

Opportunities to Improve Productivity, Mental Health of Workers:

AB 88 Important Step for Insured Workers; Needs of Uninsured Loom

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Mental Health and:

► Employment

Unemployment

Introduction

Undiagnosed and untreated mental illness has serious social and economic consequences, taking a toll not only on individuals and their families, but also on employers and society. The failure to identify and treat mental illness in the workplace often results in economic costs due to absenteeism, lost productivity and disability. One of the most common mental illnesses — depression — has an estimated annual national cost of more than \$44 billion as a result of employee absenteeism, lost productivity and direct treatment (1).

On July 1, 2000, California will begin implementing Assembly Bill 88 (Thomson), known informally as the mental health parity law. The law requires health plans to provide coverage for the diagnosis and treatment of severe mental illnesses of a person of any age, and serious emotional disturbances of a child, under the same terms and conditions

applied to other medical conditions. AB 88 contributes to recent federal and state legislative action intended to improve mental health coverage through private insurance. In 1996, the federal

government passed the Mental Health Parity Act (S. 2031), and subsequently, 31 states enacted various types of mental health parity legislation. Concurrent with this legislative change, awareness has grown about the burden of disability associated with mental illness. The United States Surgeon General's report on mental health issued this past fall, reflects this growing understanding (see box, page 4.)

“Mental illness is real, mental illness can be reliably diagnosed, mental illness is treatable, and treatment of mental illness is cost-effective.”

— Assemblywoman Helen Thomson

This publication describes the prevalence of mental illness, particularly depression, among the *employed* population. It also looks at the effects and costs of mental illness, specifically depression, in the workplace. Finally, the publication delineates potential challenges to implementing AB 88 and provides policy recommendations to improve the mental health and productivity of California's workforce.

The California Public and Legislature Show Support for Addressing Mental Health Issues

Californians have shown strong support for providing mental health insurance coverage at levels comparable to physical health coverage. In a 1997 survey conducted by The Field Institute, 90 percent of Californians agreed that mental illnesses, such as depression or schizophrenia, should be covered by health insurance plans in the same way diseases such as diabetes and asthma are covered (2).

Building on this public support, on September 27, 1999, Governor Gray Davis approved AB 88. Although AB 88 is a “limited” mental health parity law that addresses only severe mental illnesses, it is stronger than the federal statute (S. 2031). For example AB 88 does not allow small employer exclusions (see box, page 2.)

Indicative of the momentum in this area, 35 mental health-related bills have been introduced during the 1999-2000 legislative session. The California Legislature has also created the Joint Committee on Mental Health Reform to identify promising strategies and policy recommendations to:

- Improve the quality of life for mentally ill children, adults and their families;
- Provide coordinated, culturally sensitive, and cost-effective treatment, rehabilitation, housing, and financial services to this population; and,

“A good job is one of the best health promotion strategies for California”

About the Work & Health Series

This is the first in a two-part series of publications on mental health issues and work. This publication focuses on the effects mental health problems have on the productivity and well-being of the employed, and is intended to promote dialogue among policy-makers and concerned stakeholders about policies to improve the mental health of working Californians and their families.

- Enhance the quality and accountability of existing programs designed to serve persons with mental illnesses regardless of income or housing status.

The committee's findings and recommendations were submitted to the California Legislature earlier this spring and are intended to shape and inform future mental health legislation.

Impacts of Mental Illness on Workers, Employers

The national picture. It is estimated that 40 million adults in the United States suffer from some type of mental illness each year (3), and that collectively mental illnesses (including suicide) account for 15 percent of the overall burden of disease from all causes (4). Although current cost estimates are unavailable, the magnitude of the impact of mental illness in the United States is evident from a 1996 study which estimated the indirect cost of mental illness to be \$79 billion (1990 dollars). This figure includes indirect costs such as lost productivity due to illness, premature mortality and for the time of individuals providing family care (5).

