Approach to Public Health Analysis

California Health Benefits Review Program

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What Are Public Health Impacts?

- Baseline data relative to the mandate in question (rates of condition- or disease-related morbidity, mortality, etc.)

- Gender and racial/ethnic disparities in relevant health outcomes

- Premature death

- Economic loss associated with disease

- Long-term health impacts (beyond first 12 months of mandate enactment)
Inputs

Public Health Data

Medical Effectiveness

Cost, Coverage and Utilization

Public Health Impact:
- Health outcomes
- Economic loss
- Long term impacts
- Disparities
Step 1

- Identify baseline data on:
  - Frequency of relevant conditions in the population (incidence) and/or
  - Proportion of the population with relevant conditions (prevalence)
  - Utilization of treatment relevant to the mandate
Step 1 cont’d.

- **Data Sources**
  - Surveys, registries, cost-effectiveness/benefit studies, grey literature, evidence-based studies

- **Potential sources:**
  - Centers for Disease Control and Prevention, California or National Health Interview Survey, Behavioral Risk Factor Survey, disease-specific state surveys/registries
Step 1

Example: Tobacco Cessation

Proposed mandate (AB 1738) required coverage for tobacco cessation counseling and medications

- California baseline data:
  - **Smoking prevalence: 13.4%** (gender/racial disparities evident)
  - **60% of smokers attempted to quit** in the 12 months preceding the California Tobacco Survey.
Step 2

- Will more people have coverage for the mandated services/treatments?
  - Review projections from cost and utilization analysis regarding changes in coverage and use of services

- Example: Tobacco Cessation
  - Pre-mandate: 1.92 million adult insured smokers; 304K use cessation treatment
  - Post-mandate: 27% increase in utilization
Step 3

- **Combine ME and Cost**
  - Estimated effectiveness of the intervention (ME team)
  - Estimates of change in utilization of intervention by newly covered populations (Cost team)

**Example: Tobacco Cessation**

- 5,287 Californians are estimated to quit annually due to mandate.
Step 4

- For any additional utilization, **what is the impact on health outcomes** (includes harms from intervention when relevant)?

**Example: Tobacco Cessation**

- Fewer premature deaths from tobacco use (estimated 37,009 – 65,559 years of potential life gained for quitters in the first year after enactment.)

- $27.4 million reduction in OOP expenses
## Possible PH Conclusions

<table>
<thead>
<tr>
<th>Quantitative</th>
<th>Qualitative</th>
<th>No Impact</th>
<th>Unknown Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Numeric estimate of insured persons with improved outcomes or reduced financial burden</td>
<td>• Indicate direction of mandate’s effect “Likely increase/decrease in [health outcome]”</td>
<td>• Full coverage at baseline, or no change in utilization expected.</td>
<td>• Insufficient evidence on medical effectiveness or utilization</td>
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<tr>
<td>• Tobacco Cessation</td>
<td>• Maternity Services</td>
<td></td>
<td>• Prescription Pain Drugs</td>
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</table>
Challenges For CHBRP Program specific

- Interpreting bill language
- Quantifying disparities impacts with limited data or literature for insured population
  - Literature, research, and policy aims are generally for people *without* insurance
- Disconnect with legislators’ aims:
  - Lack of impact for uninsured, despite policymakers’ intent
Challenges For CHBRP
Generalizable

- Lack of clear policy intent
- Lack of relevant data
- Assessing short term vs. long term impacts
- Rigor vs. Policy Relevance
  - Need rapid response to inform policy
Outline

- Brief overview of private health insurance in US and CA
- What are benefit mandates?
- Overview of CHBRP
- Medical Effectiveness analysis approach
- Benefit Coverage, Cost, Utilization analytical approach
- Public Health analysis approach

Takeaways