California Health Benefits Review Program

California Health Insurance

John Lewis
Associate Director

January 23, 2020
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
2020 Estimates – CA Health Insurance

Total CA Population – 39,648,000

- Uninsured: 3,982,000
- Insured, Not Subject to Mandate*: 8,222,000
- Medi-Cal FFS, Not Subject to Mandate: 1,351,000
- Medi-Cal COHS, Not Subject to Mandate: 1,603,000
- State-regulated health insurance subject to Mandate: 24,490,000
- CDI or DMHC-Reg (Not Medi-Cal): 16,899,000
- DMHC-Reg (Medi-Cal): 7,591,000

*Such as enrollees in Medicare or self-insured products

Source: California Health Benefit Review Program, 2019
# 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 List

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

December 5, 2019

Prepared by
California Health Benefits Review Program
www.chbpr.org

Suggested Citation: California Health Benefit Review Program (CHBPR). (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)
  o Federal Preventive Services
  o 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
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)

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

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 Health Benefits Review Program

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

1. Mandate Bill Introduced and Request sent to CHBRP
2. Team Analysis
3. Vice Chair/CHBRP Director Review
4. National Advisory Council
5. Revisions
6. Final to Legislature
CHBRP’s Website: www.chbrp.org
California Health Benefits Review Program

Providing Evidence-Based Analysis to the California Legislature

2020 Legislative Briefing

Ana Ashby
Policy Analyst
Showcasing CHBRP’s Methods: A review of AB 767 Infertility

Adara Citron, MPH
Principal Analyst

January 23, 2020
## 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

AT A GLANCE

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

1. CHBPR estimates that, in 2020, of the 24.5 million Californians enrolled in state-regulated health insurance, 14.5 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 for planned OC would increase from 0% premandate to 100% postmandate. AB 767 would likely exceed EHS.

3. Utilization. Utilization of infertility services would increase between 4% for diagnostic tests and 356% for IVF with intracytoplasmic sperm injection (ICSI). Utilization of planned OC is expected to increase from 0% to between 2% to 4%.

4. Expenditures. AB 767 would increase total net annual expenditures by $62,260,000 or 0.59% due to a $53,777,000 increase in total health insurance expenditures, adjusted by decreases in enrollee expenses for covered and non-covered benefits.

   a. Enrollees with uninsured expenses at baseline would receive on the whole a $139,977,000 reduction in their out-of-pocket spending for covered and non-covered expenses.

   b. Per member per month premiums would increase between $2.79 for enrollees in CAPERS HMO (an increase of 0.47%) and $2.72 in the DMHC-regulated small group market (an increase of 0.58%).

5. Medical effectiveness.

   a. There is a preponderance of evidence that IVF is an effective treatment for infertility.

   b. There is evidence that OC provides a form of fertility preservation. While fertility preservation usually refers to the preservation of fertility in advance of medical procedures that can lead to 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-relevant 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

<table>
<thead>
<tr>
<th>Category</th>
<th>Required Coverage</th>
<th>Above Average Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uninsured</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>DMHC-HMO</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>DMHC-Reg</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

   Source: California Health Benefits Review Program, 2019

   Notes: "Required beneficiaries, enrollees in self-funded products, etc.

   1 Refer to CHBPR’s full report for full citations and references.
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?
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
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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