Depression. In the workplace, depression is a leading cause of absenteeism and diminished productivity. Depressive symptoms can affect work habits and the ability to work with others, as well as cause problems with concentration, memory and decision-making. Nationally, up to 10 percent of all adults (19 million) experience clinical depression each year, costing a total of \$44 billion. Of that total cost, 55 percent (\$23 billion) is associated with absenteeism and reduced productivity, 28 percent with direct health expenditures, and 17 percent with premature mortality costs (6).

Substance abuse and mental health. Approximately 15 percent of all adults who have a mental disorder also experience a substance abuse (alcohol or other drug) disorder (3). Further, it is estimated that 32 percent of individuals with major depres-

sion also have a substance abuse problem (7). Most experts agree that if substance abuse problems are not addressed and treated, they can further complicate the identification and treatment of mental illness, as well as increase overall costs.

The California experience. Despite California's robust economy and diverse workforce, Californians are not immune to health problems associated with mental illness. It is estimated that approximately one in five Californians is affected by mental illness (8). It is also estimated that approximately 800,000 (9) of the 16 million employed Californians (10) have experienced severe depressive symptoms. The Work and Health Survey funded by The California Wellness Foundation as a part of its Work and Health Initiative, polled representative samples of 1,771 and 2,044 California adults in June 1998 and 1999 respectively, on a variety of work and health topics. This survey included a depression scale to assess severe depressive symptoms among respondents. Principal findings concerning the incidence of severe depression include:

- Five percent of employed Californians experienced severe depressive symptoms;
- The working poor (<\$20,000 per year household income) were at least four times more likely to experience severe depressive symptoms than those who earn more than \$20,000 per year;
- African Americans, Latinos and Asian/Pacific Islanders were more likely to have severe depressive symptoms than White populations; and,
- Those employed and uninsured were twice as likely (8 percent versus 4 percent) than those who were employed and insured to experience severe depressive symptoms (9) (see table 1, page 3.)

AB 88 Compares Favorably to Federal Law (Parity Act)

	AB 88 ¹	Mental Health Parity Act, 1996 ²
<i>What it does:</i>	Requires every health plan that provides medical or surgical coverage to also provide equal coverage for diagnosis and treatment of severe mental illnesses of a person of any age, and for serious emotional disturbances of a child.	Requires <i>only</i> employer-sponsored health plans that offer mental health coverage to have the same annual and lifetime dollar limits for mental health coverage as for medical and surgical health coverage.
<i>What it covers:</i>	<ul style="list-style-type: none"> • Schizophrenia • Schizoaffective disorder • Bipolar disorder (manic depressiveness) • Major depressive disorders • Panic disorder • Obsessive-compulsive disorder • Pervasive developmental disorder or autism • Anorexia nervosa • Bulimia nervosa 	<ul style="list-style-type: none"> • Mental health illnesses as defined under their health plan.
<i>Exemptions:</i>	<ul style="list-style-type: none"> • Specialized health plan contracts, e.g., Medicare supplement policies and Medi-Cal contracts. 	<ul style="list-style-type: none"> • Employers with 50 or fewer employees. • Health plans that experience an increase in plan claims costs of at least one percent due to compliance.

Sources:

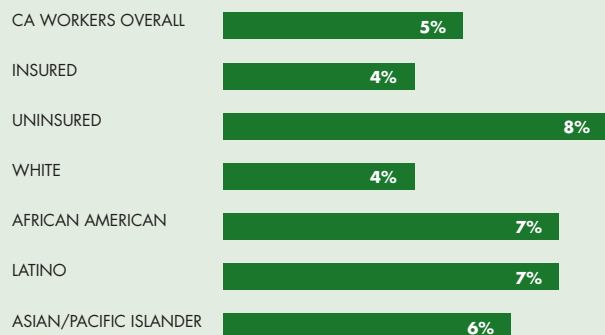
1. C. 534 of 1999 (AB 88).

2. P.L. 104-204, title VII, 110 Stat. 2847, 2944-50.

TABLE 1

The California Workforce: Uninsured, Racial/Ethnic Populations More Likely to Have Severe Depression

Percentage of workers reporting severe depressive symptoms.



