California
Health Benefits
Review Program

California Health Insurance

John Lewis

Associate Director

January 23, 2020

CALIFORNIA
HEALTH BENEFITS REVIEW PROGRAM

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 at the federal level or at both the federal and state level

- may be (or may not be) subject to state laws, such as benefit mandates

State-regulated health insurance…

health care service plan contracts are:

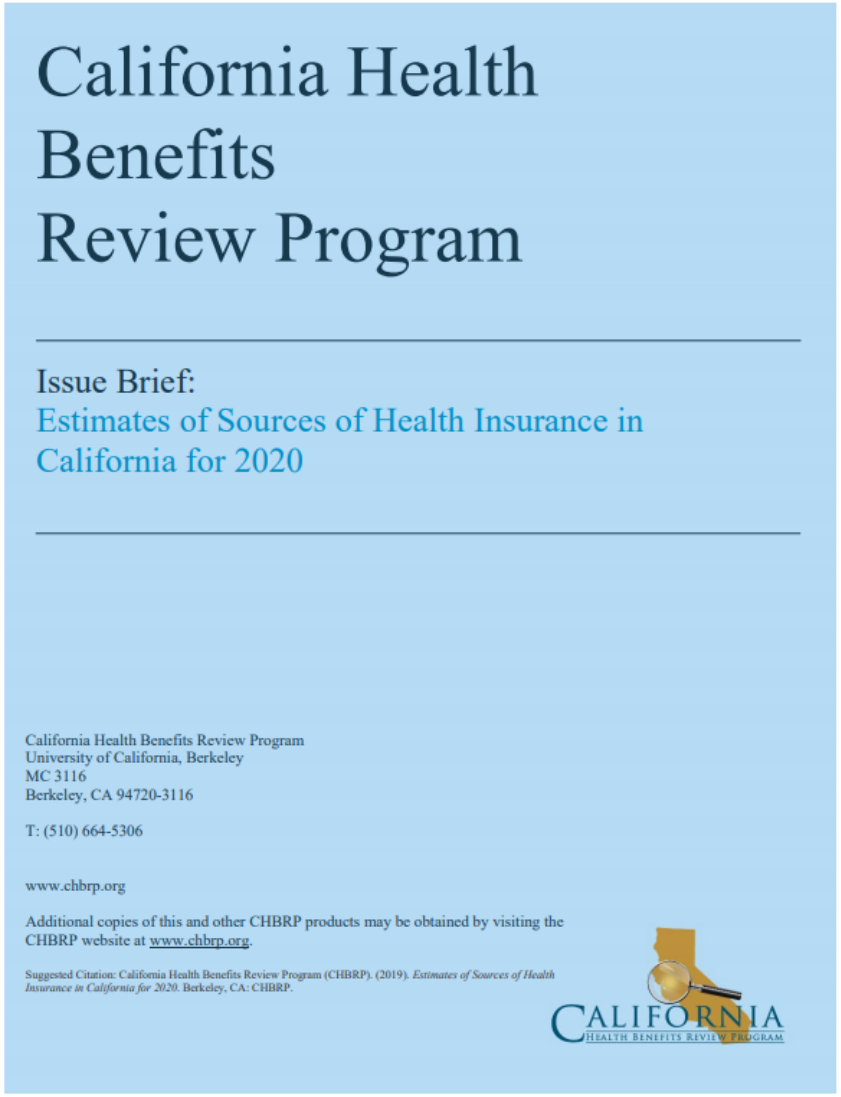
- Subject to CA Health & Safety Code
- Regulated by DMHC

State-regulated health insurance…

health insurance policies *are*:

- Subject to CA Insurance Code
- Regulated by CDI

Sources of Health Insurance



California Health Benefits Review Program

Issue Brief:
Estimates of Sources of Health Insurance in California for 2020

California Health Benefits Review Program
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www.chbrp.org

Additional copies of this and other CHBRP products may be obtained by visiting the CHBRP website at www.chbrp.org.

Suggested Citation: California Health Benefits Review Program (CHBRP). (2019). *Estimates of Sources of Health Insurance in California for 2020*. Berkeley, CA: CHBRP.

