

California Health Benefits Review Program

California Health Insurance

Garen Corbett
Director

February 6, 2019



Health Insurance ...



- Covers the cost of an enrollee's medically necessary health expenses (excepting some exclusions).
- Protects against some or all financial loss due to health-related expenses.
- Can be publicly or privately financed.

Health Insurance ...

- is regulated
- is divided into markets
- may be (or may not be) subject to state laws, such as benefit mandates



State-regulated health insurance...

is either defined by a *health care service plan contract* that is:

- Subject to CA Health & Safety Code
- Regulated by DMHC



State-regulated health insurance...

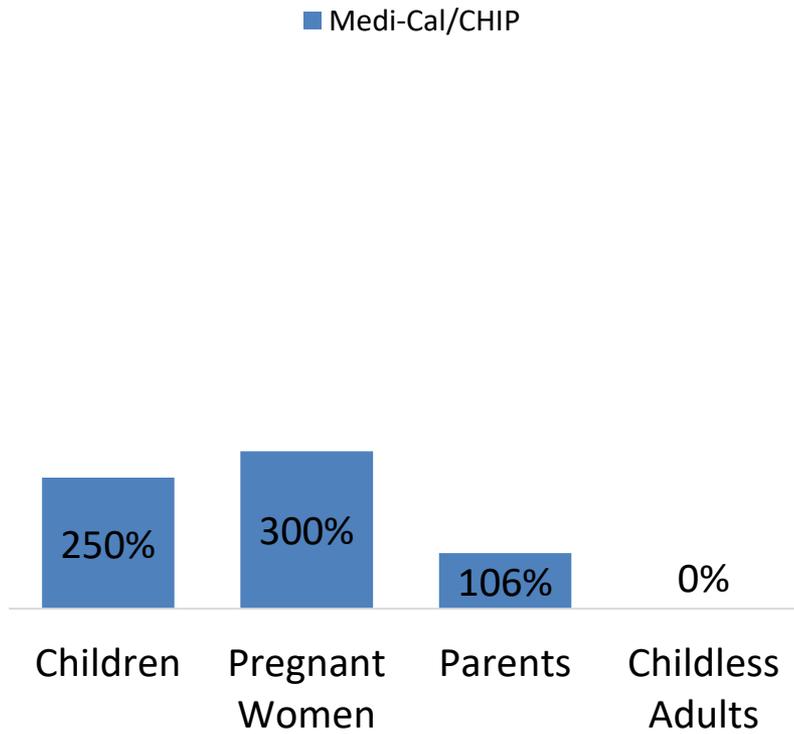
or is defined by a *health insurance policy* that is:

- Subject to CA Insurance Code
- Regulated by CDI

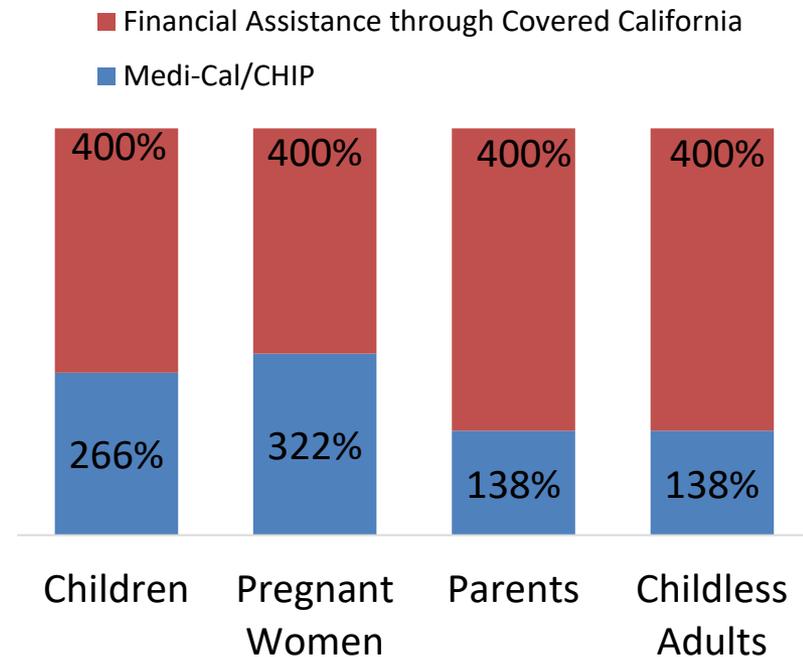


Medi-Cal/CHIP and Marketplace Eligibility in California Pre- and Post- ACA Implementation