Source: *The Work and Health of Californians*. Institute for Health Policy Studies and The Field Institute, 1998, 1999.

Beyond Parity: Employer Challenges to Improving the Mental Health of Employees

Detection and treatment. Nearly two-thirds of people with diagnosable mental disorders do not seek treatment (11). In particular, workers experiencing depression may be reluctant to identify themselves as depressed and seek treatment because of the stigma associated with mental illness and the possible work-related consequences. Some workers may not recognize their depressive symptoms, which include fatigue and low self-confidence, and this may contribute to delays in seeking treatment. Successful mental health care requires a proactive and systematic approach to detection and management in the workplace. For example, research has shown that more than 80 percent of people with clinical depression can be treated effectively, generally without missing much time from work or needing hospitalization (12).

The working and uninsured. The majority of Californians obtain their health insurance through their employer. In California, almost all employers who do offer health insurance also offer both outpatient and inpatient mental health services benefits, but with restrictions on the maximum number of outpatient visits covered (13). However, many working Californians are not insured. This problem is particularly prevalent among those who work in small businesses. Research has shown that businesses with 10 to 50 employees are much less likely than larger employers (greater than 50 employees) to offer their employees health benefits (62 percent versus 94 percent) (13). Of the small firms (10 to 50 employees) that do offer health insurance to their employees (62 percent), only 8 in 10 employees accept coverage (13). Unfortunately, this working, uninsured population is most vulnerable to negative physical and mental health outcomes (13).

Implementation of AB 88. Many employer groups who have opposed mental health parity bills believe that the increased costs of parity may benefit only a few at the expense of the employer. From monitoring implementation of parity legislation across the nation, several employer responses intended to avoid the potential cost impact of parity legislation have been identified. These include: redesigning benefit packages by reducing physical healthcare benefits; dropping health benefits altogether; increasing employee cost-sharing mechanisms (co-payments); and imposing more restrictive service limits for hospital days or outpatient visits (14). Furthermore, AB 88 requires that healthcare and mental health coverage be provided by the same health plan. California employers and health plans have identified this as a potential problem which must also be carefully monitored as the law is implemented (15).

The Future of Addressing Mental Health Issues in California

Expansion of AB 88. Senate Bill 468 (Polanco), a more inclusive mental health parity law than AB 88, was introduced on February 17, 1999 and is still under consideration by the California Legislature. SB 468 goes beyond AB 88's scope of providing coverage for only severe mental illnesses by requiring health insurers to cover *most* forms of mental illness under the same rates, terms and conditions as applied to other medical conditions.

Monitoring costs. Initial cost estimates of federal mental health parity legislation in 1996 anticipated premium increases ranging from 3 percent to 11 percent (16), but these estimates were calculated assuming utilization of mental health services occurred in an environment with low penetration of managed care. Experts believe that because managed care penetration in California is so high, California is a favorable environment in which to implement mental health parity with relatively lower implementation cost consequences. The Substance Abuse and Mental Health Services Administration (SAMHSA) found that the impact of parity on premiums would vary widely by plan type, with HMOs experiencing the smallest premium increases (0.6 percent) (17). Similarly, a U.S. General Accounting Office (GAO) report on the Mental Health Parity Act reported that for those health plans implementing parity, the resulting cost increases were less than one percent (14).

Defining a comprehensive mental health agenda. Monitoring and evaluating current and future state and federal mental health legislation will be critical to developing an effective mental health agenda. Although AB 88 is a key step in California, mental health parity only helps the insured. The mental health agenda should also account for vulnerable, uninsured populations such as the working poor or unemployed. Identifying and supporting effective strategies that protect and maintain good mental health, as well as prevent and treat mental illness, will be critical to assuring the future health and productivity of all Californians.