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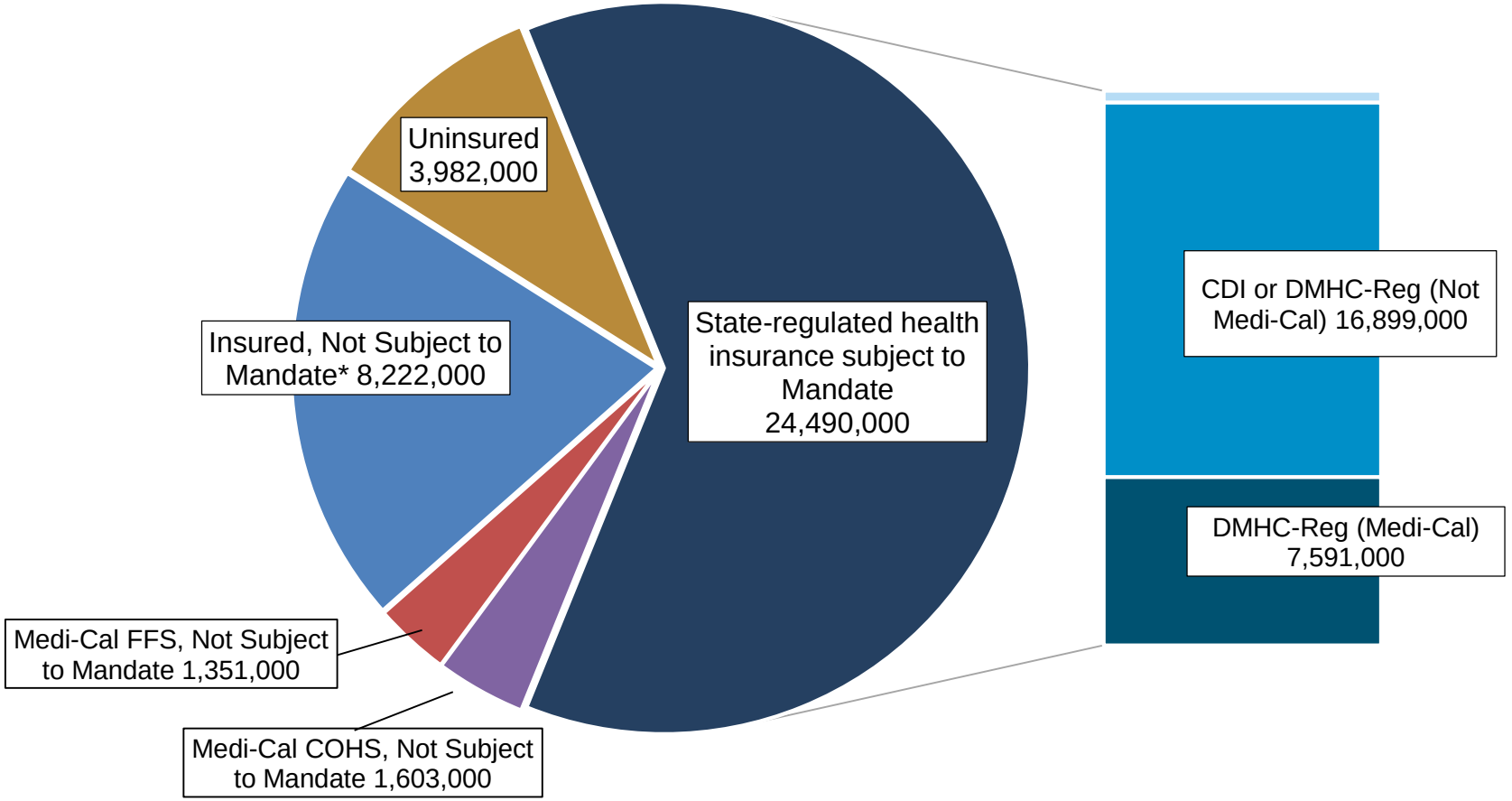
2020 Estimates – CA Health Insurance

