



California Health Benefits Review Program

Legislative Briefing about CHBRP:

Providing Independent and Evidence-based Analysis of
Health Insurance Benefit Mandate and Repeal Bills

February 5, 2016





California Health Benefits Review Program

Overview

John Lewis, MPA

February 5, 2016





Outline for this Briefing

- Overview of CHBRP
 - What, Who, How
 - The Process for Benefit Mandates
- The Health Insurance Landscape in California
- What you will find in CHBRP's Reports
 - Medical Effectiveness Analysis
 - Benefit Coverage, Cost, Utilization Analysis
 - Public Health Analysis
- Other useful other publications/products
- CHBRP Reauthorization



California Health Benefits Review Program

Overview of CHBRP

Karla Wood

Program Specialist

February 5, 2016





What is CHBRP?

- CHBRP is an independent, analytic resource serving the Legislature, grounded in academia and policy analysis
 - Administered by the University of California
 - Provides timely, evidence-based information to the Legislature
 - Charged with analyzing the:
 - 1) Medical effectiveness;
 - 2) Projected cost(s); and
 - 3) Public health impacts of health insurance benefit mandates or repeals.
 - 4) Other insurance topics, including SDOH



Who is CHBRP?

- Task Force of faculty and researchers
- Actuarial firm (new contract as of January 2016):
PricewaterhouseCoopers
- Librarians
- Content Experts
- National Advisory Council
- CHBRP Staff

Who is CHBRP?

Public Health Team

UC Davis (Primary)
UC San Diego

Medical Effectiveness Team

UC San Diego
UC San Francisco

Cost Team

UC Los Angeles (Primary)
UC San Diego





CHBRP Reports Enhance Understanding

- Expert – leverages faculty and researchers, policy analysts, and an independent actuary to perform evidence-based analysis
- Neutral – without specific policy recommendations
- Fast – 60 days or less

CHBRP's Website: www.chbrp.org

The screenshot shows the CHBRP website homepage. At the top left is the logo for the California Health Benefits Review Program, with the tagline "Providing Objective Legislative Analysis". To the right of the logo are social media icons for LinkedIn and Twitter, and a search bar with the text "Search CHBRP.org" and a "Search" button. Below the logo is a dark blue navigation bar with links for "Home", "About CHBRP", "Completed Analyses", "Recent Requests", and "Contact". Underneath the navigation bar is a row of four images: a large hall with many rows of wooden chairs, a document with the word "BENEFITS" and "Contract will", a magnifying glass over a document with the word "insurance", and a document with the word "re-search". Below the images is a grey banner with an information icon and the text: "CHBRP is now seeking candidates for its 2016 Summer Internship Program. Attend CHBRP's Legislative Briefing on Health-insured Related Bills." Below the banner is a sidebar with five red buttons: "About CHBRP", "Completed Analyses", "Recent Requests", "Analysis Methodology", and "Other Publications". To the right of the sidebar is a "What's New..." section with two entries: "CA Mandates for 2016" (labeled "Resource") and "Analysis of AB 533: Out-of-Network Coverage" (labeled "Bill Analysis"). To the right of the "What's New..." section is a "MAILING LIST" sign-up box with the text "ADD ME to the MAILING LIST" and a "Click here" button. Below the mailing list box is a "Latest Tweets" section with a tweet from "California Health Officials and Journalists" posted "about 6 days ago".

CALIFORNIA
HEALTH BENEFITS REVIEW PROGRAM
Providing Objective Legislative Analysis

Social Hubs - [in](#) [t](#)

Search CHBRP.org Search

Home About CHBRP Completed Analyses Recent Requests Contact

BENEFITS.
Contract will

Health insurance policy

re-search' ri'sɔ:tʃ
(plural) 1 serious st
discover new facts
research into
student

CHBRP is now seeking candidates for its 2016 Summer Internship Program.
Attend CHBRP's Legislative Briefing on Health-insured Related Bills.

About CHBRP

Completed Analyses

Recent Requests

Analysis Methodology

Other Publications

What's New...

Resource
CA Mandates for 2016
CHBRP has updated its CA Mandates Resource for 2016.

Bill Analysis
Analysis of AB 533: Out-of-Network Coverage
CHBRP has submitted its analysis of Assembly Bill 533, Out-of-Network Coverage.