2013 Medi-Cal/CHIP Eligibility by Federal Poverty Level



2017 Medi-Cal/CHIP and Covered California Assistance Eligibility by Federal Poverty Level

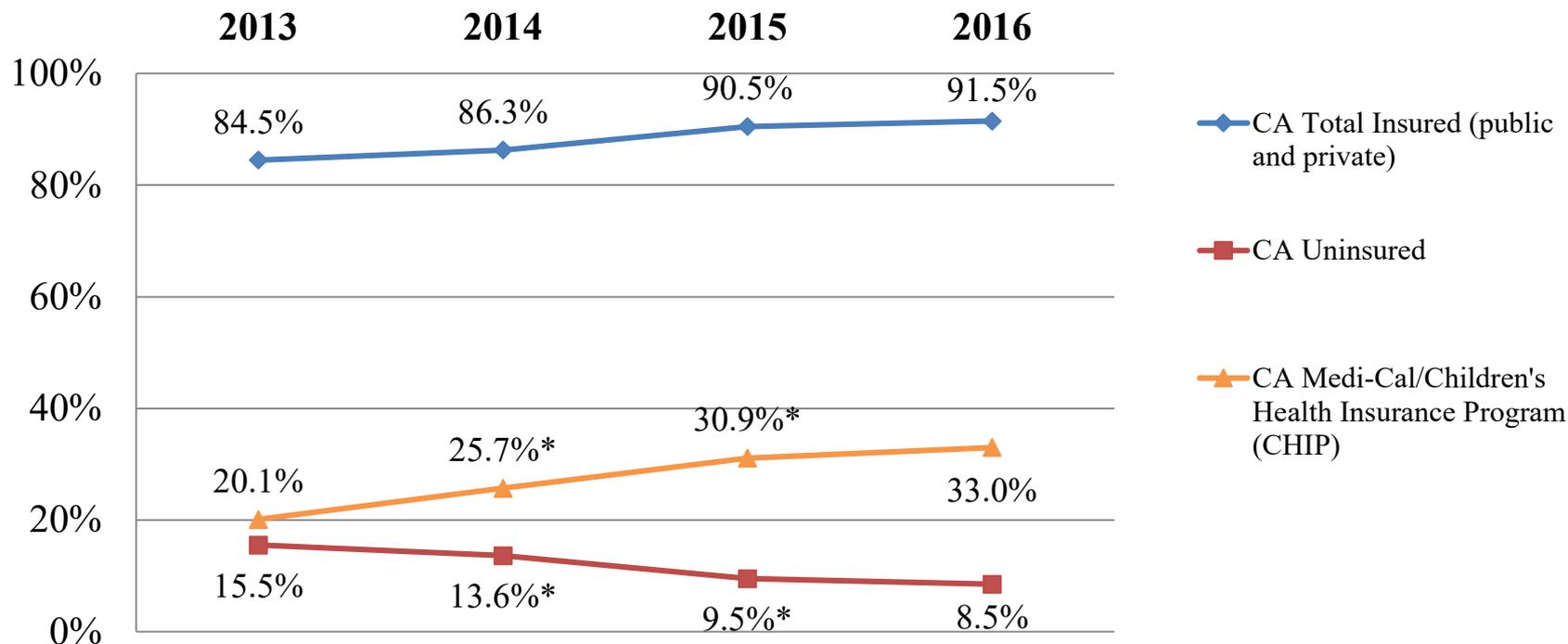


Source: Kaiser Family Foundation, 2018.

Health Insurance Status Of Californians Under Age 65, 2016



By Insurance Coverage Type, 2013-2016



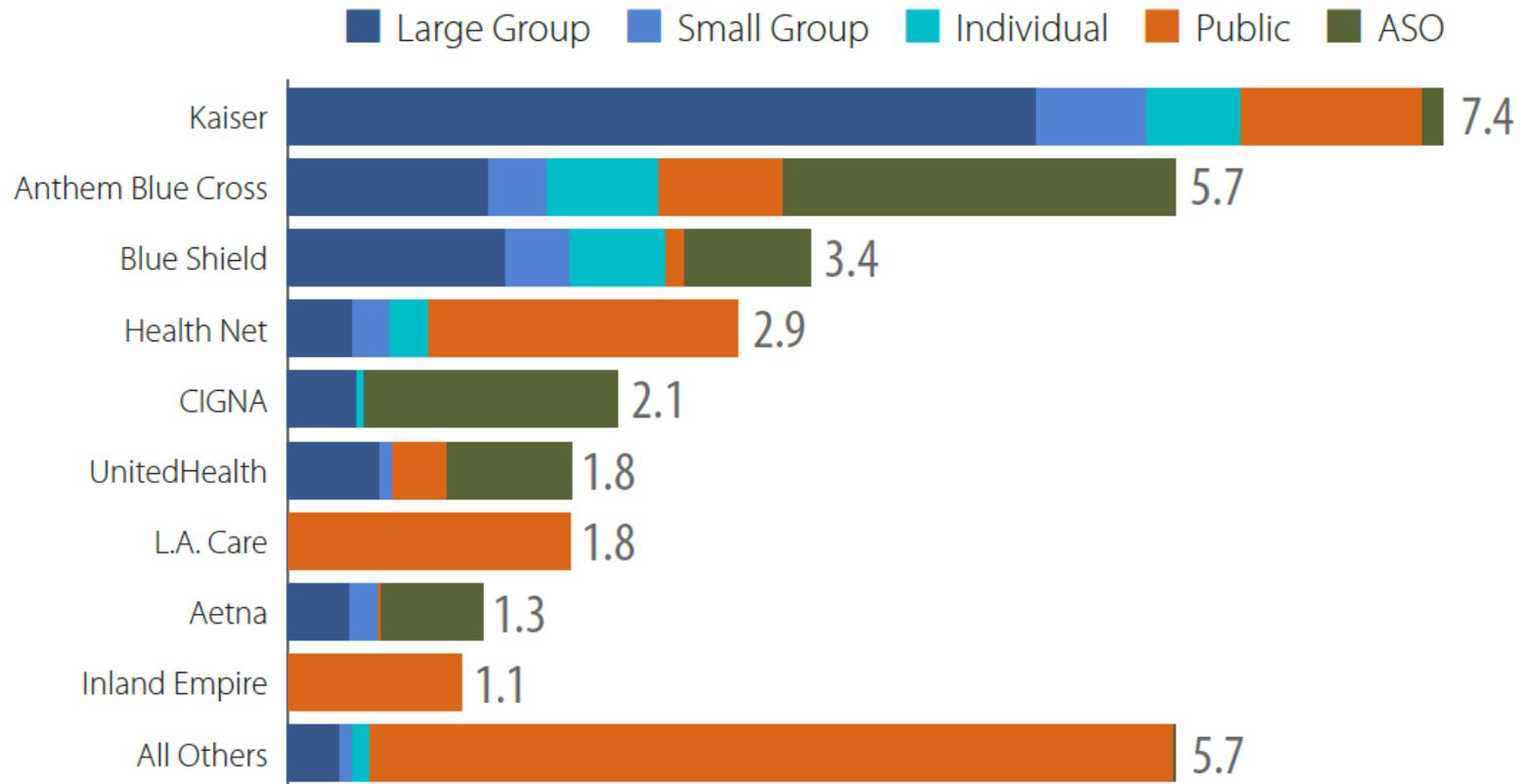
Note: * Indicates a statistically significant change from previous year

Source: Becker T. 2017. *Number of Uninsured in California Remained at Record Low in 2016*. Los Angeles, CA: UCLA Center for Health Policy Research.

