

California Health Benefits Review Program

Bridging the Divide: Lessons Learned Providing Evidence-Based Analysis to the California Legislature

State Health Research and Policy Interest Group Meeting

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CHBRP REPORTS ENHANCE UNDERSTANDING

- CHBRP is independent, analytic resource serving the California Legislature, grounded in academia and policy analysis
 - Administered by the University of California
 - Provides timely, evidence-based information to the Legislature
- Neutral – without specific policy recommendations
- Fast – 60 days or less
- Expert – leverages faculty and researchers, policy analysts, and an independent actuary to perform evidence-based analysis

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

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 banner with four images: a large hall, a document with "BENEFITS. Contract will", a magnifying glass over a document, and a dictionary page with "re-search". Below the banner is a grey box 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." To the left of the main content area is a vertical sidebar with red buttons for "About CHBRP", "Completed Analyses", "Recent Requests", "Analysis Methodology", and "Other Publications". The main content area has a "What's New..." section with two items: "CA Mandates for 2016" (with a "Resource" tag) and "Analysis of AB 533: Out-of-Network Coverage" (with a "Bill Analysis" tag). 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 showing a tweet from "California Health Officials and Journalists" posted "about 6 days ago".

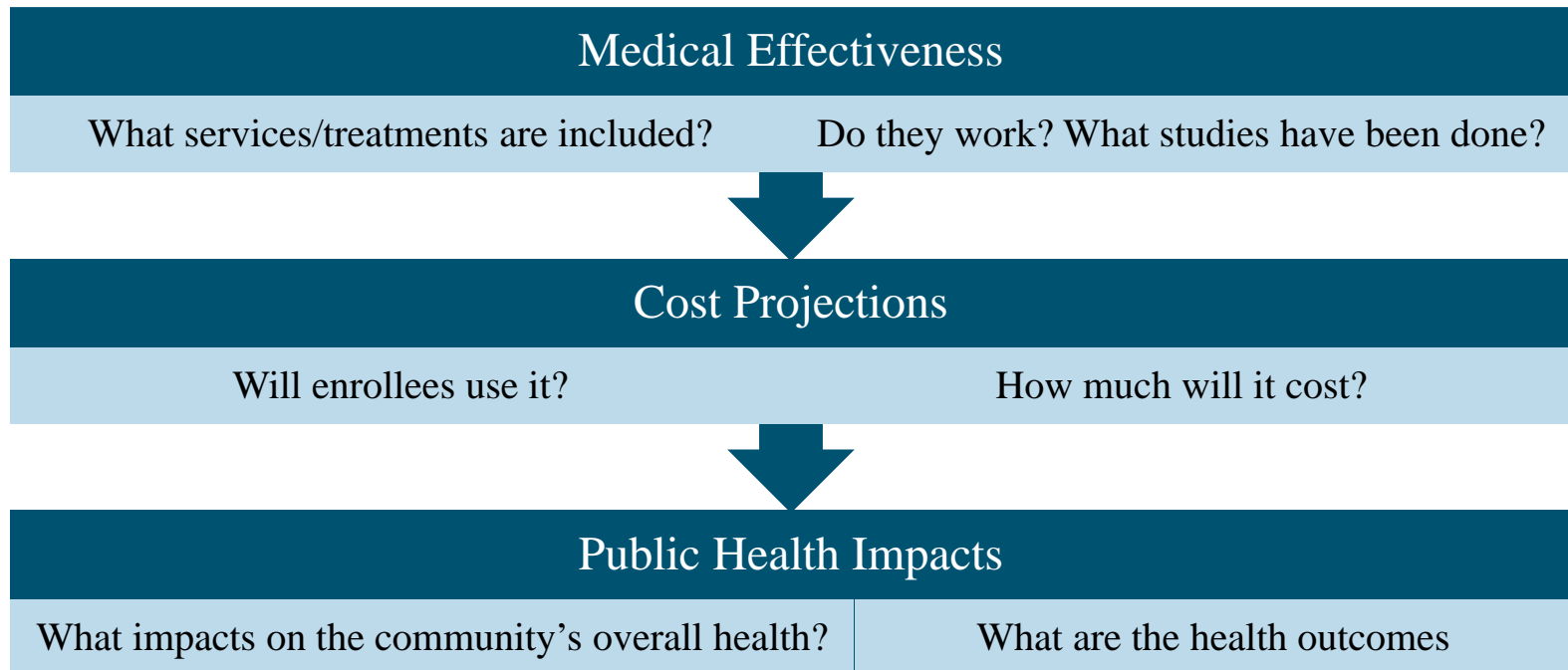
california for beginners

also palm trees and earthquakes
and beaches and freeways
and missions and in-n-out!
everywhere! duuuude!



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:



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



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.

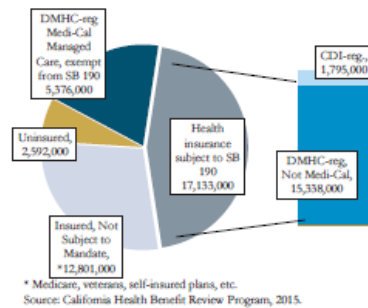
ACQUIRED BRAIN INJURY

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.

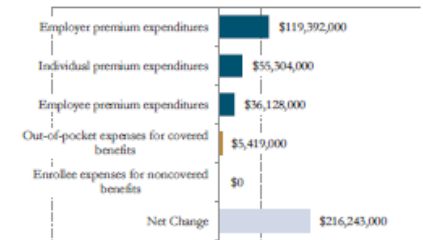
CHBRP found that coverage of PARTRS is not universal among persons with health insurance subject to SB 190 and so projects that 83% of these enrollees would gain benefit coverage. Because these enrollees already have coverage for other post-acute rehabilitation services (outpatient and SNF-based), CHBRP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

KEY DESIGN FEATURES OF CHBRP: LESSONS

- Partner with public universities
- Ensure impartiality/ objectivity/ strong COI
- “Freeze legislation” for analysis period
 - 60 Days: “Blessing and Curse”
 - Peer review, feedback, and drafts create intense bursts of productivity and effort
- Find or secure a designated revenue source
- Emphasis on Quality and Accuracy: Flexibility

KEY DESIGN FEATURES OF CHBRP: LESSONS

- Invest by securing and partnering for data sources and ally with policy centers
- Role of actuaries, content experts, and consultants is **key**
- Emphasis on accessibility (Key Findings), clarity, and elevation of policy debate/literacy
- Focus on continuous quality improvement and engagement with users and stakeholders
- Faculty/researchers have clear stake and commitment to long-term success of the program.

KEY DESIGN FEATURES OF CHBRP: LESSONS

- Flexibility/Skills of Taskforce and Staff
 - Very limited academic politics with focus on collaboration
 - Find “policy wonks” but leave politics to staff
- Reserve (great) faculty time in advance
- Multi-faceted policy/project management staff
- Develop robust templates, timelines, and internal processes that ensure smooth flow

CHBRP MODEL: OTHER STATE TOPICS?

- Comparative effectiveness work at state levels
- Health disparities
- Delving into Social Determinants of Health
- Essential Health Benefits
- Medicaid/ state employee/ benefits mandates
 - Cost effectiveness studies
 - Public Health / Disparities Work

Wrap-up

Questions? Want more info?
www.chbrp.org

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