Recommendations to Improve Mental Health for Workers

- Plan for, monitor and evaluate the implementation of AB 88. Develop and implement an evaluation plan that will assess the direct and indirect effects of AB 88. Evaluation questions to consider could include: short-term implementation problems, including the issue of direct contracting between employers and mental health plans; premium cost changes; employer drop rates for health benefits; utilization rates of mental health services; and what population utilizes mental health services.
- Consider next steps to address mental health issues in California including: the expansion to broader-based mental health parity coverage (based on the outcomes and evaluations of AB 88); and strategies to address mental health access and treatment issues for the uninsured.
- Continue to support, fund and disseminate research about mental health and mental illness including: estimating the need for mental health services in California; identifying effective modes of treatment and systems of mental health care delivery; conducting research on ways to help

employers recognize mental illness in the workplace and facilitate help-seeking for employees; identifying the financial barriers to treatment; and developing work-related strategies and policies to prevent mental illness.

- Consider extending the legislative timeline for the California Joint Committee on Mental Health Reform past November 2000 to continue work in identifying promising strategies and policy recommendations relating to mental health.

The first Surgeon General's report on mental health (1999) was prepared against a backdrop of growing awareness of the burden of disability associated with mental illnesses. The report reviews the scientific literature and documents the advances in the study of mental health and mental illnesses, providing policy-makers with a scientifically-based reference tool to help guide decision-making about mental health issues. You can access the full report at www.surgeongeneral.gov/library/mentalhealth/index.html.

References

1. Greenberg PE, Stiglin LE, et al. The economic burden of depression in 1990. *Journal of Clinical Psychiatry*. 2:32-35. 1993.
2. Crowell A. *Emotional Health Services for Children, Youths: Coordinated Care, Insurance Coverage Needed*. California Center for Health Improvement. 1998.
3. U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health. 1999.
4. Murray CJ & Lopez AD. *The global burden of disease. A comprehensive assessment of mortality and disability from diseases, injuries and risk factors in 1990 and projected to 2020*. Harvard School of Public Health. 1996.
5. Rice DP & Miller LS. The economic burden of schizophrenia: Conceptual and methodological issues, and cost estimates. In M Moscarelli, A Rupp, & N. Sartorius (eds.), *Handbook of mental health economics and health policy. Vol. 1: Schizophrenia* (pp. 321-324). New York: John Wiley and Sons.
6. National Institute of Mental Health. *What to do When an Employee is Depressed: A Guide for Supervisors*. [Online] Available: <http://www.nimh.nih.gov/publicat/depemployee.cfm> [May 2000].
7. National Institute of Mental Health. *Co-Occurrence of Depression with Medical, Psychiatric, and Substance Abuse Disorders*. [Online] Available: <http://www.nimh.nih.gov/publicat/abuse.cfm> [May 2000].
8. Conversation with Kathy Styc, Chief of Statistics and Data Analysis. California Department of Mental Health. May 25, 2000.
9. University of California, San Francisco and The Field Institute. California Work and Health Survey. 1998, 1999. [Online] Available: <http://medicine.ucsf.edu/programs/cwhs> [May 2000].
10. California Employment Development Department, Labor Market Information Division. *California Civil Labor Force and Employment*. May 12, 2000.
11. Kessler RC, Nelson CB et al. The epidemiology of co-occurring addictive and mental disorders: Implications for prevention and service utilization. *American Journal of Orthopsychiatry*. (66); 17-31. 1996.
12. National Institute of Mental Health. *Fact Sheet: Depression Research at the National Institute of Mental Health*. [Online] Available: <http://www.nimh.nih.gov/publicat/depresfact.cfm> [May 2000].
13. Schauffer HH and Brown ER. *The State of Health Insurance in California, 1999*. Berkeley, CA: Regents of the University of California. January 2000.
14. United States General Accounting Office. *Mental Health Parity Act: Despite New Federal Standards, Mental Health Benefits Remain Limited*. May 2000.
15. Conversation with Maureen O'Haren, California Association of Health Plans. June 6, 2000.
16. Goldman W and Frank RG. "Mental Health Coverage Parity: Separating Wheat from Chaff," National Health Policy Forum Issue Brief No. 745, July 20, 1999.
17. Substance Abuse and Mental Health Services Administration. *The Cost and Effects of Parity for Mental Health and Substance Abuse Insurance Benefits*. 1998.



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