California Commercial Payers

As a result of consolidation, the current commercial market is dominated by three major insurers – Kaiser, Anthem Blue Cross, and Blue Shield.

ENROLLMENT, BY INSURER AND MARKET, 2015 (IN MILLIONS)



Changes Federally and in the ACA

Recent changes

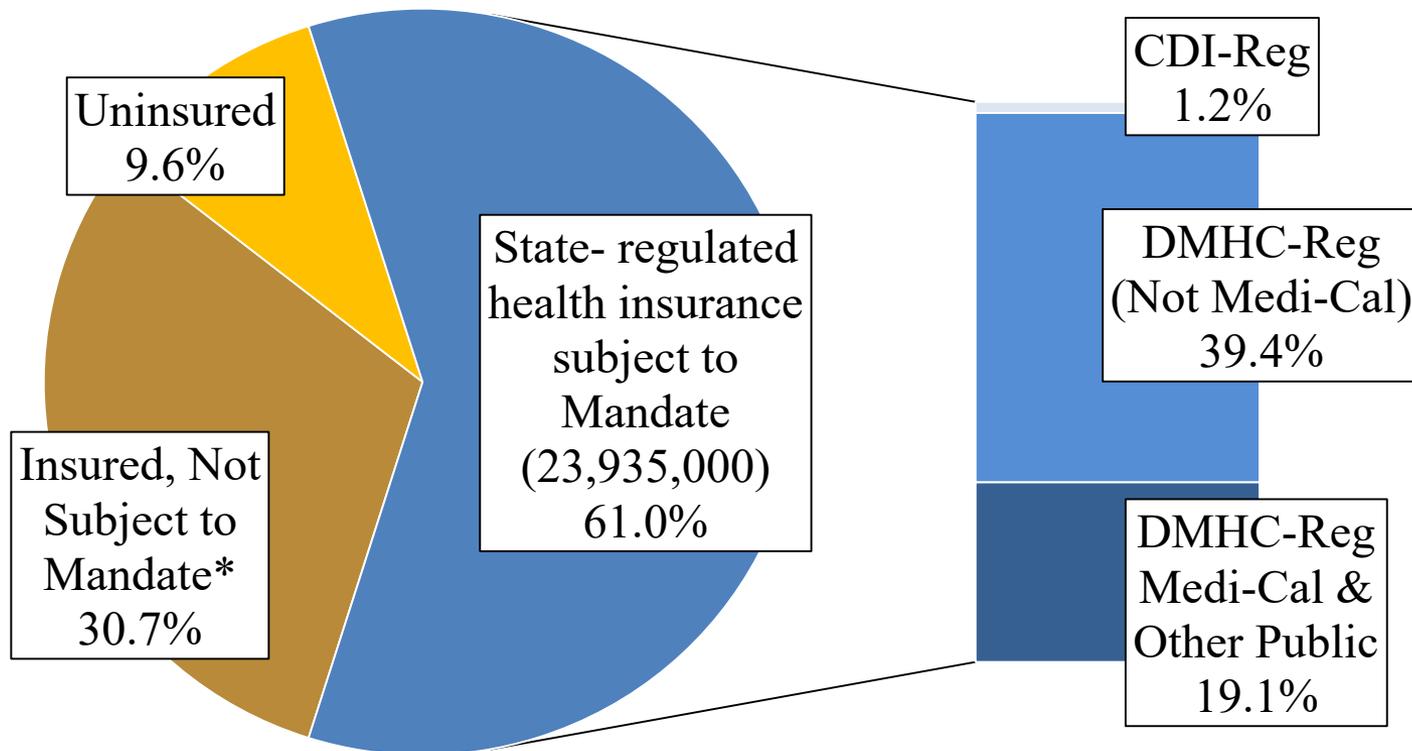
- Repeal of Individual Mandate Penalty in 2019 through the Tax Cuts and Jobs Act of 2017

Future changes

- Other federal action through CMS or executive order

2019 Estimates – CA Health Insurance – All Ages

Total Population – 39,212,000



*Such as enrollees in Medicare or self-insured products
Source: California Health Benefit Review Program, 2018

Health Insurance Markets in California

DMHC-Regulated Plans	CDI-Regulated Policies
Large Group (101+)	Large Group (101+)
Small Group (2-100)	Small Group (2-100)
Individual	Individual
Medi-Cal Managed Care*	-----

*except county organized health systems (COHS)

Benefit Mandates

State Laws (Health & Safety/Insurance Codes)

- 74 benefit mandates in California

Federal Laws

- Pregnancy Discrimination Act
- Newborns' & Mothers' Health Protection Act
- Women's Health and Cancer Rights Act
- Mental Health Parity and Addiction Equity Act
- Affordable Care Act

Benefit Mandates List

California Health Benefits Review Program

Resource:

[Health Insurance Benefit Mandates in
California State and Federal Law](#)

January 11, 2018

California Health Benefits Review Program
MC 3116
Berkeley, CA 94720-3116

www.chbrp.org

Additional free copies of this and other CHBRP bill analyses and publications may be obtained by visiting the CHBRP website at www.chbrp.org.

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California
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Universal Coverage and Single
Payer Efforts in California

Karla Wood
Project/Policy Analyst

February 6, 2019



Learning Objectives

- Universal Health Care vs Single Payer
- The Uninsured in California and Pathways to Universal Coverage
- Current Efforts: Transformational Universal Coverage Waivers

Universal Coverage vs Single Payer

- Universal coverage guarantees everyone access to good quality health services without suffering financial hardship
- Single payer is one possible structure for financing a health care system
- Countries that provide universal coverage use both single payer and multi-payer models

What is Single Payer?

