

California Health Benefits Review Program

2017 Legislative Briefing

February 2, 2017



California
Health Benefits
Review Program

California Health Insurance – and
the Possibility of Early 2017
Changes

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Associate Director

February 2, 2017



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.

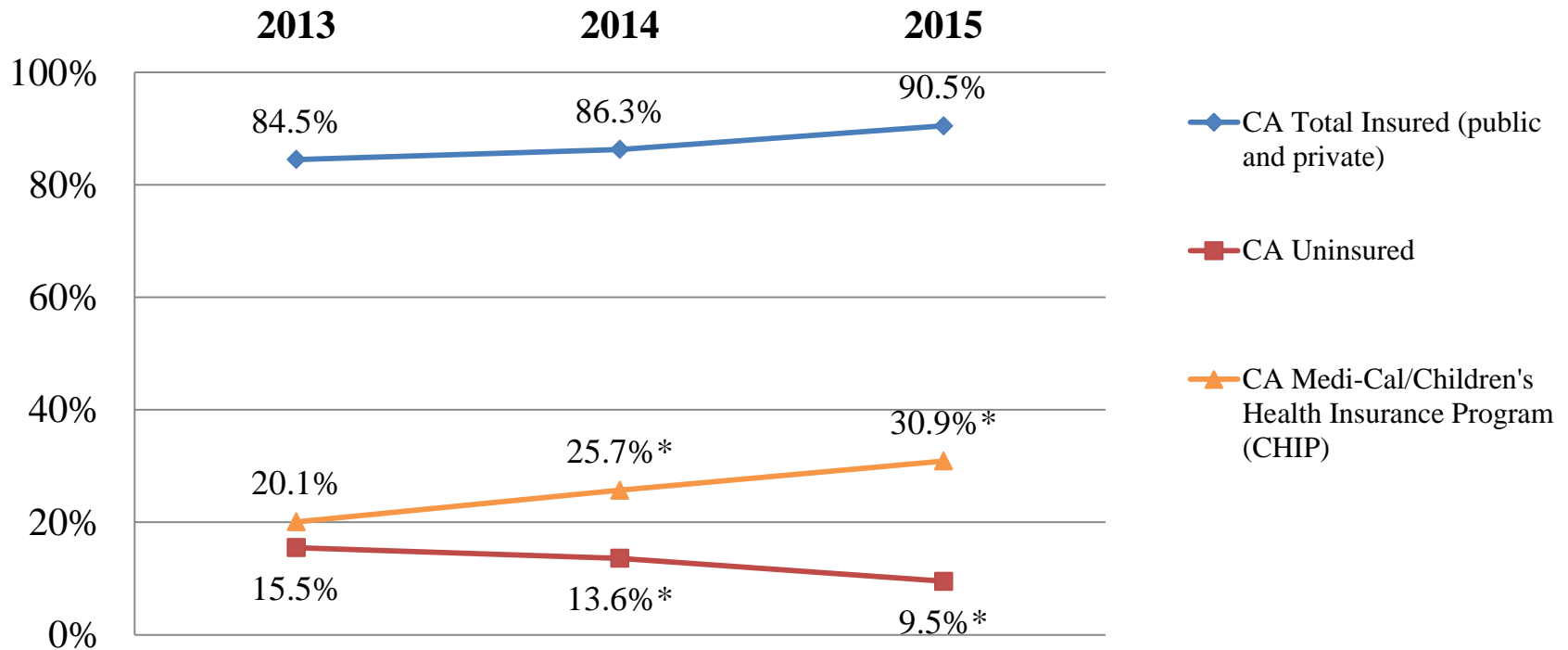
Health Insurance ...

- is regulated
 - is divided into markets
 - may be (or may not be) subject to state laws, such as benefit mandates

Health Insurance Status Of Californians Under Age 65



By Insurance Coverage Type, 2015



Note: * Indicates a statistically significant change since 2013
 Source: California Health Interview Survey (CHIS)

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...