Total CA Population – **39,648,000**



*Such as enrollees in Medicare or self-insured products

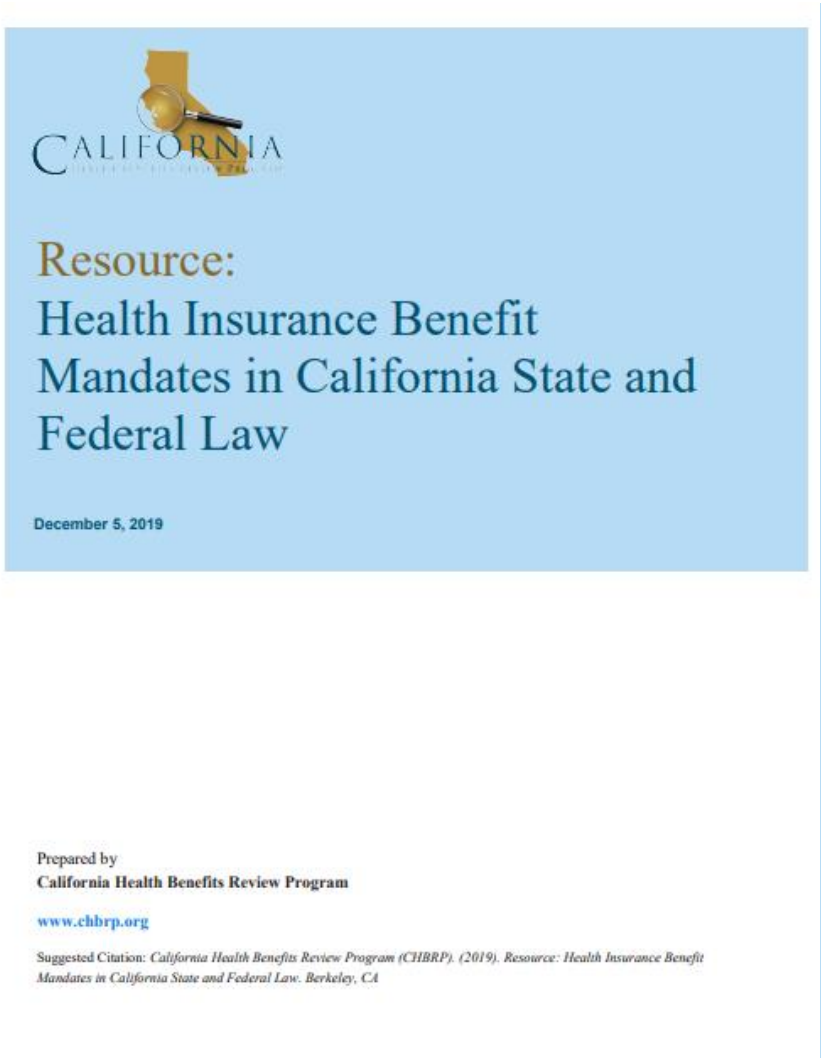
Source: California Health Benefit Review Program, 2019

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 List


CALIFORNIA

Resource:
Health Insurance Benefit Mandates in California State and Federal Law

December 5, 2019

Prepared by
California Health Benefits Review Program

www.chbrp.org

Suggested Citation: *California Health Benefits Review Program (CHBRP). (2019). Resource: Health Insurance Benefit Mandates in California State and Federal Law. Berkeley, CA*