- Centralized, publicly organized means of financing and administering health care for a defined population
- Delivery of health care remains mostly private
- Public agency (single payer) defines benefits, pools money, and negotiates rates in order to pay for all medical expenses
- Would require significant changes to current health care system in CA

Current Single Payer Models

United States

- Medicare
- Veteran's Administration (VA)

Global

- Canada
- Taiwan
- South Korea

The Uninsured in California

- Approximately *3 million Californians* remain uninsured after ACA implementation
- Efforts to insure uninsured include
 - increasing Covered California subsidies
 - increasing Medi-CAL outreach
 - coverage of undocumented individuals until age 26

INSURING THE UNINSURED IN CALIFORNIA: PATHWAYS TO UNIVERSAL COVERAGE

Figure 4

Profile of Uninsured Californians

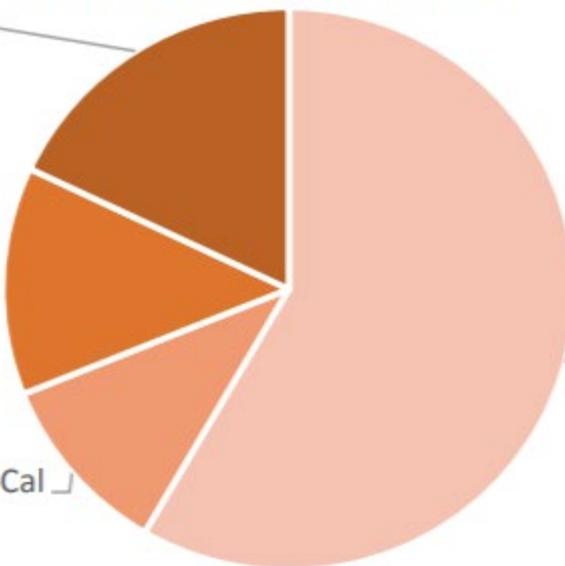
Nonelderly, 2017 Projections

Non-subsidy Eligible
Citizens & Lawfully
Present Immigrants
550,000

Eligible for Subsidies
through Covered CA
401,000

Eligible for Medi-Cal
322,000

Not Eligible due to
Immigration
Status
1,787,000



Source: *Insure the Uninsured Project; Miranda Dietz, Dave Graham-Squire, Tara Becker, Xiao Chen, Laurel Lucia, and Ken Jacobs, "Preliminary CalSIM v 2.0 Regional Remaining Uninsured Projections," August 2016.*

Single Payer Efforts in California

- SB 562 (Lara): The Healthy California Act
- Governor Newsom's Request for Universal Coverage Waivers (January 2019)
- Advisory Panel on Health Care Delivery Systems and Universal Coverage (AB 2517)

Universal Coverage Waivers: Path to Single Payer Health Care System

- Transformational Cost and Universal Coverage Waivers

Lays ground work for single payer by allowing states to re-invest Fed funds, combined with state funds to improve coverage

Interested in learning more about Universal Coverage in California?

E. Richard Brown Symposium

March 1, 2019 10:00am-12:00pm

State Capitol Building, Room 4203

Sacramento, CA

California Health Benefits Review Program

2019: Overview of CHBRP

Garen Corbett
Director



What is CHBRP?

- CHBRP is an independent, analytic resource housed at UC to support the Legislature, grounded in objective policy analysis
 - CHBRP is multi-disciplinary, drawing from faculty & researchers across the University of California.
 - Provides timely, evidence-based information to the Legislature, leveraging faculty expertise since 2003.
 - Neutral and unbiased analysis of introduced bills at the **request** of the Legislature (Policy Context, Medical Effectiveness, Cost, Public Health).

Who is CHBRP?

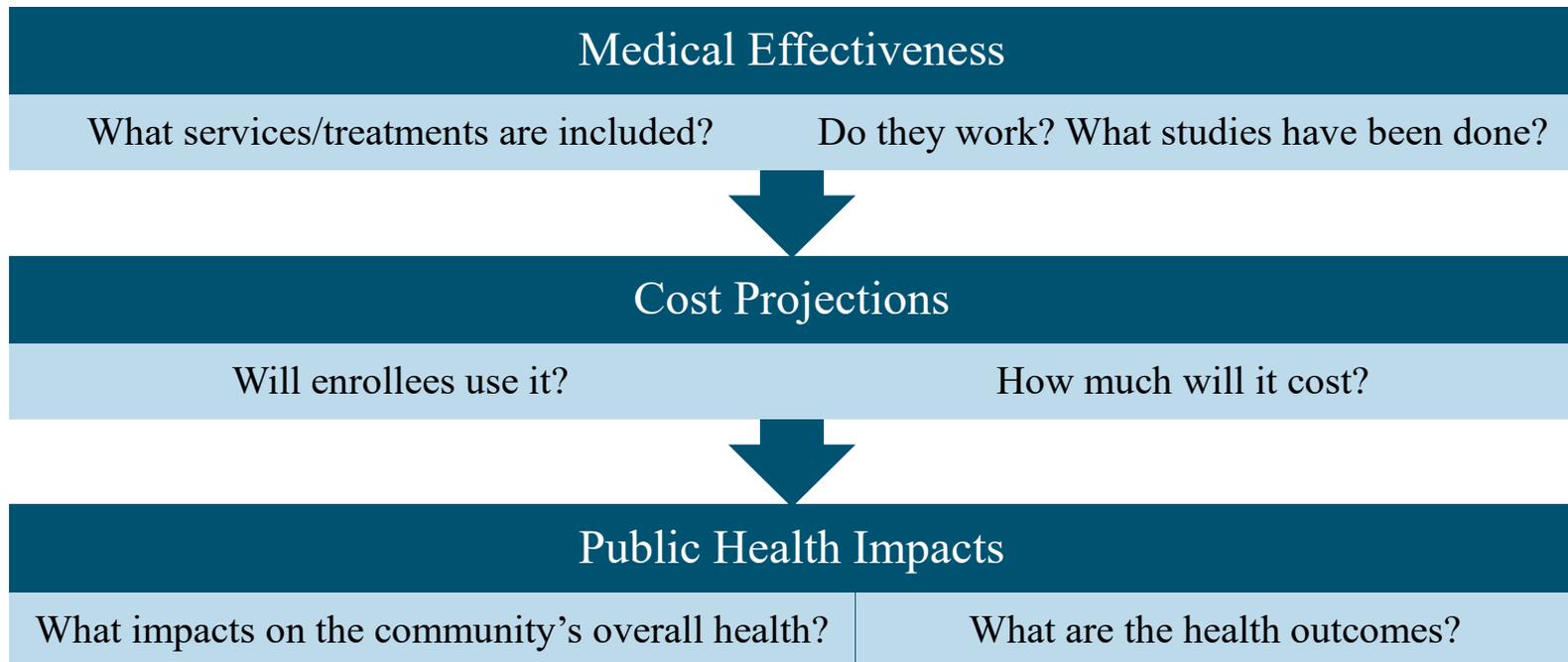
- CHBRP Staff (based at UC Berkeley)
- Task Force of faculty and researchers
- Actuarial firm: Milliman, Inc.
- Librarians
- Content Experts
- National Advisory Council

