ACADEMIC RIGOR ON A LEGISLATURE'S TIMELINE

The California Health Benefits Review Program (CHBRP), drawing on multi-disciplinary faculty and researchers based at the University of California, provides the California Legislature with **timely, independent, and rigorous evidence-based analyses** of introduced health insurance benefits-related legislation. Most frequently, CHBRP analyzes proposed health insurance benefit mandates (e.g. mandates to cover a test, treatment, or service such as continuous glucose monitors).

Four Core Components of CHBRP Analyses

Background and Policy Context: *What's the history and status of this topic?*	Medical Effectiveness: *Does the test, treatment, or service work?*	Cost Impacts: *How much will it cost?*	Public Health Impacts: *How will it affect population-level health?*
• How might this legislation interact with current state and federal law? • What condition(s) does this bill attempt to treat? • Are there disparities in the condition or current access to treatment?	• Estimate the cost impacts on coverage and utilization in the first year of implementation • Examine impact on insurance premiums, cost-sharing, and total expenditures	• Estimate the cost impacts on coverage and utilization in the first year of implementation • Examine impact on insurance premiums, cost-sharing, and total expenditures	• Assess impacts on specific population groups and social determinants of health • Estimate long-term costs and benefits

CHBRP's Analyses and Methods. CHBRP has completed analyses of 161 bills from the California Legislature, all available on our website. Each analysis is completed within a 60-day period. This timeline ensures that reports are submitted before the Legislature formally considers the bill. A typical report summarizes scientific evidence regarding the medical effectiveness of clinical interventions relevant to the bill and estimates the marginal cost and public health impacts in the first year of implementation.

To ensure objectivity, CHBRP's analyses do not offer policy recommendations. CHBRP's work is intended to support policymakers in their decision-making.

History and Structure. CHBRP was initially authorized by statute in 2002. The state funds CHBRP's work through a small annual assessment on health plans and insurers in California.

CHBRP is comprised of a small team of staff at the University of California, Berkeley, who coordinate the contributions of its Faculty Task Force, researchers, librarians, and a contracted actuarial firm. The task force, comprised of senior faculty, is drawn from several University of California campuses.

A strict conflict of interest policy ensures that no financial or other interests bias the analyses. Experts in pertinent areas of clinical practice and research are retained to advise CHBRP on each bill. Guidance and review of CHBRP analyses is also provided by a National Advisory Council, made up of health care and health policy experts from outside of California.

CHBRP's Other Publications. CHBRP regularly produces and updates various resources, as well as issue and policy briefs, all of which are available on our website.

Timeline for Report Production (60 days) -- Overview

Team Member	Day 1-Day 9	Day 10-Day 19	Day 20-29	Day 30-Day34	Day 35-Day 44	Day 45-Day 54	Day 55-Day 59	Day 60
CHBRP Staff Lead	▪ Receive & post request to website ▪ Schedule weekly conference call for analytic team ▪ Check re recusals ▪ Identify bill language or interpretation ambiguity ▪ Draft Bill Specific Coverage Survey due	▪ Clarify intent with bill author ▪ Finalize interpretation of bill language ▪ With analytic team leads, finalize scope of analysis ▪ Finalize and transmit Bill-Specific Survey ▪ Screen content expert per protocol and schedule call with team ▪ Request information/confirmation from Public Programs	▪ Blind and post responses to Bill-Specific Surveys ▪ Post responses from Public Programs ▪ Compile public demand info ▪ 1st draft of Policy Context section & appendices due ▪ Review other sections	▪ Revised section & appendices due ▪ Assemble draft report for reviews	Vice Chairs Review Team revisions due	NAC Subgroup Review + Peer Faculty Reviewer* + Content Expert Review + Editor Review Team revisions due	Editor Proof Team revisions due	CHBRP staff finalize report, transmit to the legislature, and post it on the website
Medical Effectiveness Team Lead	▪ Identify relevant diseases/services, health outcomes ▪ Identify potential content experts ▪ Initial literature search specifications due	▪ Finalize list of relevant diseases/conditions, treatments/services, and health outcomes ▪ Review abstract database and finalize analytic approach ▪ Draft tables summarizing effectiveness literature	▪ 1st draft ME section & appendices ▪ Review other draft sections	▪ Revised section & appendices due				
Cost Team Lead	▪ Initial literature search specifications due ▪ Review draft Bill-Specific Coverage Survey	▪ Review abstract database and finalize analytic approach ▪ Identify relevant diseases/conditions, treatments/services/procedures for actuaries to pull baseline utilization and cost from claims database ▪ Review draft Table 1, draft cost model, medical effectiveness literature analysis, and evidence from the literature to identify: Per-unit cost; impact projection assumptions (utilization, cost offsets, long-term impacts, relevant CEA literature); bill specific assumptions	▪ 1st draft Cost section & appendices ▪ Review other draft sections	▪ Revised section & appendices due				
Lead Actuary	▪ Review draft Bill-Specific Coverage Survey	▪ Provide per-unit cost (if available from claims databases) ▪ Draft Table 1 due ▪ 1st draft cost model due (baselines and suggested formats for Tables 1, X, and Y)	▪ Compile responses to Bill-Specific Survey and responses from Public Programs ▪ 2nd draft cost model due (baselines and impacts) ▪ H team data runs due ▪ Review draft Cost section					
Public Health Team Lead	▪ Initial literature search specifications due	▪ Review abstract database and finalize analytic approach ▪ Compile baseline prevalence, incidence, and disparities information ▪ Review 1st draft cost model ▪ PH specific requests for actuaries due	▪ Provide evidence for impacts on subpopulations ▪ 1st draft Background, PH section & appendices ▪ Review other draft sections	▪ Revised section & appendices due				
Librarian		▪ Initial abstract database due	▪ Any revised/additional abstract databases shared					