ADD ME
to the
MAILING LIST
Click here

Latest Tweets

about 6 days ago California
Health Officials and Journalists

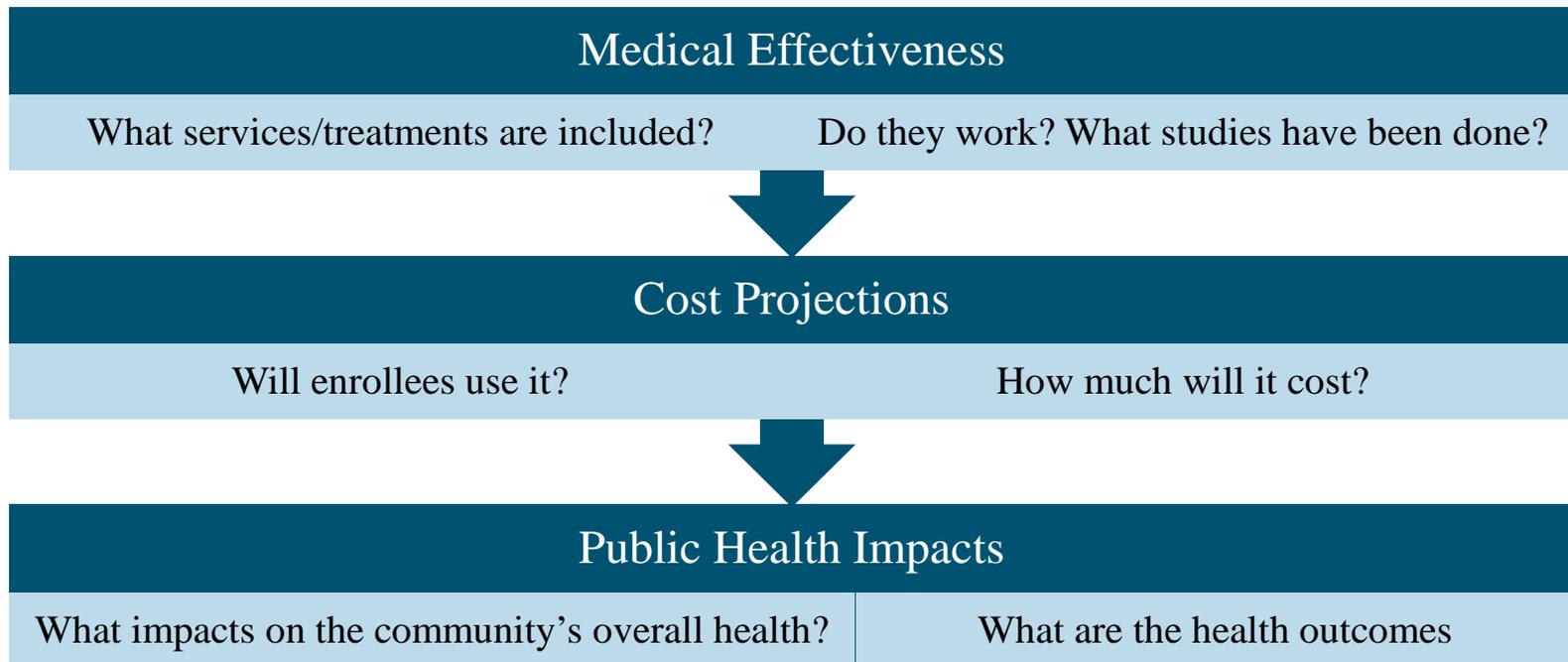


CHBRP Reports Enhance Understanding of Health Insurance

- Health Insurance Benefits:
 - Benefits are tests/treatments/services appropriate for one or more conditions/diseases
- Health Insurance Benefit Mandates are:
 - Requirements imposed on health insurance (whether publicly financed or privately financed) to cover specific benefits or alters terms and conditions of coverage

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





California Health Benefits Review Program

Legislative Briefing about CHBRP:

Providing Independent and Evidence-Based Analysis of
Health Insurance Benefit Mandate and Repeal Bills

February 5, 2016



California Health Benefits Review Program

Health Insurance Overview

John Lewis, MPA
Associate Director

February 5, 2016

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.





Health Insurance ...