Health Insurance Benefit Mandates

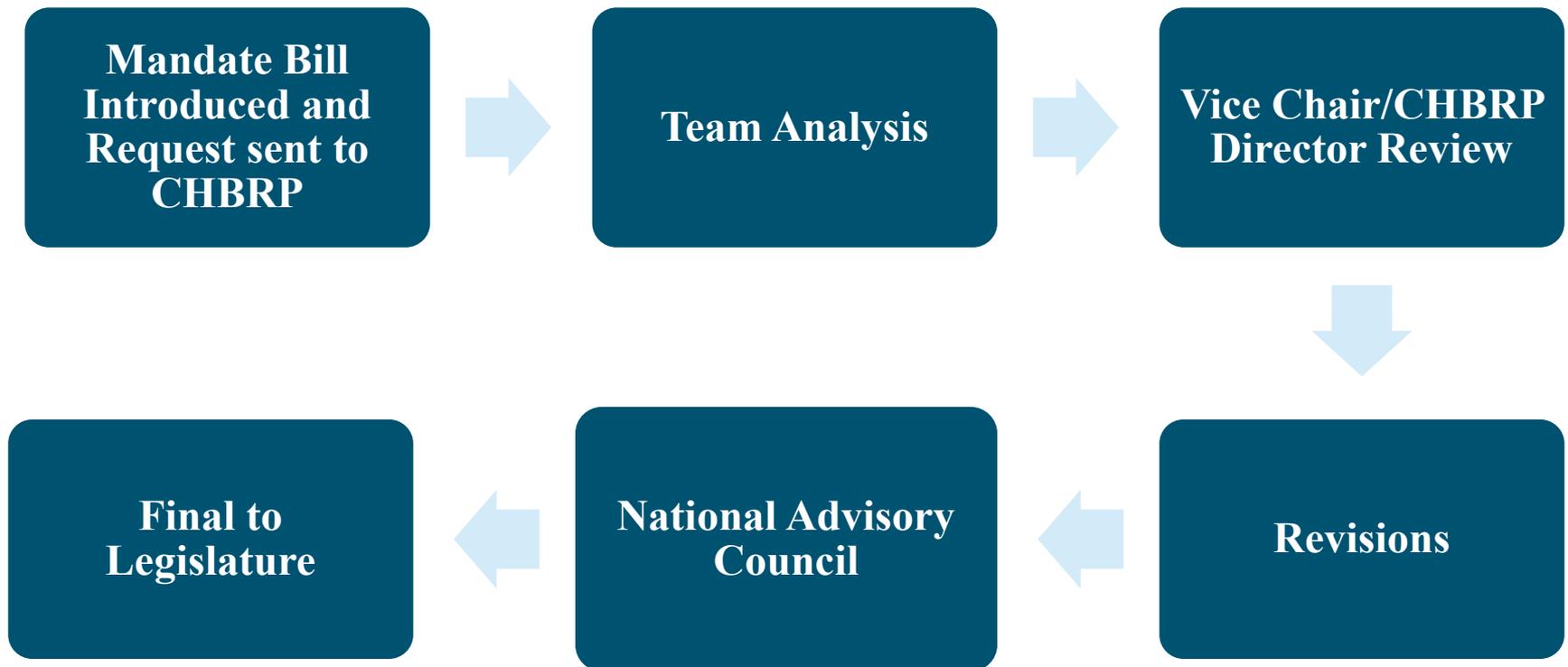
- Health Insurance Benefits:
 - Benefits are tests/treatments/services appropriate for one or more conditions/diseases
- Health Insurance Benefit Mandates may pertain to:
 - Type of health care provider
 - Screening, diagnosis or treatment of disease/condition
 - Coverage for particular type of treatment, service
 - Benefit design (limits, time frames, co-pays, deductibles, etc.)

How CHBRP Works

- Upon receipt of the Legislature's request, CHBRP convenes multi-disciplinary, analytic teams
- CHBRP staff manage the teams, complete policy context
- Each analytic team evaluates:



CHBRP's 60-Day or Less Timeline



CHBRP Analyses Provide:

Policy Context

Whose health insurance would have to comply?

Are related laws already in effect?



Medical Effectiveness

Which services and treatments are most relevant?

Does evidence indicate impact on outcomes?



Impacts

Would benefit coverage, utilization, or cost change?

Would the public's health change?

What Will You Find in a CHBRP Report?

- Key Findings
- Six major sections:
 1. Policy Context
 2. Background
 3. Medical Effectiveness
 4. Cost Impacts (Benefit Coverage Utilization and Cost Impacts)
 5. Public Health Impacts/Social Determinants of Health
 6. Long Term Impacts

Key Findings:

Analysis of California Senate Bill SB 190 Acquired Brain Injury

Summary to the 2015–2016 California State Legislature, April 2015



Key Findings: Analysis of California Senate Bill SB 190



AT A GLANCE

Senate Bill SB 190 (introduced February 2015) would require coverage for a coordinated and particularly comprehensive service set, post-acute residential transitional rehabilitation services (PARTRS), for persons with acquired brain injury (ABI).