*Peer Faculty review period is flexible. PF can either review with the Vice Chairs or with the NAC, depending on PF and CHBRP lead preference.

Key Findings

Analysis of California Assembly Bill 2258
Doula Care: Medi-Cal Pilot Program

Summary to the 2019–2020 California State Legislature, April 14, 2020

CALIFORNIA HEALTH BENEFITS REVIEW PROGRAM

AT A GLANCE

The version of California Assembly Bill (AB) 2258 analyzed by CHBRP would establish a three-year pilot program in Medi-Cal for coverage of doula care across 14 specified counties.

1. CHBRP estimates that, in the first year postmandate, 10.2 million Medi-Cal enrollees within the 14 specified counties would have insurance subject to AB 2258.
2. **Benefit coverage.** Benefit coverage of doula care would increase from 0% at baseline to 100% postmandate.
3. **Utilization.** Approximately 20% of the almost 204,000 eligible pregnant women[1] who experienced live birth, abortion, miscarriage, or stillbirth would use the doula services offered by the pilot.
4. **Expenditures.** Total net annual Medi-Cal expenditures in the 14 pilot counties would increase by $32,495,448, or 0.08%.
5. **Medical effectiveness.** The medical effectiveness review examined the impact of doulas on a multitude of maternal and neonatal and infant outcomes. Findings across outcomes varied.
6. **Public health.** AB 2258 would produce an unknown but positive impact on birth experiences, including improved agency for pregnant Medi-Cal enrollees, especially among the racial and ethnic minority populations that access community-based doula care in the first year, postmandate.
7. **Long-Term Impacts**. The reduction in cesarean deliveries among Medi-Cal managed care enrollees is unlikely to be reflected in prospectively set payments in the short-term. After 2 to 3 years when rates are recalculated, reductions in caesarian deliveries could be reflected in the payments made to plans, which may result in savings to the Medi-Cal program.

[1] CHBRP notes that persons who do not identify as "women" may also experience pregnancy.

CONTEXT

Full spectrum doulas are trained to provide *nonclinical emotional, physical, and educational support* to help women manage pain, fear, fatigue, and uncertainty throughout their pregnancy and postpartum; *doulas do not provide medical care*.[2] In addition to supporting pregnant people, doulas also may support their partners and families.

Because insurance does not commonly cover doula services, *traditional* doulas typically serve higher-income women due to the associated out-of-pocket costs. Traditional doulas are trained to provide unconditional, nonjudgmental support; however, some may lack cultural and historical understanding of how race, institutional bias, and social determinants influence birth outcomes.

In contrast, *community-based doulas* practice full spectrum care, but focus on women of color and underserved pregnant women who face disparities in care and in maternal and infant outcomes. The community-based doula practice extends beyond most traditional doula practices to encompass culturally congruent, trauma-informed care, which provides intensive support throughout the perinatal period, including extensive postpartum visits. Their training covers ways that social determinants of health affect pregnancy and birth outcomes. Many community doulas have shared experience and reside in the communities they serve.

BILL SUMMARY

Assembly Bill (AB) 2258 would establish a 3-year pilot program in Medi-Cal for coverage of full-spectrum doula care. For a pregnancy carried to term, enrollees are eligible for at least four prenatal appointments, continuous support during labor and delivery, and at least eight postpartum appointments during the first year postpartum. Beginning July 1, 2021, the Department of Health Care Services (DHCS) shall establish a "full-spectrum" doula care pilot program for all pregnant and postpartum Medi-Cal enrollees residing in 14 counties, as specified. Full-spectrum doula care is defined as

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

including prenatal and postpartum doula care, continuous presence during labor and delivery, and doula support during miscarriage, stillbirth, or abortion.