- is regulated
 - is divided into markets
 - may 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



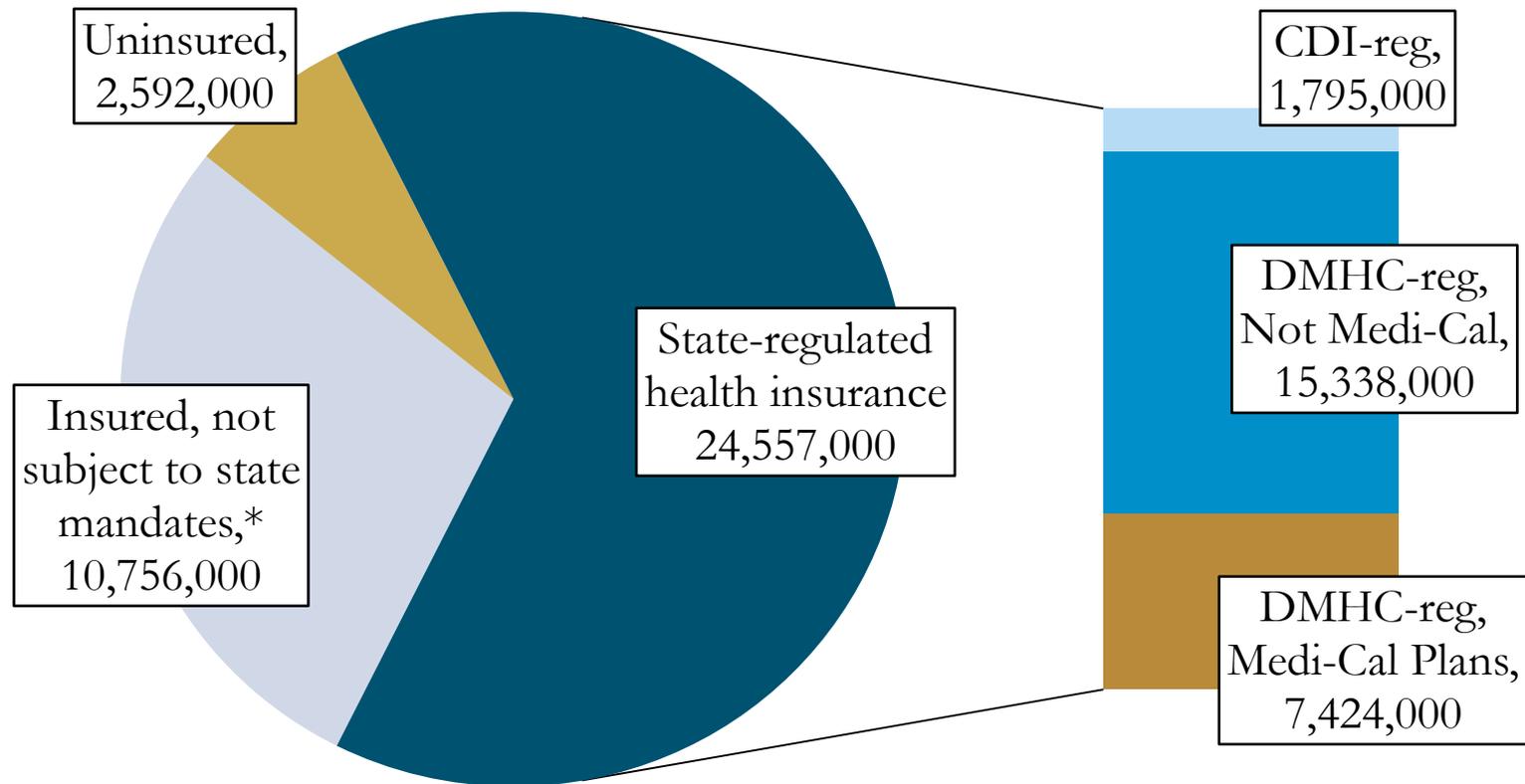
State-regulated health insurance...

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

- Subject to CA Insurance Code
- Regulated by CDI



Health Insurance Enrollment in California



*Such as Federally regulated health insurance, including Medicare and self-insured products.
Source: California Health Benefit Review Program, 2015

Health Insurance Markets in California

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

*except county operated health systems (COHS)



Benefit Mandates

Laws requiring health insurance to:

- Cover screening, diagnosis, or treatment for a condition or disease;
- Cover specific treatments or services;
- Cover specific types of providers; and/or
- Apply specific terms to benefit coverage (such as visit limits, co-pays, etc).



Benefit Mandates

State Laws (Health & Safety/Insurance Codes)

- 67 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

California Health Benefits Review Program

Resource:

Health Insurance Benefit Mandates in
California State and Federal Law

January 29, 2016

California Health Benefits Review Program
1111 Broadway, Suite 1400
Oakland, CA 94607

T: 510-287-3876

F: 510-763-4253

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.