- **Enrollees covered.** CHBRP estimates that in 2016, 17.1 million Californians will have state-regulated health insurance that would be subject to Senate Bill SB 190.
- **Impact on expenditures.** Expenditures would increase by 0.16%, due to projected shifts in utilization among persons with ABI from other post-acute rehabilitation services to PARTRS.
- **EHBs.** Because PARTRS is residential and because the residential aspects of habilitative and rehabilitative essential health benefits (EHB) requirements are unclear, it is unclear whether SB 190 would exceed EHBs.
- **Medical effectiveness.** There is a preponderance of evidence that PARTRS is associated with outcome improvements for persons with ABI. However, there is insufficient evidence to state that PARTRS results in different outcomes than other post-acute rehabilitation services. Note: insufficient evidence is not evidence of no effect.
- **Benefit coverage.** Premandate, all enrollees with ABI have coverage for post-acute rehabilitation services, but not all have coverage for PARTRS. Postmandate, all enrollees would have coverage for PARTRS.
- **Utilization.** Postmandate, among persons with moderate-to-severe ABI who gain coverage for PARTRS, utilization by 2,500 patients would shift from post-acute skilled nursing facility (SNF)-based or outpatient services to PARTRS.
- **Public Health.** Because a shift but no additional rehabilitation is projected and because there is insufficient evidence of greater medical effectiveness for PARTRS than for the other post-acute rehabilitation services, no change in health outcomes can be projected.

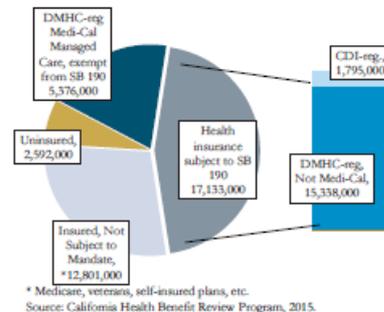
ACQUIRED BRAIN INJURY

Acquired brain injury (ABI) is a rapid onset brain injury occurring after birth. ABI excludes congenital disorders, developmental disabilities, or processes that progressively damage the brain. ABI is most frequently associated with stroke or traumatic brain injury (TBI). ABI ranges in severity, from mild concussion (requiring little or no treatment) to impairment to coma to death. Impairments suitable for rehabilitation treatment may include: physical symptoms (physical disabilities from weakness, impaired coordination, or spasticity); cognitive abilities (thinking, memory, reasoning); issues around sensory processing and/or communication; mental or behavioral health (depression, anxiety, personality changes, aggression, social inappropriateness). Acute and post-acute rehabilitation outcomes range from complete restoration of pre-injury function to permanent, severe disability.

BILL SUMMARY

As illustrated in Figure 1, SB 190 would affect the health insurance of 17.1 million Californians.

Figure 1. Health Insurance in CA and SB 190



The number of persons with ABI among persons with health insurance subject to SB 190 is less than might be expected because age interacts with both health insurance status and the two most common sources of ABI, stroke and TBI. Stroke is most common among persons over 65 years of age, and Medicare is not subject to state-level benefit mandates. TBI is most common among younger persons, who are over-represented among Medi-Cal beneficiaries, whose health insurance is exempt from SB 190.

For persons with ABI with health insurance subject to SB 190, the mandate would require coverage for post-acute residential transitional services (PARTRS). The bill defines PARTRS as a comprehensive set of services delivered to persons who have been discharged from an acute hospital stay (so "post-acute"). PARTRS is a coordinated form of care, as are most "residential" forms of rehabilitation. SB 190 defines PARTRS as inclusive of a combination of physical/occupational/speech/respiratory therapy, prosthetic/orthotic services, rehabilitation nursing, and neuropsychology and psychology services. Some or all of the elements of PARTRS may be available through other post-acute rehabilitation services, such as skilled nursing facility (SNF)-based and outpatient. However, rehabilitation nursing and neuropsychology are not commonly available in other post-acute rehabilitation services.

SB 190 would also require that terms and conditions for PARTRS coverage be in parity with other benefit coverage and SB 190 would prohibit exclusion of adult residential facilities as PARTRS providers due to their licensure.

IMPACT OF SB 190

CHBRP found no evidence of terms and conditions for PARTRS coverage not being in parity with terms and conditions for other benefit coverage and so assumes the related SB 190 requirement would have no direct impact. CHBRP also found that adult residential facilities could be excluded for reasons other than licensure, and so projects no direct impact from SB 190's related prohibition.

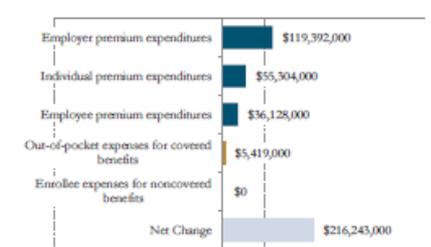
CHBRP found that coverage of PARTRS is not universal among persons with health insurance subject to SB 190 and so projects that 83% of these enrollees would gain benefit coverage. Because these enrollees already have coverage for other post-acute rehabilitation services (outpatient and SNF-based), CHBRP projects a utilization shift among enrollees with ABI who gain PARTRS

coverage, but not an increase in over-all utilization of post-acute rehabilitation services. CHBRP assumes that persons with moderate-to-severe ABI who qualify for PARTRS and who gain PARTRS coverage were already using one of the other post-acute rehabilitation services. Therefore, CHBRP projects a utilization shift—greater use of PARTRS and less use of SNF-based and outpatient rehabilitation services by 2,500 enrollees with new benefit coverage and ABI—but no greater overall use of post-acute rehabilitation.

Because the unit cost for PARTRS is higher than the unit cost for SNF-based and outpatient rehabilitation services, CHBRP projects an increase in expenditures (premiums and enrollee expenses for covered services—a.k.a. cost sharing) as a result of the utilization shift (see Figure 2).