Benefit Mandates

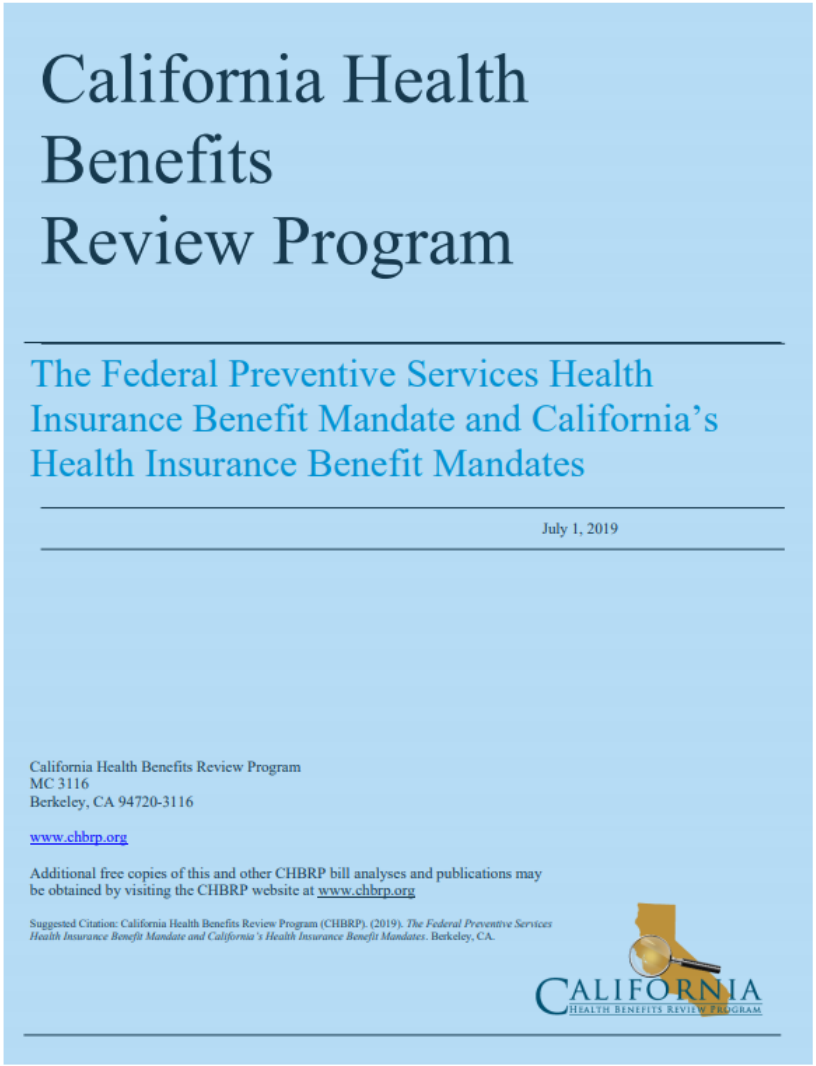
State Laws (Health & Safety/Insurance Codes)

- 79 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 (ACA)
    - Federal Preventive Services
    - Essential Health Benefits (EHBs)

Federal Preventive Services



California Health Benefits Review Program

The Federal Preventive Services Health Insurance Benefit Mandate and California's Health Insurance Benefit Mandates

July 1, 2019

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

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CALIFORNIA HEALTH BENEFITS REVIEW PROGRAM

Federal Preventive Services

~70 Benefit Mandates from these sources:

- **USPSTF** (United States Preventive Services Task Force) A and B recommendations
- **HRSA** (Health Resources and Services Administration)
  - health plan coverage guidelines for women's preventive services
  - comprehensive guidelines for infants, children, and adolescents
- **ACIP** (Advisory Committee on Immunization Practices) recommendations adopted by the CDC (Centers for Disease Control and Prevention)

Essential Health Benefits (EHBs)


CALIFORNIA

Issue Brief

California State Benefit Mandates and the Affordable Care Act's Essential Health Benefits

An Update and Overview of New Federal Regulations

January 8, 2020

Prepared by

California Health Benefits Review Program

www.chbrp.org

Suggested Citation: *California Health Benefits Review Program (CHBRP). (2020). Issue Brief: California State Benefit Mandates and the Affordable Care Act's Essential Health Benefits. Berkeley, CA*

