidence of the effect of timely follow-up outpatient care on ED visits and medication adherence.
   iii) There is insufficient evidence to determine whether receiving timely follow-up outpatient mental health services, after discharge from inpatient mental health care, improves mental health outcomes.
   iv) There is inconclusive evidence that scheduling visits for follow-up outpatient mental health services, after discharge from inpatient mental health care, affects use of mental health services including hospital readmissions.
   v) There is insufficient evidence to determine whether access to outpatient mental health providers in close proximity to a patient's business or residence increases use of outpatient mental health services following discharge from inpatient mental health care or improves mental health outcomes.
   vi) There is limited evidence that reducing cost sharing for follow-up outpatient mental health services increases use of these services.
   vii) There is insufficient evidence to determine if reducing cost sharing for follow-up outpatient mental health services improves mental health outcomes.

4) *National Committee for Quality Assurance (NCQA) measures.* According to CHBRP, the NCQA measure "Follow-up After Hospitalization for Mental Illness" assesses the timing of follow-up care of adults and children six years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm and had an outpatient visit, an intensive outpatient encounter, or a partial hospitalization with a mental health practitioner.

CHBRP reports that California data (reported by California's Office of the Patient Advocate (OPA), for 2020) show the average percent of enrollees receiving a follow-up visit within seven days after a mental health inpatient stay ranged from a low of 36% to a high of 75%. According to OPA the top health plans nationwide score 64%. For 30-day follow-up, the percentages ranged from a low of 64% to high of 87%. According to OPA the top health plans nationwide score 80%.

5) *CDI access standard.* CDI has the following time and distance standards:

   a) Primary care network providers within 30 minutes or 15 miles of each covered person's residence or workplace;
   b) Medically required network specialists with sufficient capacity to accept covered persons within 60 minutes or 30 miles of a covered person's residence or workplace;
   c) Mental health professionals within 30 minutes or 15 miles of a covered person's residence or workplace;
   d) A network hospital within 30 minutes or 15 miles of a covered person's residence or workplace; and,
   e) There are some instances where insurers ask and are granted exceptions to these rules.

6) *California State Auditor (CSA) audit on the LPS Act.* The CSA released *LPS Act: California Has Not Ensured That Individuals with Serious Mental Illnesses Receive Adequate Ongoing Care* on July 28, 2020. The audit focused on the following issues in three counties (Los Angeles, San Francisco, and Shasta):

   a) Criteria for involuntary detention for those who are a danger to self or others or gravely disabled, due to a mental health condition, and criteria for conservatorship, and whether the counties have consistently followed those criteria;
   b) Differences in approaches among the counties in implementing the LPS Act, if any;
   c) Funding sources, and whether funding is a barrier to implementing the LPS Act; and,
   d) Availability of treatment resources in each county.

   Most relevant to this bill is the fact that the audit found in Los Angeles and San Francisco individuals exiting involuntary holds have not been enrolled consistently in subsequent care that could help them live safely in their communities. Specifically, of almost 7,400 people in Los Angeles who each had been placed on five or more short-term holds from fiscal years 2015–16 through 2017–18, only 9% were enrolled during fiscal year 2018–19 in full-service partnerships or assisted outpatient treatment—the most comprehensive and intensive methods available to all counties for providing community-based care to individuals with serious mental illnesses. In San Francisco, the proportion was even lower. The LPS Act is intended to stabilize individuals who are experiencing crises because of their mental illnesses. Thus, people leaving LPS Act holds often need continuing mental health services; in particular, individuals who have experienced several short-term holds represent a high-need population that should be connected to counties' most intensive community-based care. However, Los Angeles and San Francisco did not always identify individuals who had been on multiple short-term holds or ensure that these individuals received the ongoing care they needed. One reason for this gap in care is that counties do not have access to confidential state-managed data about the specific individuals who have been placed on holds in the past.

7) *Related legislation.* AB 2242 (Santiago) requires a person who has been involuntarily detained for purposes of evaluation and treatment, and placed under a conservatorship, to receive a care coordination plan developed by specified entities. Requires the DHCS to convene a stakeholder group to create a model care coordination plan to be followed when discharging those held under temporary holds or a conservatorship. Requires the Mental Health Services Oversight and Accountability Commission to develop, implement, and oversee a public and comprehensive framework for tracking and reporting spending on mental health programs and services. Permits county mental health plans to pay for the provision of services for individuals placed under involuntary detentions and conservatorship using specified funds, including Mental Health Services Act funds. *AB 2242 is set for hearing on June 22, 2022 in this Committee.*

8) *Prior legislation.* SB 221 (Wiener, Chapter 724, Statutes of 2021) codifies existing timely access to care standards for health plans and health insurers, applies these requirements to Medi-Cal managed care plans, adds a standard for non-urgent follow-up appointments for nonphysician mental health care or substance use disorder providers that is within 10 business days of the prior appointment, and, prohibits contracting providers and employees from being disciplined for informing patients about timely access standards.

