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

<table>
<thead>
<tr>
<th>Group</th>
<th>250%</th>
<th>300%</th>
<th>106%</th>
<th>0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pregnant</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Parents</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Childless</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Adults</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Group</th>
<th>400%</th>
<th>266%</th>
<th>322%</th>
<th>138%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pregnant</td>
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</tr>
<tr>
<td>Adults</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Health Insurance Status Of Californians Under Age 65, 2016

By Insurance Coverage Type, 2013-2016

<table>
<thead>
<tr>
<th>Year</th>
<th>Uninsured</th>
<th>Public</th>
<th>Private</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>8.5%</td>
<td>36.5%</td>
<td>55.0%</td>
</tr>
<tr>
<td>2014</td>
<td>15.5%</td>
<td>86.3%</td>
<td>8.5%</td>
</tr>
<tr>
<td>2015</td>
<td>13.6%*</td>
<td>90.5%*</td>
<td>9.5%*</td>
</tr>
<tr>
<td>2016</td>
<td>9.5%</td>
<td>91.5%</td>
<td>8.5%</td>
</tr>
</tbody>
</table>

Note: * Indicates a statistically significant change from previous year

Changes Federally and in the ACA

Recent changes
- Repeal of Individual Mandate Penalty in 2019 through the Tax Cuts and Jobs Act of 2017
- Purchase of insurance across state lines through Association Health Plans

Future changes
- Cost Sharing Reduction Subsidy funding uncertainty
- Other federal action through CMS or executive order
2019 Estimates – CA Health Insurance – All Ages

Total Population – 39,212,000

- Insured, Not Subject to Mandate* (23,935,000) 61.0%
- State-regulated health insurance subject to Mandate 30.7%
- Uninsured 9.6%
- CDI-Reg 1.2%
- DMHC-Reg (Not Medi-Cal) 39.4%
- DMHC-Reg Medi-Cal & Other Public 19.1%

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

<table>
<thead>
<tr>
<th>DMHC-Regulated Plans</th>
<th>CDI-Regulated Policies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Large Group (101+)</td>
<td>Large Group (101+)</td>
</tr>
<tr>
<td>Small Group (2-100)</td>
<td>Small Group (2-100)</td>
</tr>
<tr>
<td>Individual</td>
<td>Individual</td>
</tr>
<tr>
<td>Medi-Cal Managed Care*</td>
<td>-----------------------</td>
</tr>
</tbody>
</table>

*except county organized health systems (COHS)
Benefit Mandates

State Laws (Health & Safety/Insurance Codes)
• More than 70 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 briefs and publications may be obtained by visiting the CHBRP website at www.chbrp.org

California Health Benefits Review Program

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 independent, and neutral.
  - Unbiased.
  - Provides timely, evidence-based information to the Legislature, leveraging faculty expertise since 2003.
  - Analyzes introduced bills at the request of the Legislature (Policy Context, Medical Effectiveness, Cost, Public Health).
Who is CHBRP?

• Task Force of faculty and researchers
• Actuarial firm: PricewaterhouseCoopers (PwC)
• Librarians
• Content Experts
• National Advisory Council
• CHBRP Staff
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
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:

  - **Medical Effectiveness**
    - What services/treatments are included?
    - Do they work? What studies have been done?

  - **Cost Projections**
    - Will enrollees use it?
    - How much will it cost?

  - **Public Health Impacts**
    - What impacts on the community’s overall health?
    - What are the health outcomes
CHBRP’s 60-Day or Less Timeline

Mandate Bill Introduced and Request sent to CHBRP → Team Analysis → Vice Chair/CHBRP Director Review → Final to Legislature

National Advisory Committee → Revisions
CHBRP Analyses Provide:

<table>
<thead>
<tr>
<th>Policy Context</th>
<th>Medical Effectiveness</th>
<th>Impacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whose health insurance would have to comply?</td>
<td>Which services and treatments are most relevant?</td>
<td>Would benefit coverage, utilization, or cost change?</td>
</tr>
<tr>
<td>Are related laws already in effect?</td>
<td>Does evidence indicate impact on outcomes?</td>
<td>Would the public’s health change?</td>
</tr>
</tbody>
</table>

CALIFORNIA HEALTH BENEFITS REVIEW PROGRAM
CHBRP’s Website: www.chbrp.org
California Health Benefits Review Program

Two 2017 CHBRP Analyses
Showcasing Methods

February 7, 2018
2017 Analysis:

AB 447 – Continuous Glucose Monitors

Adara Citron
Principal Analyst

Source: Naomi Berrie Diabetes Center, Columbia University Medical Center, 2014

CHBRP concludes that there is a preponderance of evidence based on one well-conducted systematic review of 7 RCTs that the use of retrospective CGMs for patients with type 1 diabetes mellitus are not effective.
## MEDICAL EFFECTIVENESS SUMMARY

<table>
<thead>
<tr>
<th></th>
<th>Retrospective</th>
<th>Real-time</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type 1 Diabetes</strong></td>
<td>Preponderance of evidence - not effective</td>
<td>Limited evidence - effective</td>
</tr>
<tr>
<td><strong>Type 2 Diabetes</strong></td>
<td>Limited evidence – not effective</td>
<td>Limited evidence – not effective</td>
</tr>
<tr>
<td><strong>Gestational Diabetes</strong></td>
<td>Limited evidence - effective</td>
<td>Insufficient evidence</td>
</tr>
</tbody>
</table>
COST AND PUBLIC HEALTH IMPACTS

• Cost Impacts
  – Benefit Coverage ↑ by 9% among Medi-Cal Managed Care enrollees, and 100% for FFS
  – Utilization ↑ by 2,255 users
  – Expenditures ↑ by $2.1 million in Managed-Care, $385,000 in COHS and unknown increase for FFS
2017 Analysis:

AB 1316 – Childhood Lead Poisoning Prevention

Erin Shigekawa
Principal Analyst
• 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

Lead exposure in the Golden State

Childhood lead poisoning is often associated with poverty-stricken neighborhoods in the Rust Belt and East Coast. But newly released data shows many neighborhoods across California also have lead exposure problems which can leave children with life-long health impacts. In the worst hit zip code in Fresno, 13.6 percent of children tested had elevated lead levels, nearly three times the rate found in Flint, Michigan during that city’s water contamination crisis.

PERCENTAGE OF CHILDREN UNDER AGE 6 TESTED WITH ELEVATED BLOOD LEAD LEVELS BY ZIPCODE, 2012

- None/data not available
- Less than 1.0%
- 1.1-5.0%
- 5.1-10.0%
- More than 10.0%

Note: An elevated blood lead level is 5 micrograms per deciliter or higher. A test result of 4.5 or higher is rounded up to 5.

Source: California Department of Public Health

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

www.chbrp.org