Approach to Public Health Analysis

California Health Benefits Review Program

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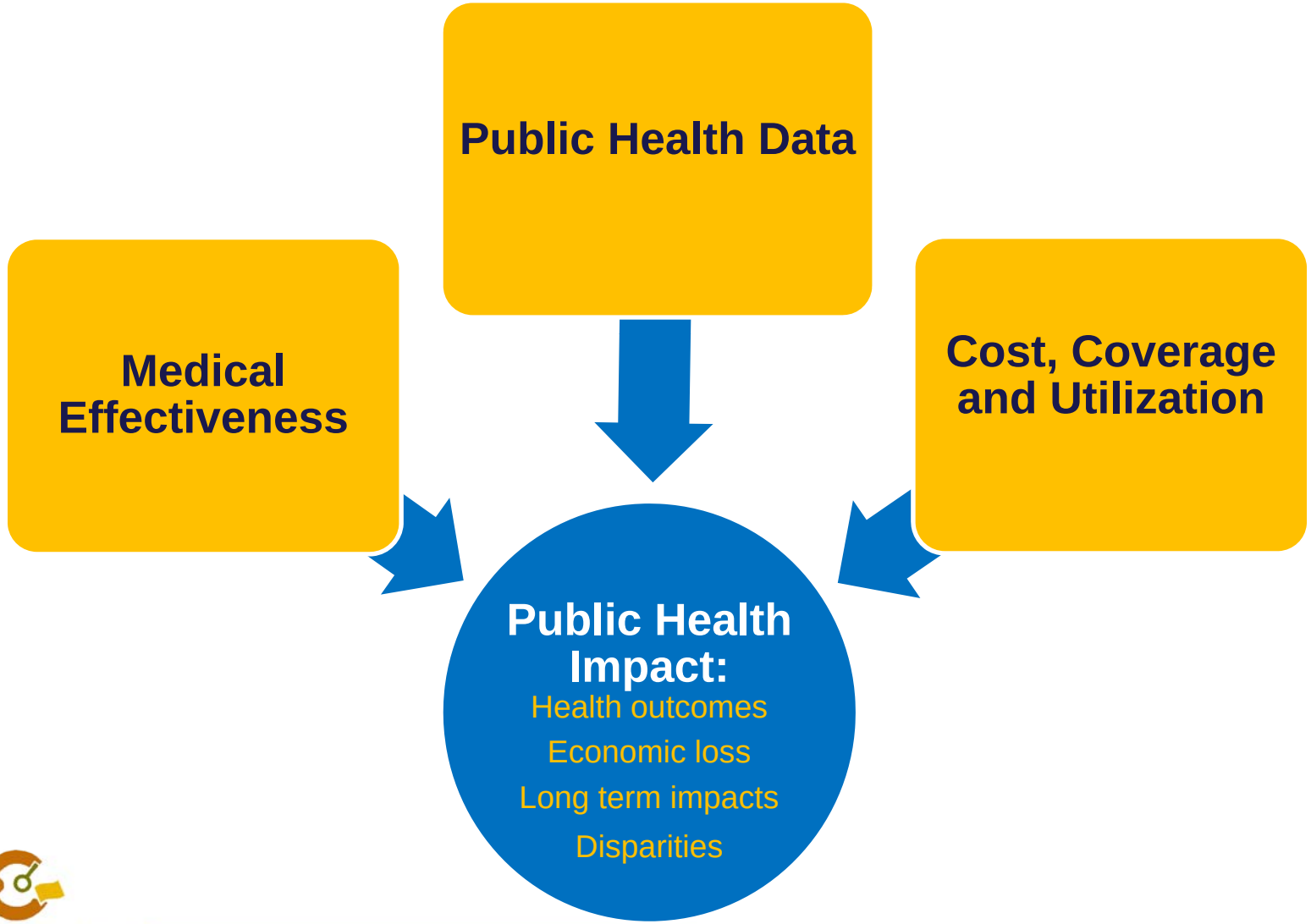
CALIFORNIA
HEALTH BENEFITS REVIEW PROGRAM

What Are Public Health Impacts?

- Baseline data relative to the mandate in question (rates of condition- or disease- related morbidity, mortality, etc.)
- Gender and racial/ethnic disparities in relevant health outcomes
- Premature death
- Economic loss associated with disease
- Long-term health impacts (beyond first 12 months of mandate enactment)

Inputs



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Step 1

- **Identify baseline data on**:
  - Frequency of relevant conditions in the population (incidence) and/or
  - Proportion of the population with relevant conditions (prevalence)
  - Utilization of treatment relevant to the mandate

Step 1 cont'd.

- **Data Sources**
  - Surveys, registries, cost-effectiveness/benefit studies, grey literature, evidence-based studies

- **Potential sources**:
  - Centers for Disease Control and Prevention, California or National Health Interview Survey, Behavioral Risk Factor Survey, disease-specific state surveys/registries

Step 1

Example: Tobacco Cessation

Proposed mandate (AB 1738) required coverage for tobacco cessation counseling and medications

- California baseline data:
  - **Smoking prevalence: 13.4%** (gender/racial disparities evident)
  - **60% of smokers attempted to quit** in the 12 months preceding the California Tobacco Survey.

Step 2

- **Will more people have coverage for the mandated services/treatments?**
  - Review projections from cost and utilization analysis re changes in coverage and use of services

- **Example: Tobacco Cessation**
  - *Pre-mandate*: 1.92 million adult insured smokers; 304K use cessation treatment
  - *Post-mandate*: 27% increase in utilization

Step 3

- **Combine ME and Cost**
  - Estimated effectiveness of the intervention (ME team)
  - Estimates of change in utilization of intervention by newly covered populations (Cost team)

Example: Tobacco Cessation

- 5,287 Californians are estimated to quit annually due to mandate.

Step 4

- For any additional utilization, **what is the impact on health outcomes** (includes harms from intervention when relevant)?

Example: Tobacco Cessation

- Fewer premature deaths from tobacco use (estimated 37,009 – 65,559 years of potential life gained for quitters in the first year after enactment.)
- $27.4 million reduction in OOP expenses

Possible PH Conclusions

Quantitative	Qualitative	No Impact	Unknown Impact
•Numeric estimate of insured persons with improved outcomes or reduced financial burden •**Tobacco Cessation**	•Indicate direction of mandate's effect "Likely increase/ decrease in [health outcome]") •**Maternity Services**	•Full coverage at baseline, or no change in utilization expected. •**Breast Cancer - Lumpectomy**	•Insufficient evidence on medical effectiveness or utilization •**Prescription Pain Drugs**

Challenges For CHBRP
Program specific

- Interpreting bill language
- Quantifying disparities impacts with limited data or literature for insured population
  - Literature, research, and policy aims are, generally, for people *<u>without</u>* insurance
- Disconnect with legislators' aims:
  - Lack of impact for uninsured, despite policymakers' intent

Challenges For CHBRP Generalizable

- Lack of clear policy intent
- Lack of relevant data
- Assessing short term vs. long term impacts
- Rigor vs. Policy Relevance
  - Need rapid response to inform policy

Outline

- Brief overview of private health insurance in US and CA
- What are benefit mandates?
- Overview of CHBRP
- Medical Effectiveness analysis approach
- Benefit Coverage, Cost, Utilization analytical approach
- Public Health analysis approach
- Takeaways