Suggested Citation: California Health Benefits Review Program (CHBRP) (2016). *Health Insurance Benefit
Mandates in California State and Federal Law*. Oakland, CA.





California Health Benefits Review Program

What will you find in a CHBRP report?



California Health Benefits Review Program

What Will You Find in a CHBRP Report?

AJ Scheitler and Erin Shigekawa
Principal Analysts

February 5, 2016
CALIFORNIA HEALTH BENEFITS REVIEW PROGRAM





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.

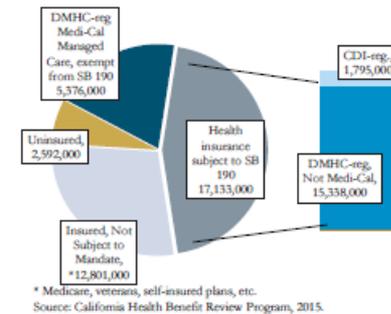
ACQUIRED BRAIN INJURY

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.

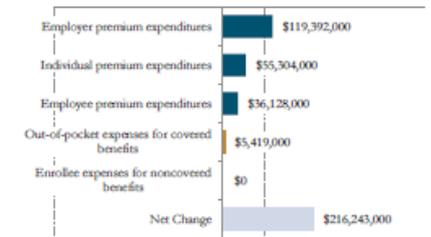
CHBRP found that coverage of PARTRS is not universal among persons with health insurance subject to SB 190 and so projects that 83% of these enrollees would gain benefit coverage. Because these enrollees already have coverage for other post-acute rehabilitation services (outpatient and SNF-based), CHBRP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



Policy Context



POLICY CONTEXT

- What would the bill do?
- Who would the legislation impact?
- How does the impact differ between the 2 state health insurance regulators (DMHC and CDI)?
- How would the bill interact with existing state and federal law such as the Affordable Care Act?
- What are CHBRP's key assumptions for the analysis?



AB 1738 (HUFFMAN)

SMOKING CESSATION PROGRAMS, 2012

- Mandates certain tobacco cessation services and treatments for at least 2 courses in a 12-month period.
- Covered programs included specific types of counseling, FDA-approved prescription medications, and FDA-approved OTC medications.
- Prohibited plans and policies from imposing co-payments for such services and imposing prior authorization or stepped care requirements.



AB 1738 (HUFFMAN)

SMOKING CESSATION PROGRAMS, 2012

- **ACA:** AB 1738's requirements would broaden the ACA's preventive services tobacco cessation mandate to include grandfathered DMHC-regulated plans and CDI-regulated policies.
- **CA Existing Laws:** Tobacco tax revenues also fund the California Tobacco Control Program (CTCP) which provides financing for anti-smoking programs (in local health departments, nonprofits).
- **Other States:** CHBRP is aware of similar mandates in seven other states which require coverage for smoking cessation treatment.

Background





BACKGROUND

- Bills CHBRP analyzes are generally focused on:
 - Coverage for screening, diagnosis or treatment of disease/condition;
 - Coverage for medical equipment, supplies or drugs;
 - Receipt of services from a particular type of provider;
 - Terms or conditions (e.g., cost sharing);
 - Other health insurance issues (new, starting in late 2015).
- What is the disease/condition?
- How widespread is the disease/condition?
- What is the impact on different populations?



BACKGROUND ON SMOKING AND RELATED DISEASES

- Tobacco use contributes to an estimated 443,000 deaths per year nationally.
- 13.4% of insured Californians were current smokers in 2009 (CHIS, 2012).
- In California (Table 6), 19% of heart disease mortality is attributed to smoking, followed by overall mortality from cancer (trachea, bronchus, and lung), chronic obstructive pulmonary disease and stroke, at 6%, 5%, and 5%, respectively (CDPH/CTCP, 2010a).

Medical Effectiveness



MEDICAL EFFECTIVENESS

- Based on scientific evidence, is the treatment or service effective?
 - Sources include:
 - Peer-reviewed publications (e.g., randomized controlled trials, etc.);
 - Other published information (e.g., clinical guidelines and best practices); and
 - Expert opinion.