Because the number of persons with moderate-to-severe ABI annually qualifying for PARTRS is limited and because facilities that are PARTRS-ready or near-PARTRS-ready exist, CHBRP expects that persons with new benefit coverage would find a facility providing PARTRS.

Figure 2. SB 190 Postmandate Expenditure Changes



Medical Effectiveness and Public Health Impacts

CHBRP finds insufficient evidence to suggest that a switch to PARTRS from other post-acute rehabilitation services would change health outcomes. Note: insufficient evidence is not evidence of no effect.

A CHBRP Report Addresses:

- Does scientific evidence indicate whether the treatment/service works?
- What are the estimated impacts on benefit coverage, utilization and costs of the treatment/service?
- What is the potential value of a proposed health benefit mandate? What health outcomes are improved at what cost?
- What are the potential benefits and costs of a mandate in the long-term?
- If relevant, what is the impact on the social determinates of health?

WORKING DEFINITION: UC'S CALIFORNIA HEALTH BENEFITS REVIEW PROGRAM

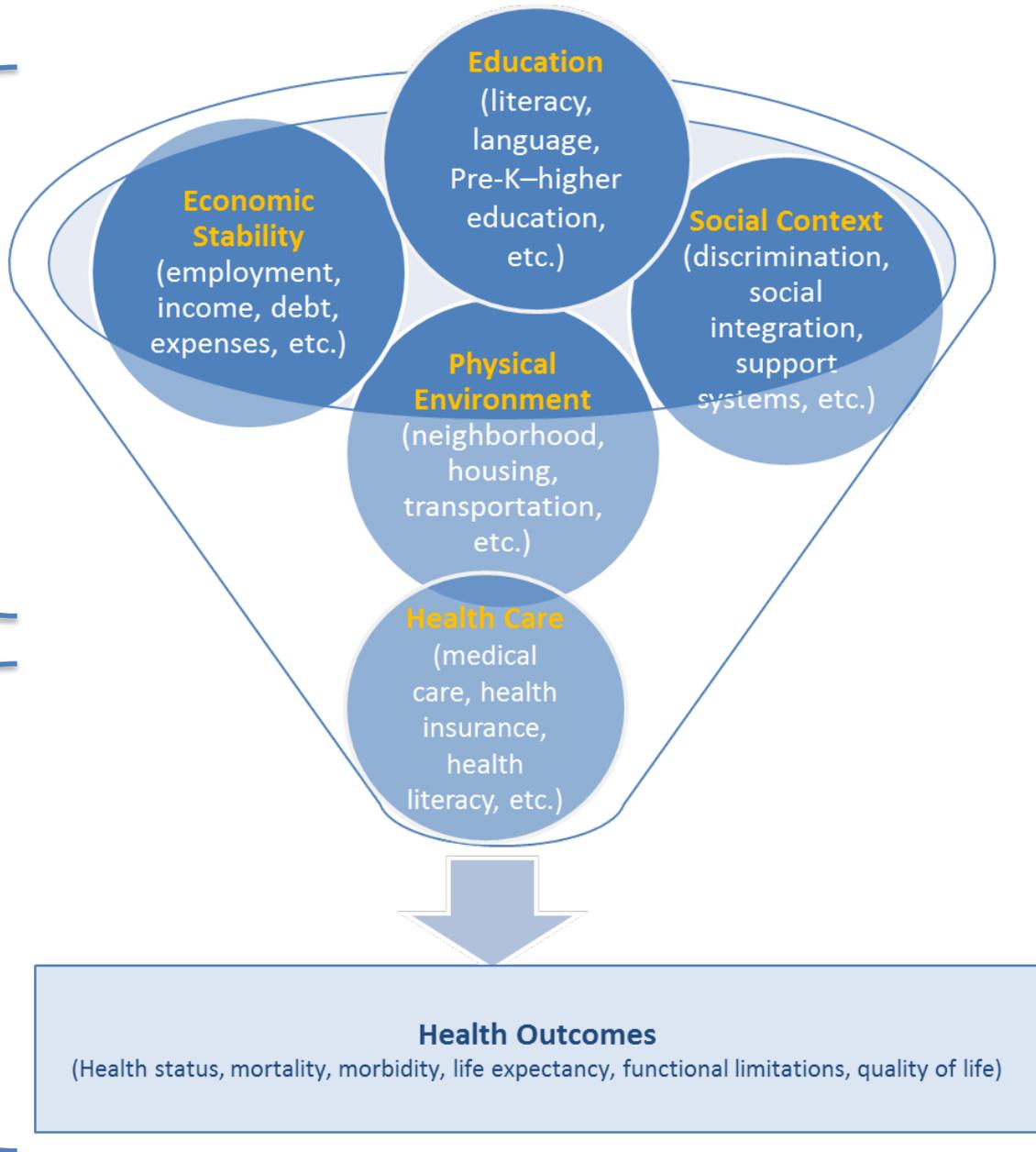
- Social determinants of health **are conditions in which people are born, grow, live, work, learn, and age.** These social determinants of health (economic factors, social factors, education, physical environment) are shaped by the distribution of money, power, and resources and are impacted by policy.

(adapted from Healthy People 2020, 2015; APHA, 2014).

SDOH FRAMEWORK

Upstream factors

Downstream factors



SDOH AND HEALTH INSURANCE

- Health insurance can mediate health outcomes by affecting access to medical care
- Less commonly, health insurance and medical care may influence SDOH
 - Screen-detected high lead levels in young children
 - changed policy on water source
 - impacted subsequent lead exposures in the community.
 - Clinical care in schools for children with asthma or diabetes
 - influence both short-term health outcomes and educational attainment
 - improve long-term outcomes in employment, income, and adult health status

HEALTH DISPARITIES

- The World Health Organization (WHO) defines health disparities as:
 - Differences in health outcomes that are
 - closely linked with social, economic, and environmental disadvantage — are often driven by the social conditions in which individuals live, learn, work and play.