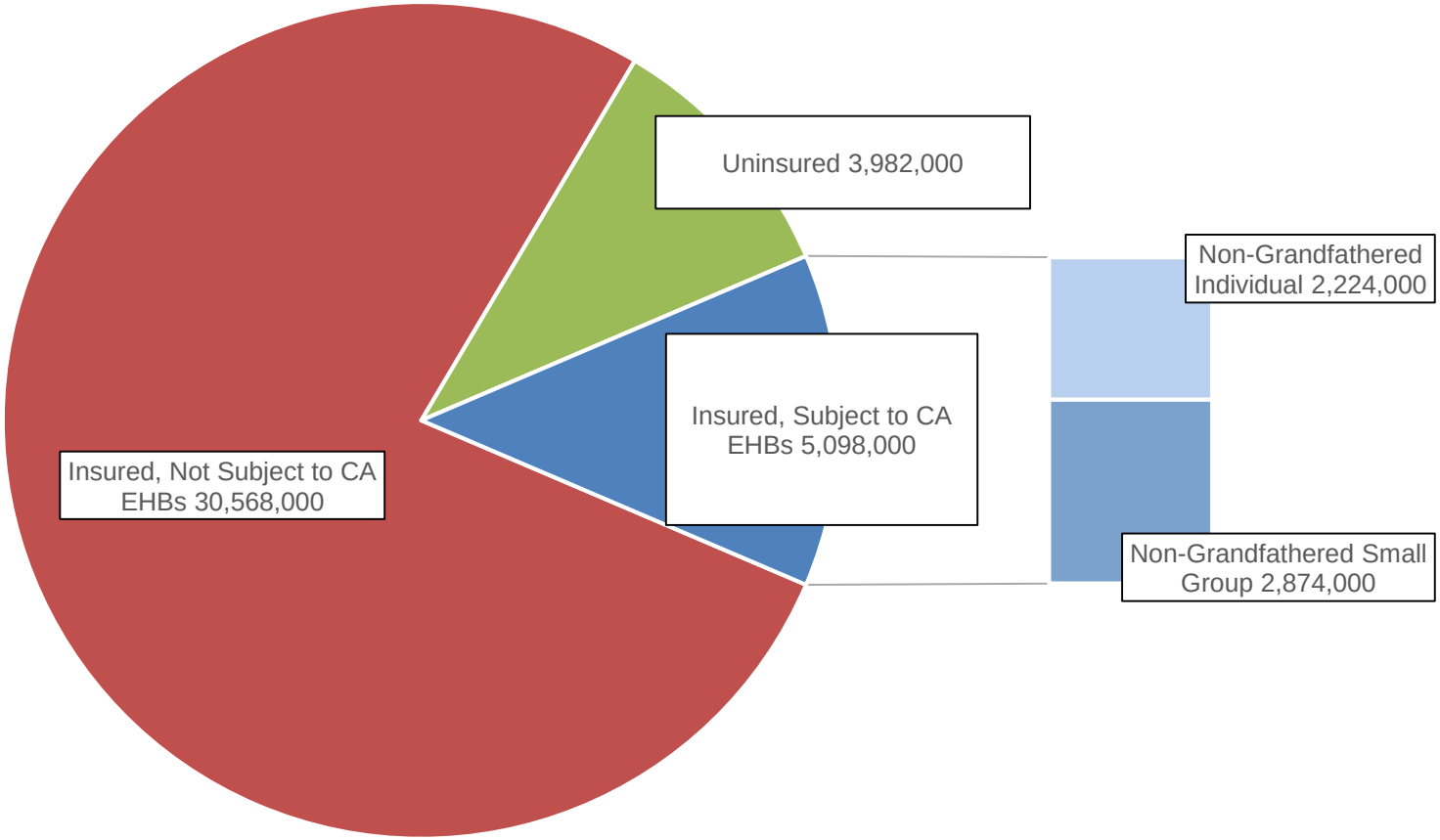
Essential Health Benefits (EHBs)

Categories

1. Ambulatory patient services;
2. Emergency services;
3. Hospitalization;
4. Maternity and newborn care;
5. Mental health substance use disorder services, including behavioral health treatment;
6. Prescription drugs;
7. Rehabilitative and habilitative services and devices;
8. Laboratory services;
9. Preventive and wellness services and chronic disease management; and
10. Pediatric services, including oral and vision care.

ESSENTIAL HEALTH BENEFITS

Total CA Population – **39,648,000**



Notes: "Insured, Not Subject to CA EHBs" includes Medicare beneficiaries, enrollees in self-insured or large group plans/policies, and enrollees in grandfathered individual and small group plans/policies

California
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California Health Insurance

John Lewis
Associate Director

January 23, 2020

California Health Benefits Review Program

Providing Evidence-Based Analysis to the California Legislature

2020 Legislative Briefing

Ana Ashby

Policy Analyst

WHAT IS CHBRP?