   SB 855 (Wiener, Chapter 151 Statutes of 2020) repeals California's mental health parity law and replaces it with a broader requirement on health plans and disability insurers to cover medically necessary treatment of mental health and substance use disorders under the same terms and conditions applied to other medical conditions; establishes new requirements for medically necessary care determinations and utilization review; and bans discretionary clauses in health plan contracts.

9) *Support.* This bill's sponsor, the Depression and Bipolar Support Alliance (DBSA) writes the LPS Act as implemented has serious issues, the greatest overall is that it provides very little useful treatment. DBSA supports legislation that provides voluntary treatment as part of this process and provides as much of a warm handoff as possible. This bill, while not providing a true warm handoff, is a first step toward ensuring that individuals placed on an involuntary hold actually receive voluntary treatment in a timely manner. The National Association of Social Workers, California Chapter writes upon release from an involuntary hold, the process for obtaining follow-up care can be complicated and frustrating. This care is crucial to keep these individuals from facing another mental health crisis. This bill will help improve mental health outcomes and ensure timely access to care. This is an extremely important bill to ensure mental health parity and to help those suffering from a serious mental health crisis obtain care. The National Alliance on Mental Illness – California writes that individuals with mental illnesses must have timely access to treatments that have been recognized as effective by the Food and Drug Administration and the National Institute of Mental Health. NAMI California is adamant that individuals with mental illness have timely access to clinically appropriate medications, evidence-based services, and treatment, including psychotherapy that are provided in a person-centered approach. This bill requires that the location of the facilities providing the mental health services will be within reasonable proximity of the business or residence of the patient.

10) *Support if amended.* The County Behavioral Health Directors Association of California requests amendments, and writes that covering the costs of mental health services to enrollees detained under a 5150 aligns with California's mental health parity law enacted under SB 855 and this bill should make clear that all medically necessary mental health

services associated with the 5150 process, including crisis intervention services, screening and evaluation of an individual placed on a 5150 hold, whether detained or released, regardless of location of service, should be reimbursed by the plan and insurer. Under parity laws, costs relative to the transportation of the insured when additional medically necessary services are needed to stabilize the individual, including urgent care, residential or hospital services should also be reimbursed by the plan and insurer. Providing clarity in this bill that mental health parity requires a plan and insurer to cover these medically necessary services when performed by a noncontracted provider will ensure that private plan and insurer enrollees have access to these critical services and the financial responsibility falls on the appropriate entity.

11) *Opposition.* The California Association of Health Plans, the Association of California Life and Health Insurance Companies, and America's Health Insurance Plans states that this bill, taken together with AB 2024 (Friedman, related to breast imaging and AB 2516 (Aguiar-Curry, related to HPV), will increase premiums on Californians by nearly $123 million. California has been a national leader in maintaining a stable market despite rising costs and uncertainty at the federal level over the individual and employer market. Opponents write that now is not the time to inhibit competition with proscriptive mandates that reduce choice and increase costs. California needs to protect the coverage gains made and stay focused on the stability and long-term affordability of our health care system. Benefit mandates impose a one-size-fits-all approach to medical care and benefit design driven by the legislature, rather than consumer choice. State mandates increase costs of coverage especially for families who buy coverage without subsidies, small business owners who cannot or do not wish to self-insure, and California taxpayers who foot the bill for the state's share of those mandates. These bills will lead to higher premiums, harming affordability and access for small businesses and individual market consumers.

12) *Oppose unless amended.* The California Chamber of Commerce writes Sections 1 and 2 of this bill would increase administrative costs for health plans and insurers. From an employer perspective, it is concerning that an increase in administrative costs could lead to higher premiums for employers and employees. When looking at administrative cost increases in isolation they seem tolerable, however, this bill must be considered in context. Premiums for employers and enrollees consistently increase year after year due to a number of issues including benefit mandates. The 2021 Kaiser Family Foundation Employer Health Benefits Survey indicated that the average premium for family coverage has increased 22% over the last five years and 47% over the last 10 years. Additionally, for job-based coverage, the average annual premium for single coverage was $7,739. The average annual premium for family coverage was $22,221 marking a 4% increase compared to the prior year. On average, covered workers contribute 17% of the premium for single coverage and 28% of the premium for family coverage. California should not increase health care coverage costs for employers and employees with increased administrative burdens. The California Chamber of Commerce requests these portions be removed this bill**.**

13) *Amendments*. The Chair is requesting amendments to clarify that screening and evaluation treatment for services under 5150 is also to be approved by plans and insurers, and that plans and insurers must ensure a follow-up appointment as part of the enrollee's or insured's discharge plan within seven days of release or based on the timely access requirements in existing law.

SUPPORT AND OPPOSITION:

Support: Depression and Bipolar Support Alliance (sponsor)
California Council of Community Behavioral Health Agencies
National Alliance on Mental Illness
National Association of Social Workers, California Chapter
Steinberg Institute

Oppose: Americas Health Insurance Plans
Association of California Life and Health Insurance Companies
California Association of Health Plans
California Chamber of Commerce (unless amended)

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