MEDICAL EFFECTIVENESS: CATEGORIES OF EFFECTIVENESS

Clear & Convincing	Preponderance of Evidence	Ambiguous / Conflicting	Insufficient Evidence
It works. OR It doesn't work.	It seems to work. OR It seems not to work.	The evidence cuts both ways.	There is not enough evidence to determine whether it does or does not work.



MEDICAL EFFECTIVENESS OF SMOKING CESSATION PROGRAMS AND PHARMACOLOGY PRODUCTS

- There is clear and convincing evidence that use of multiple types of counseling increases smoking cessation.
- Pharmacological agents are also effective, especially in conjunction with counseling.
- The analysis looked at the comparative effectiveness of different types of pharmacological interventions, broken into first- and second-line agents.



MEDICAL EFFECTIVENESS OF SMOKING CESSATION – IMPORTANCE OF COVERAGE

- FURTHER, evidence shows that persons who have coverage for pharmaceutical treatments are more likely to use those treatments; the more generous the coverage, the higher likelihood of use.
- The evidence of the effect of more generous coverage for smoking cessation counseling and pharmacotherapy relative to less generous coverage on abstinence from smoking is ambiguous.



Cost and Utilization Impacts



COST AND UTILIZATION IMPACTS

- This section measures incremental change on state-regulated health insurance in three areas:
 - **Coverage:** Will more enrollees have coverage for the treatment/service?
 - **Utilization:** With coverage for the treatment/service, will demand and use change?
 - **Cost:** What is the change in total cost? This accounts for any change in coverage and utilization of a treatment/service, or other effect of the legislation.



WHAT WE TALK ABOUT WHEN WE TALK ABOUT COST

- **Insurance premiums** (paid by employers, public programs and enrollees)
- **Enrollee cost sharing** (copays, deductibles, co-insurance)
- **Non-covered health expenses** (paid by enrollees who have health insurance but whose insurance doesn't cover specified services)
- **Total expenditures** for health insurance premiums, enrollee cost sharing and non-covered health expenses



CAVEATS OF THE COST IMPACT ANALYSIS

- **Estimates:** They are average, state-wide estimates.
- **12-month timeframe:** They reflect the 12 months after enactment of the benefit.
- **Affects only state-regulated health insurance:** Not all enrollees with health insurance will be affected, only those with state-regulated health insurance, or insurance specified in the proposed legislation.



COST AND UTILIZATION OF SMOKING CESSATION

- Postmandate, of the 1.92 million insured adult smokers, CHBRP estimated that the utilization of counseling services would increase 13.2%, OTC treatments by 44%, and prescription treatments by 25.4%.
- Postmandate utilization of one or more smoking cessation treatments would increase by 27.5%, representing an additional 83,300 insured adult smokers using smoking cessation treatments.
- Estimated premium increases per member per month (PMPM) vary by market segment from low of 0% (\$0.00) for DMHC-regulated Medi-Cal HMO plans to a high of 0.28% (\$.058) for CDI-regulated plans.



Public Health Impacts



PUBLIC HEALTH IMPACTS

- Builds upon medical effectiveness and cost findings.
- What health outcomes are improved?
 - Impacts on premature death and economic loss
- Will it impact certain populations more than others (by race, ethnicity, gender, age, income, etc.)?
- Depending on available information, findings may be qualitative, quantitative, unknown, no impact.



PUBLIC HEALTH IMPACT OF COVERAGE FOR SMOKING CESSATION PROGRAMS

- Mandate would increase the number of successful quitters by 5,287 annually.
- Overall benefits outweigh minimal risks associated with the few rare adverse events with pharmacological treatments.
- There is clear and convincing evidence that the bill would contribute to a reduction in premature death due to smoking, but we were not able to specifically quantify.



INCORPORATING THE SOCIAL DETERMINANTS OF HEALTH

- CHBRP 2015 reauthorization requests an increased focus on social determinants of health.
- We'll discuss more in a few minutes.

Long-Term Impacts



LONG-TERM IMPACTS

- CHBRP analyses focus heavily on the marginal impact of a mandate through one year after implementation.
- However, a change in health outcomes and/or costs related to legislation may accrue years after the first year of implementation (e.g., vaccine coverage).



LONG-TERM IMPACTS OF SMOKING CESSATION COVERAGE

- Many studies have examined the long-term cost consequences of reductions in tobacco use, and all generally find that smoking cessation is effective at reducing smoking rates.
- There are potential long-term savings resulting from quitting, including the potential impact of total annual costs of treatment for smoking cessation declining in future years because there are fewer smokers.