CHBRP's Website: www.chbrp.org

CALIFORNIA
HEALTH BENEFITS REVIEW PROGRAM
Providing Objective Legislative Analysis

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Posted 06/01/2017

2017 Analysis:

AB 1316 – Childhood Lead Poisoning Prevention

Ana Ashby
Graduate Assistant, Health Policy



CHILDHOOD LEAD EXPOSURE

- No level of lead in the body is known to be safe.
- Common sources of lead include:
 - Lead-based paint (pre-1978);
 - Lead contaminated soil;
 - Dust contaminated with lead from paint or soil;
 - Some foods, cosmetics, and dishware with leaded glaze.
- Testing is one step of many.
 - Interventions: Environmental, educational, nutritional interventions, medical (chelation therapy)

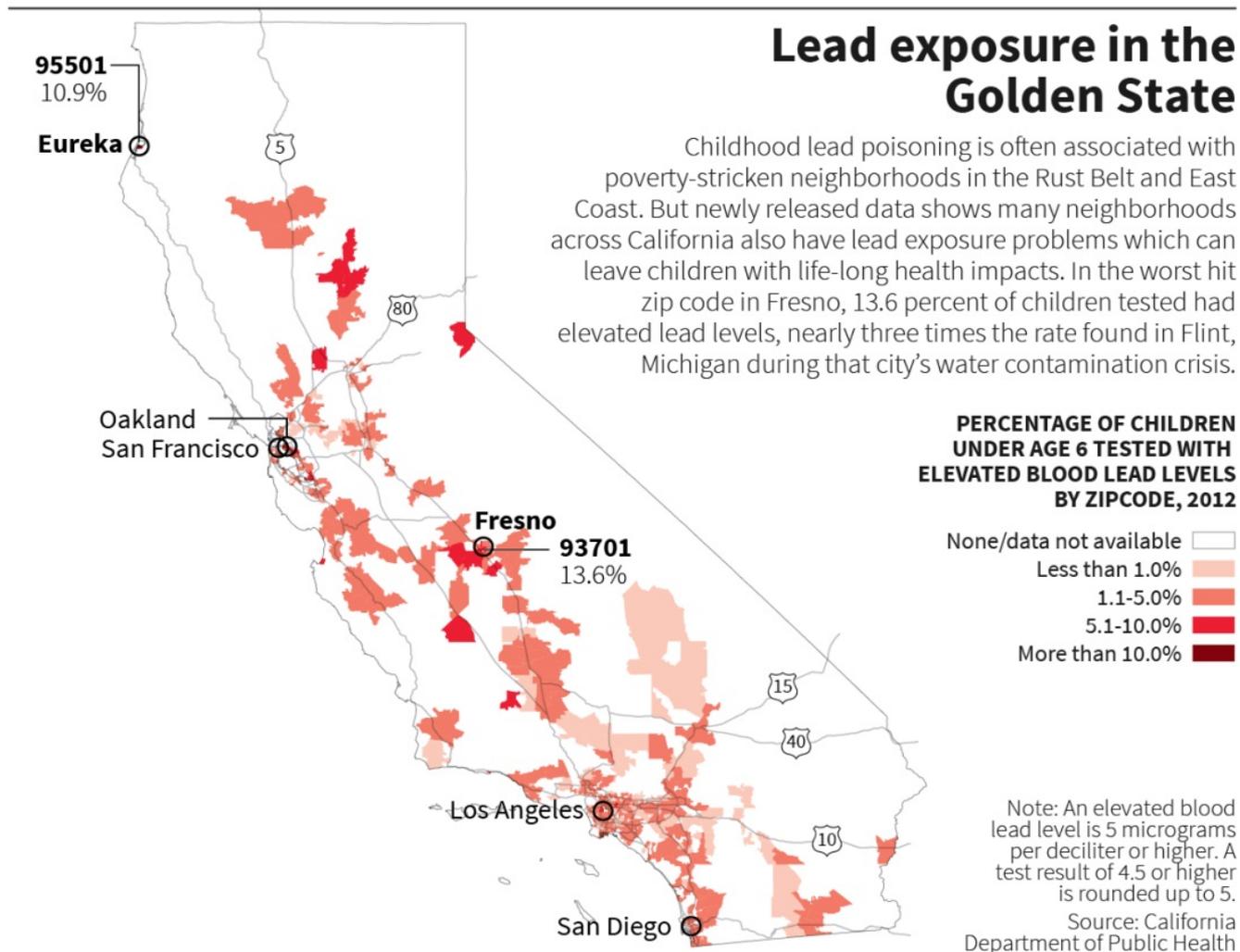
AB 1316: CHILDHOOD LEAD POISONING PREVENTION

As analyzed by CHBRP, AB 1316 would require:

- Certain health care service plans to **test blood lead levels of all children 6-72 months** (rather than only those “at-risk”)
 - Targeted → universal
- Appropriate case management if lead poisoning identified (via Department of Public Health)



LEAD EXPOSURE IN CALIFORNIA



C. Chan, M.B. Pell 21/03/2017

REUTERS

MEDICAL EFFECTIVENESS IMPACTS OF AB 1316



- **Individual Level:**
 - Damage is irreversible
 - However, steps can be taken to minimize further exposure



- **Population Level:**
 - Insufficient evidence that a universal screening approach is more effective than a targeted approach

PUBLIC HEALTH IMPACTS OF AB 1316



- **Individual Level:**

- CHBRP estimates 4,800 additional children with elevated blood lead levels would be identified in the first year; mitigation can occur

- **Population Level:**

- Potential for future identification of lead exposure “hot spots”
 - lead abatement, prevention on community level
 - requires action by other state agencies, stakeholders



COST IMPACTS OF AB 1316

- Benefit coverage would not change; standard of care changes
- Estimate ~250,000 additional blood lead level tests in kids
 - Increase total net annual expenditures by \$6,221,000 (0.004%)



Questions?

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