AB 2258 provides multiple definitions related to doula care, specifies how reimbursements for doula care are provided and determined, establishes a state-wide doula registry, requires notification of availability of doula care to eligible enrollees, establishes a set of "core competencies" doulas must possess, and requires a program evaluation.

CHBRP is unable to determine how many doulas currently exist in California, how many provide care, and how many would meet the core competency requirements specified within AB 2258. CHBRP assumes the supply of doulas in California would meet the needs of Medi-Cal enrollees in the 14 specified counties for the purposes of this analysis.

IMPACTS

Benefit Coverage, Utilization, and Cost

CHBRP estimates that approximately 204,000 female Medi-Cal beneficiaries aged 15 to 44 years (childbearing age) who reside in the 14 counties identified by AB 2258 would be eligible for the doula pilot program due to pregnancy or postpartum status.

Benefit Coverage

Currently, no enrollees in Medi-Cal that would be subject to AB 2258 have coverage for full-spectrum doula services as proposed in AB 2258. Postmandate, 100% of enrollees in the 14 counties would have coverage for doula care through the pilot program.

Utilization

Due to the lack of benefit coverage, CHBRP concludes that Medi-Cal is providing no doula services to their enrollees in the 14 pilot counties, and if any Medi-Cal enrollees are using doula services they are paying out-of-pocket for the service or relying on other community or hospital programs that are not covered by Medi-Cal. While CHBRP is aware of some existing doula care pilot programs, these programs are not available to all pregnant enrollees and may not be available as of July 1, 2021.

Postmandate, CHBRP estimates approximately 20% of the almost 204,000 eligible pregnant women who experience live birth, abortion, miscarriage, or stillbirth would use the doula services offered by the pilot. As a result, vaginal deliveries would increase by 3,441 (2.44%), while cesarean deliveries would decrease by the same number (which represents a 5.84% decrease because the number of vaginal deliveries exceeds the number of cesarean deliveries in Medi-Cal).

Expenditures

The prices CHBRP used to calculate the costs associated with the doula pilot program are based on external benchmarks and relative costs of equivalent programs. The rates used by Medi-Cal in each pilot county could differ substantially, and therefore the costs of the program estimated by CHBRP may not be supported by final reimbursement rates and methods used by DHCS in estimating the expenditures for the pilot or the long-term actual costs of the pilot program.

CHBRP estimates that each pilot participant would use, based on the language in AB 2258, four prenatal doula visits ($120), one labor/delivery attendance or equivalent service ($360), and eight postpartum doula visits ($240), for a total all-inclusive rate of $720 on average for each pilot program participant. Despite the predicted reduction in cesarean deliveries due to the pilot program, the blended Medicaid maternity supplemental (kick) payments used to compensate health plans for labor and delivery costs will not reduce Medicaid expenditures enough to offset the costs of administering the program.

AB 2258 would increase total net annual Medi-Cal expenditures in the 14 pilot counties by $32,495,448, or 0.08%.

Number of Uninsured in California

Because the change in expenditures is limited to the Medi-Cal program and does not cause increases in private insurance premiums, CHBRP expects no measurable change in the number of uninsured persons due to the enactment of AB 2258.

Medical Effectiveness

The medical effectiveness review summarizes findings from evidence on the effectiveness of doula care for pregnant and postpartum persons, including prenatal and postpartum doula care, continuous presence during labor and delivery, and doula support during miscarriage, stillbirth, and abortion. Specifically, this review assesses the incremental impact of adding doula care to the standard perinatal care that pregnant women receive as compared with standard perinatal care alone.

There is evidence that adjunctive doula care interventions are *more effective* than standard perinatal care alone for decreasing the use of pain medication (including epidurals) during labor, and increasing the incidence of spontaneous vaginal delivery.

There is evidence that adjunctive doula care interventions are *not more effective* than standard perinatal care alone for managing severe labor pain, reducing the use of synthetic oxytocin for labor augmentation, reducing the incidence of perineal trauma, managing postpartum depression, promoting sustained breastfeeding after hospital discharge, managing pain during surgical abortions or miscarriages, reducing NICU admissions, and reducing the duration of hospital stays for infants.

There is *inconclusive evidence* regarding the effectiveness of adjunctive doula care interventions as compared with standard labor care alone for duration of labor, rates of cesarean delivery, rates of operative vaginal delivery, breastfeeding initiation, preterm birth, and low neonatal birth weight.

There is *insufficient evidence* to assess the effectiveness of doula care interventions as compared with standard labor care alone for attendance at childbirth classes, infant mortality, maternal mortality, and prenatal depression or anxiety. Please note that absence of evidence is not evidence of no effect. Maternal and infant mortality are rare outcomes, and no studies to date have been of sufficient size to assess the effect of doula care interventions on mortality.