Wrap-up

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



California Health Benefits Review Program

Social Determinants of Health: What are they and how do they interact with health insurance?

Joy Melnikow, MD, MPH
Director, UC Davis Center for Healthcare Policy and Research
CHBRP Vice Chair, Public Health
Legislative Briefing about CHBRP
February 5, 2016

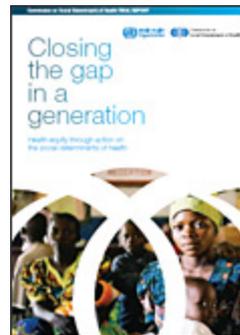
CHBRP: 2015 AUTHORIZING STATUTE

- Public health impact estimates should consider social determinants of health:

“...the impact on the health of the community, including diseases and conditions **where disparities in outcomes associated with the social determinants of health** as well as gender, race, sexual orientation, or gender identity are established in peer-reviewed scientific and medical literature.”

DEFINING SDOH

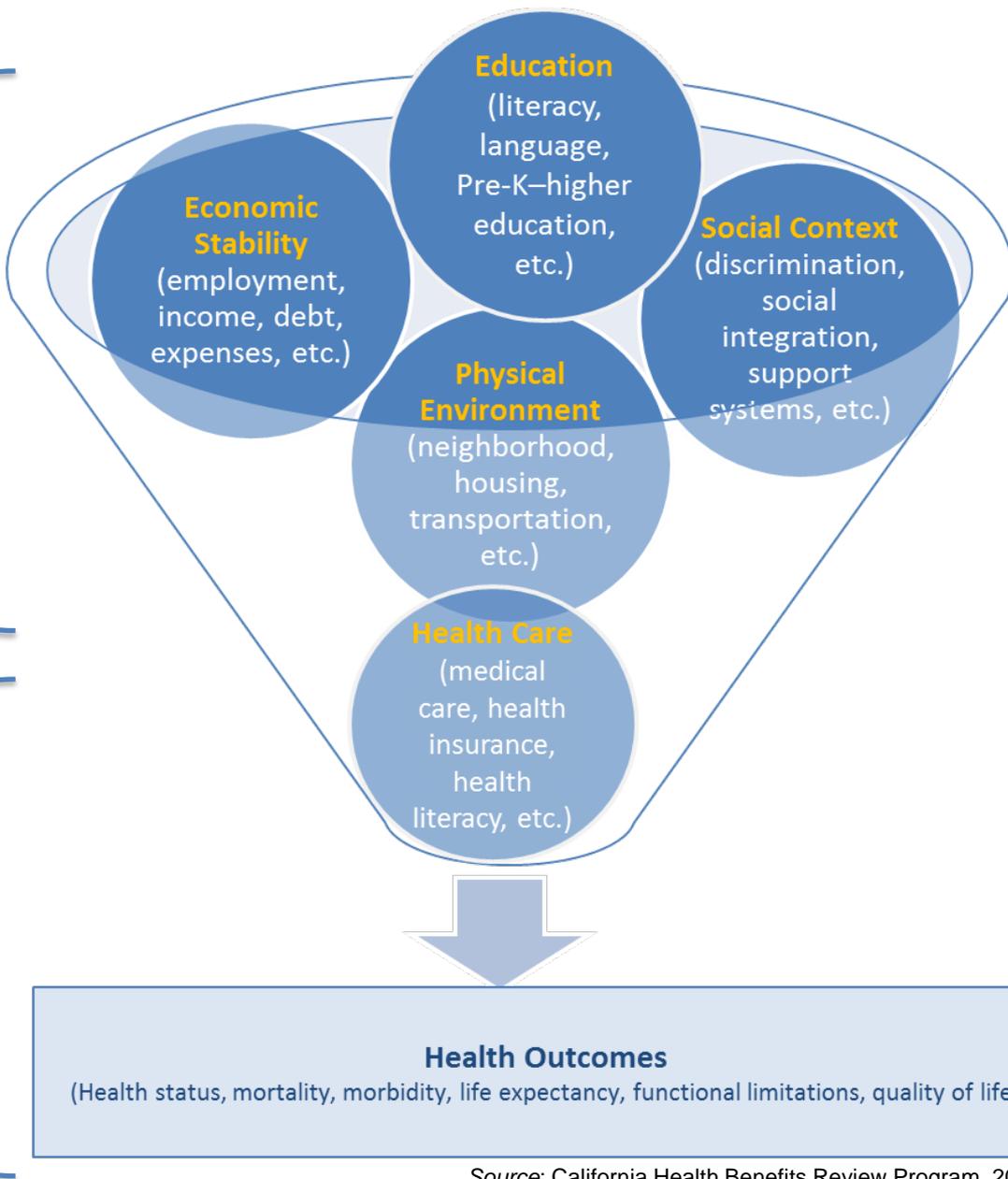
- Many factors outside of the health care system
 - Affect health status and health outcomes
 - Contribute to disparities in health.
- Many definitions and frameworks:
 - World Health Organization, Centers for Disease Control and Prevention, Healthy People 2020, American Public Health Association, etc.