- Independent, analytic resource grounded in objective policy analysis
- Multi-disciplinary
- Rapid, evidence-based information to the Legislature, leveraging faculty expertise
- Neutral and unbiased analysis of introduced health insurance benefit mandate bills at the **request** of the Legislature

CHBRP'S STATUTE

- Health and Safety Code Section 127660-127665
- Health insurance benefit mandates and repeals
- Public health impacts
- Medical impacts
- Cost impacts
- Analysis within 60 days
- Funding
- Conflict of Interest

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

HOW CHBRP WORKS

- Upon receipt of the Legislature's request, CHBRP convenes analytic teams to provide analysis ***before*** policy committee hearing
- CHBRP staff act as project managers and provide context
- CHBRP analyzes health insurance benefit mandates

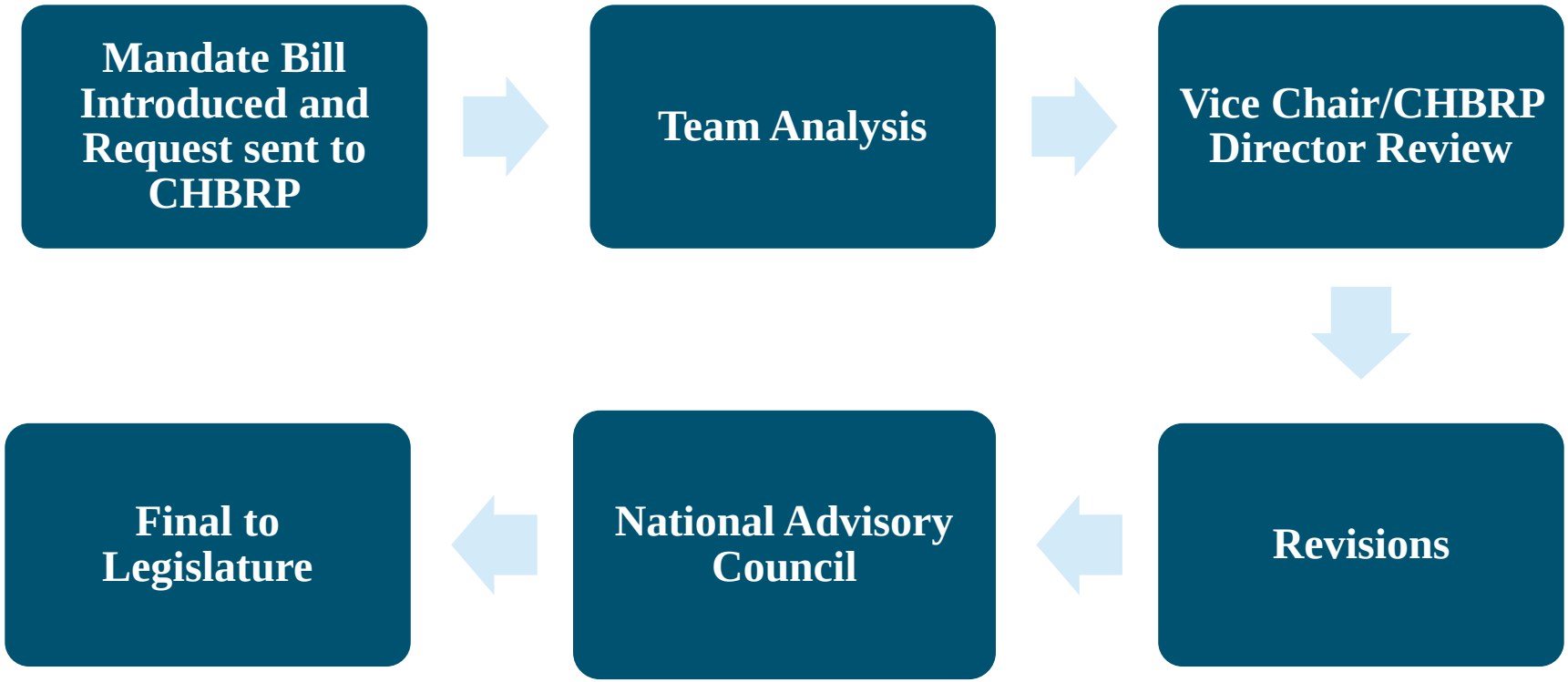
HEALTH INSURANCE BENEFIT MANDATES

- Test/treatments/services for the treatment of one or more conditions/diseases
- May pertain to:
  - Provider type
  - Screening, diagnosis, or treatment of a specific disease/condition
  - Coverage for a particular type of test/treatment/service
  - Benefit design

A CHBRP REPORT ANSWERS THE FOLLOWING:

- 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 determinants of health?