Finally, there is insufficient evidence to determine whether adjunctive doula care — delivered at any stage of pregnancy or postpartum, during labor and delivery, or for abortion, miscarriage, or stillbirth — is associated with harms.

CHBRP notes the lack of studies using certified doulas, and, more specifically, the community doula model, in the U.S. Medicaid population. The above outcomes with inconclusive or insufficient evidence outcomes are due to this lack of studies. The limited and preponderance of evidence conclusions are based on more studies with the limitations as noted in the main body of the analysis.

Public Health

In the first year postmandate, CHBRP estimates AB 2258 would:

- *Decrease* disparities in access to doula services between Medi-Cal (low income) and higher income pregnant women;
- *Increase* spontaneous vaginal births by about 3,400 cases (with a commensurate decrease in cesarean births);
    - *Likely reduce* disparities between Medi-Cal beneficiaries' and privately insured enrollees' cesarean birth rates and *may decrease* disparities within the Medi-Cal population among racial/ethnic groups, specifically for Latina and black Medi-Cal beneficiaries, who experience the highest rates of cesarean deliveries in California;
- *Decrease* unwanted/unnecessary pain medication use during labor by an unknown quantity; and
- *Increase* maternal satisfaction with the birth experience.

Due to evidence of no effectiveness of doula services, CHBRP projects that AB 2258 would *not change* rates of severe labor pain, utilization of synthetic oxytocin, breastfeeding, NICU admission, or prolonged infant hospital stay.

CHBRP is unable to project a change in rates of maternal mortality, infant mortality, preterm birth and low birth weight due to insufficient or inconclusive evidence of doula services.

The projected decrease in cesarean deliveries would likely result in some decreased rate of complications from wound infections, organ damage during surgery, prolonged healing, and increased risk for future cesarean deliveries. Infant rates of negative health outcomes (e.g., asthma, decreased intestinal microbiome diversity) could also be reduced. CHBRP also anticipates an unquantified decrease in the use of pain medication, including epidurals, based on the evidence reviewed.

Long-Term Impacts

The 14-county pilot program proposed in AB 2258 is limited to three years without further legislative or administrative action. If the program is successful based upon the required evaluation, DHCS would have the option of expanding the pilot to additional counties and also continuing to operate the pilot in the existing counties. If the pilot results in additional doulas obtaining training, obtaining a National Provider Identification number, and being added to the registry, additional supply would be available to provide services to pregnant women in the state if doula services became more popular and readily accessible. That could result in additional women participating (above the estimated 20% participation rate) and additional utilization of services.

Despite the cost offsets created by fewer cesarean births in fee-for-service Medi-Cal, the long-term costs would increase if utilization increased over time. In the case of this pilot, the reduction in cesarean deliveries among Medi-Cal managed care enrollees is unlikely to be reflected in the prospectively set maternity supplemental (kick) payments made to plans in the short term. However, after 2 to 3 years when rates are recalculated, if the mix of cesarean and vaginal delivery changes due to the program, it could be reflected in the maternity supplemental (kick) payments made to plans, which may result in savings to the Medi-Cal program.

To the extent that (1) the doula supply expands according to the bill's criteria, and (2) pregnant Medi-Cal beneficiaries learn about and engage doula support, CHBRP projects an unknown, positive public health impact on some physical and emotional perinatal outcomes in years 2 and 3 of the pilot program due to physical, educational, and social supports provided by community-based doulas. These improvements include continued reductions in potentially preventable cesarean deliveries and use of pain medication, including epidurals. Qualitative evidence also supports the conclusion that doulas would improve pregnant Medi-Cal beneficiaries' birth experiences as well as access to community and social supports.

In the long term, because Medi-Cal covers approximately 50% of births in California, the pilot program established by AB 2258 could begin to reduce statewide racial/ethnic and income disparities in spontaneous vaginal delivery rates and birth experiences (e.g., undesired pain medication use); however, the extent of the changes is unknown.

Essential Health Benefits and the Affordable Care Act

Medi-Cal plans are not subject to the same set of Essential Health Benefits (EHBs) as nongrandfathered small group and individual market plans and policies and are not subject to the requirement to defray costs, should a benefit exceed EHBs.

At the time of this CHBRP analysis, there is substantial uncertainty regarding the impact of the COVID-19 pandemic on premium rates and health plan enrollment, including how the pandemic will impact healthcare costs in 2021. Because the variance of potential outcomes is significant, CHBRP does not take these effects into account as any projections at this point would be speculative, subject to federal and state decisions and guidance currently being developed and released. In addition, insurers', providers', and consumers' responses are uncertain and rapidly evolving to the public health emergency and market dynamics.