SDOH FRAMEWORK

Upstream factors

Downstream factors



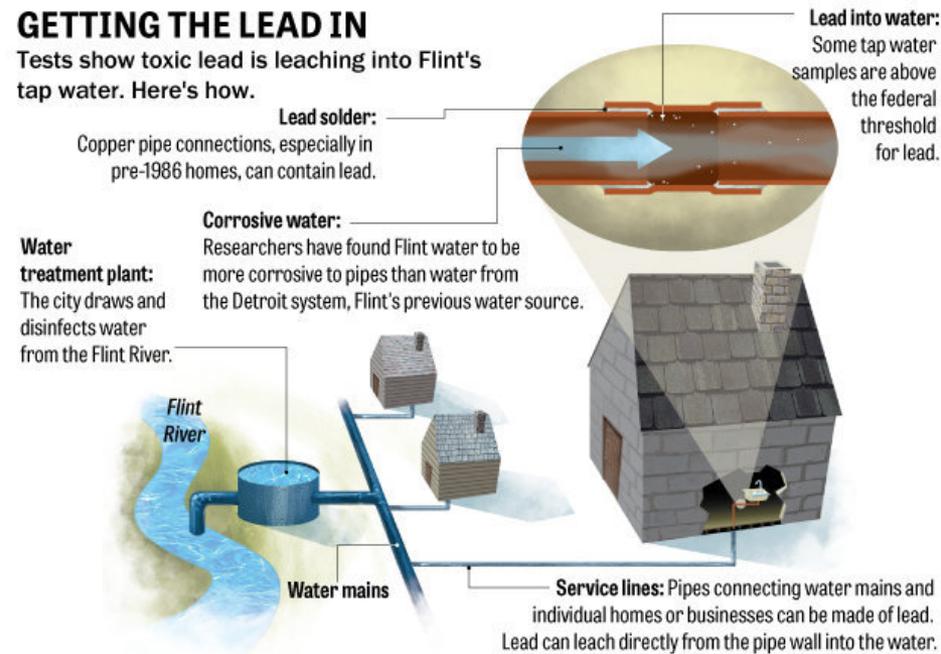
Source: California Health Benefits Review Program, 2016

CURRENT EXAMPLE: FLINT, MICHIGAN

- Policy decision changed the water source
- Significant lead contamination to city water supply
 - More than doubled childhood lead poisoning cases
 - Lead poisoning in children has long term effects:
 - inhibit brain development
 - permanent intellectual impairment.

GETTING THE LEAD IN

Tests show toxic lead is leaching into Flint's tap water. Here's how.



EXAMPLE: FLINT, MICHIGAN

- Upstream policy decision (new water source) resulted in downstream negative health outcomes and worsened health disparities.
- Policy impact on the physical environment
- Interactions with the health care system, social and political system.
- Affected health outcomes, resources needed to address the problem.