CHBRP's 60-Day Timeline



CHBRP's Website: www.chbrp.org

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Policy Analyst

California Health Benefits Review Program

Showcasing CHBRP's Methods: A review of AB 767 Infertility

Adara Citron, MPH
Principal Analyst

January 23, 2020

CALIFORNIA
HEALTH BENEFITS REVIEW PROGRAM

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?

2019 ANALYSIS: AB 767 INFERTILITY

As introduced, AB 767 would require coverage of infertility treatments, including in vitro fertilization, and mature oocyte cryopreservation.

Prevalence of infertility in the US:

- 12% of women ages 15-44
- 9% of men of age 19-44

KEY FINDINGS

Key Findings:
Analysis of California Assembly Bill 767
Infertility

Summary to the 2019–2020 California State Legislature, April 18, 2019

CALIFORNIA HEALTH BENEFITS REVIEW PROGRAM

AT A GLANCE

The version of California Assembly Bill (AB) 767 analyzed by CHBRP would require coverage of infertility treatments, including in vitro fertilization (IVF), and mature oocyte cryopreservation (OC).

1. CHBRP estimates that, in 2020, of the 24.5 million Californians enrolled in state-regulated health insurance, 14.6 million of them will have insurance subject to AB 767.
2. **Benefit coverage.** Benefit coverage for infertility treatments, including IVF, would increase from 4.3% premandate to 100% postmandate. Benefit coverage of planned OC would increase from 0% premandate to 100% postmandate. AB 767 would likely exceed EHBs.
3. **Utilization.** Utilization of infertility services would increase between 9% for diagnostic tests and 350% for IVF with intracytoplasmic sperm injection (ICSI). Utilization of planned OC is expected to increase from 0% to between 2% and 5%.
4. **Expenditures.** AB 767 would increase total net annual expenditures by $627,288,000 or 0.39% due to a $537,777,000 increase in total health insurance premiums, adjusted by decrease in enrollee expenses for covered and/or noncovered benefits.
    a. Enrollees with uncovered expenses at baseline would receive on the whole a $133,897,000 reduction in their out-of-pocket spending for covered and noncovered expenses.
    b. Per member per month premiums would increase between $2.76 for enrollees in CalPERS HMOs (an increase of 0.47%) and $3.72 in the DMHC-regulated small group market (an increase of 0.68%).
5. **Medical effectiveness.**
    a. There is a *preponderance of evidence* that IVF is an effective treatment for infertility.

AT A GLANCE, CONT.

    b. There is a *preponderance of evidence* that IVF is associated with certain maternal harms.
    c. There is *clear and convincing evidence* that IVF can lead to multiple gestation and preterm delivery. However, these outcomes can be mitigated by single embryo transfers.
    d. CHRBP found a *preponderance of evidence* that IVF mandates are associated with lower numbers of embryos transferred per cycle, lead to fewer births per cycle, and a reduction in overall harms of IVF.
6. **Public health.** The number of pregnancies resulting from infertility treatments in the first year postmandate will increase the number of pregnancies by 6,000 (from 7,000 to 13,000) and the number of live births by 5,000 (from 6,000 to 11,000).
7. **Long-term impacts.** For each cohort of females electing to undergo mature OC for the prevention of age-related infertility in a given year, CHBRP estimates the long-term marginal impact of AB 767 would yield about 685 more live births among these women over a 20 year period.

CONTEXT

Infertility is the inability to have a child and is a complex condition that can take many forms. Approximately 12% of women aged 15–44 experience infertility and approximately 9% of men aged 19–44 report some type of infertility.

The cost of undergoing infertility treatments such as assisted reproductive technology (ART) can be a prohibitive factor for couples and individuals faced with infertility.[1]

[1] Refer to CHBRP's full report for full citations and references.

BILL SUMMARY

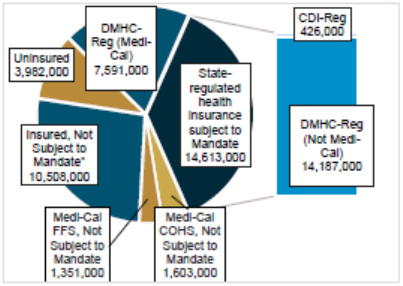
Current law requires most group health plans and policies to offer coverage for infertility services, excluding in vitro fertilization. AB 767 would require group health plans and policies, excluding the individual market and Medi-Cal, to provide coverage for infertility treatments, including in vitro fertilization (IVF), and mature oocyte cryopreservation (OC).

AB 767 defines infertility as the presence of a demonstrated condition recognized by a licensed physician and surgeon as a cause of infertility. "Treatment of infertility" includes procedures consistent with established medical practices in the treatment of infertility by licensed physicians and surgeons, including, but not limited to, diagnosis, diagnostic tests, medication, surgery, gamete intrafallopian transfer, and in vitro fertilization.

Mature OC is a form of fertility preservation. While fertility preservation usually refers to the preservation of fertility in advance of medical procedures that can lead to iatrogenic infertility (medically caused infertility), such as treatment for cancer or during sex transition, AB 767 could expand coverage of mature OC to a woman seeking to preserve her fertility for age-related reasons or to women seeking to preserve their fertility if they experience other medical conditions, such as endometriosis.

Figure A notes how many Californians have health insurance that would be subject to AB 767.

Figure A. Health Insurance in CA and AB 767



Source: California Health Benefits Review Program, 2019.
Notes: *Medicare beneficiaries, enrollees in self-insured products, etc.

IMPACTS

Revision

The initially released version of these Key Findings (April 18) referenced an incorrect figure (see the updated full report for more). This version has been updated using the correct total expenditures impact figure, 0.39%.

Benefit Coverage, Utilization, and Cost

To capture the full cost of coverage of infertility services for each year, CHBRP included the cost of pregnancies and births resulting from infertility services in year 1 into year 1 cost estimates.

No utilization data are available for planned OC in MarketScan claims data. There are no studies that estimate utilization of OC for non-iatrogenic or planned use, thus the approach to CHBRP's estimation of utilization change postmandate due to AB 767's coverage of mature OC included an estimate of potential increase in utilization per CHBRP's content expert. The estimates of utilization change do not include planned fertility preservation, however CHBRP offers an estimate of potential cost increase if a modest proportion of females of reproductive age opt to use the service in the *Planned Oocyte Cryopreservation* section.

Benefit Coverage

Currently, 4.3% of enrollees with health insurance that would be subject to AB 767 in DMHC-regulated plans or CDI-regulated policies have coverage for infertility treatments, including in vitro fertilization. No enrollees currently have coverage for mature OC as defined by AB 767. Benefit coverage for infertility treatments and planned OC would increase to 100% postmandate.

Utilization

In California, there are approximately 53,000 users of female diagnostic tests at baseline and about the same number of users of medications for infertility (i.e., only medications and no other service). IUI baseline utilization is about 9,000 users annually. IVF services alone (i.e., without ICSI) is estimated to have about 2,000 users and ICSI, which is done with IVF, is 2,000 users annually. For males, at baseline there are 25,000 users of diagnostic tests and 11,000 users of any male treatment.

MEDICAL EFFECTIVENESS IMPACTS

Definitions:

- Infertility treatments include: Diagnostic tests, medications, in vitro fertilization (IVF), IVF plus intracytoplasmic sperm injection, and intrauterine insemination.
- Mature oocyte cryopreservation (OC) is referred to as “planned OC”: Freezing eggs when a woman is younger to use at a later time.

Key Questions:

1. What is the effectiveness of IVF and planned OC as treatments for infertility?
2. What are the harms associated with IVF and planned OC?

MEDICAL EFFECTIVENESS IMPACTS, CONT.

Key Findings

1. Preponderance of evidence IVF and planned OC are effective treatments for infertility
2. Preponderance of evidence IVF is associated with certain maternal harms

Figure 1. Effectiveness of IVF as a Treatment for Infertility

BENEFIT COVERAGE, UTILIZATION, AND COST IMPACTS

- Benefit coverage among enrollees:

  4.3% at baseline ➡ 100% postmandate

- ⬆ utilization across all treatment types, but mostly for IVF and IVF-ICSI
- ⬆ total net annual expenditures by $627,288,000 or 0.39%
- Per member per month premiums ⬆ between $2.76 among CalPERS HMO enrollees and $3.72 in the DMHC-regulated small group market

PUBLIC HEALTH IMPACTS

- 5,000 live births in the first year postmandate
- mental health and quality of life
- financial barriers

Questions? Want more info?
www.chbrp.org

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