CHBRP WORKING DEFINITION

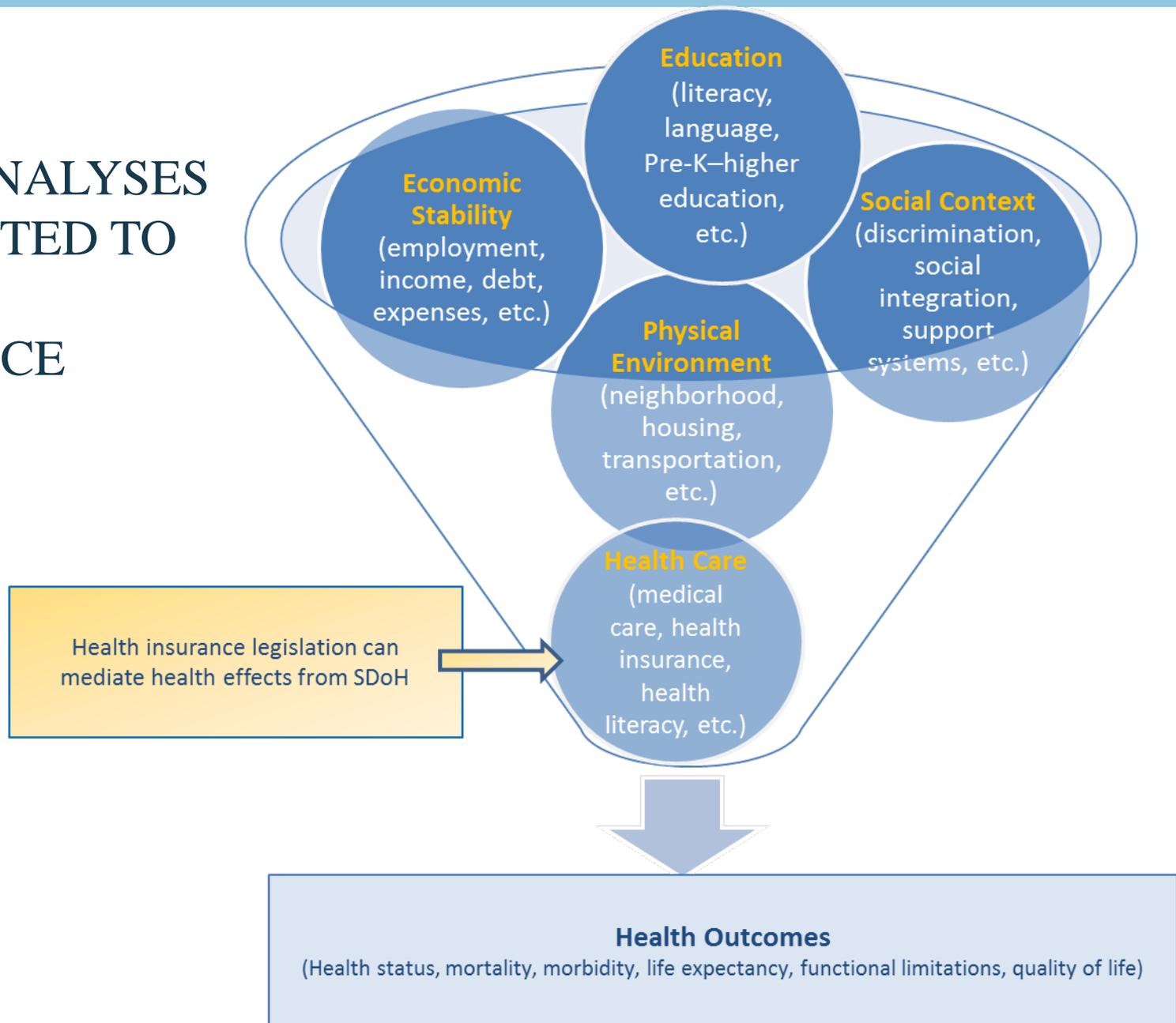
- Social determinants of health **are conditions in which people are born, grow, live, work, learn, and age.** These social determinants of health (economic factors, social factors, education, physical environment) are shaped by the distribution of money, power, and resources and are impacted by policy.

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

SDOH 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.
 - Nurse home visits to low income mothers
 - 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

CHBRP ANALYSES ARE LIMITED TO HEALTH INSURANCE IMPACTS



INCLUSION OF SDOH IN CHBRP REPORTS

PAST ANALYSES

- CHBRP has addressed some aspects of SDOH:
 - Change in coverage affects
 - Access to care
 - Out-of-pocket costs, time lost from work
 - Disparities in health status/outcomes
 - race/ethnicity
 - gender
 - Other bill-relevant determinants
 - Education (School nurses)
 - Transportation (telehealth)



INCLUSION OF SDOH IN CHBRP REPORTS

2016

- Background
 - Broader contextual information about SDOH (i.e., race/ethnicity, income, gender, sexual orientation, age, and other bill-relevant determinants such as employment, education, transportation.)
- Public Health and Long Term Impacts
 - When possible:
 - Estimate bill-related marginal impacts on SDOH-associated health outcomes and disparities
 - Consider potential direct impacts of health insurance legislation on SDOH

QUESTIONS?