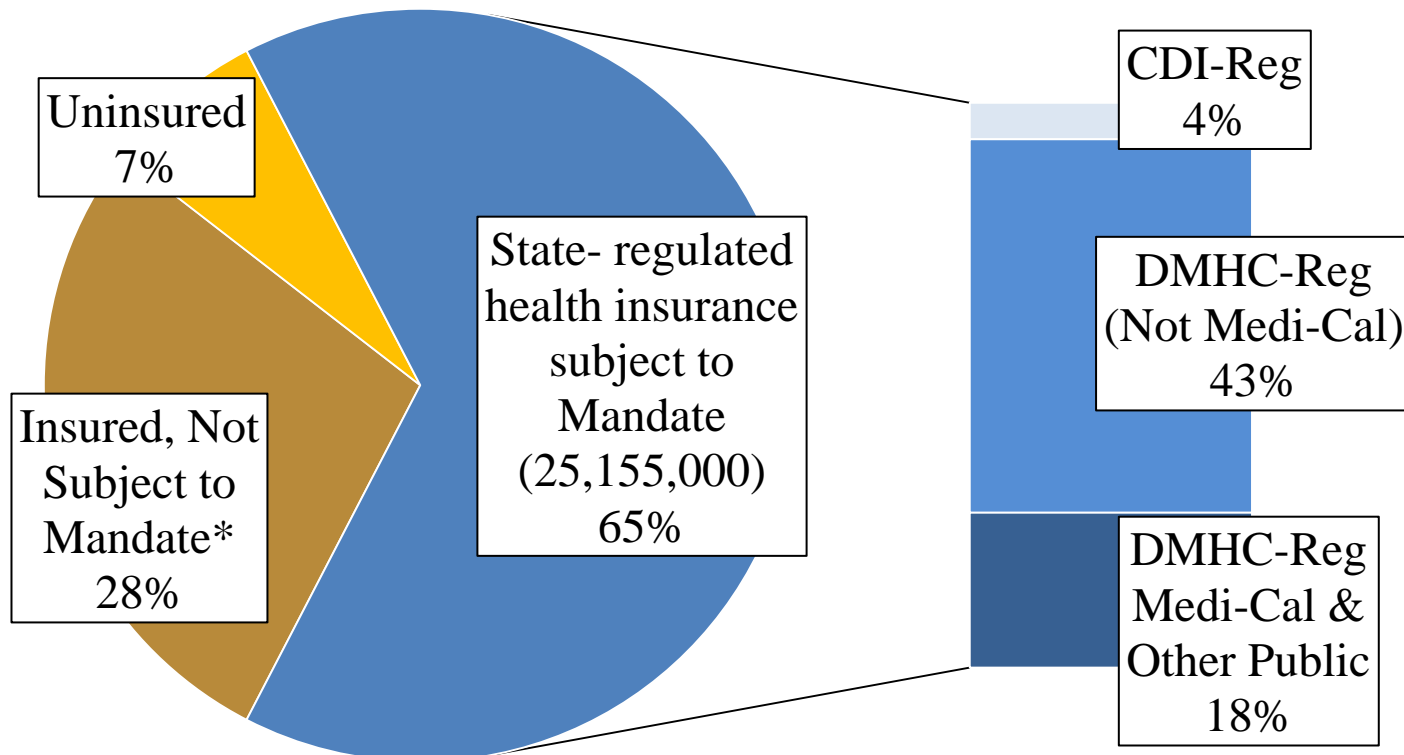
or is defined by a *health insurance policy* that is:

- Subject to CA Insurance Code
- Regulated by CDI



2017 Estimates – CA Health Insurance – All Ages

Total Population - 38,566,000



*Such as enrollees in Medicare or self-insured products
Source: California Health Benefit Review Program, 2016

Health Insurance Markets in California

DMHC-Regulated Plans	CDI-Regulated Policies
Large Group (101+)	Large Group (101+)
Small Group (2-100)	Small Group (2-100)
Individual	Individual
Medi-Cal Managed Care*	-----

*except county operated health systems (COHS)

Possible Changes in the ACA

Enacted (and possibly implemented) 1st or 2nd quarter of 2017

- Repeal of the employer requirement to offer health insurance
- Repeal of the individual requirement to have health insurance

Enacted & implemented later

- Numerous possibilities, but as yet unclear

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)

- 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 6, 2017

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Additional free copies of this and other CHBRP bill analyses and publications may be obtained by visiting the CHBRP website at www.chbrp.org.

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California Health Benefits Review Program

Overview of CHBRP

Erin Shigekawa
Principal Analyst

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: PricewaterhouseCoopers (PwC)
- Librarians
- Content Experts
- National Advisory Council
- CHBRP Staff

Who is CHBRP?

Public Health Team

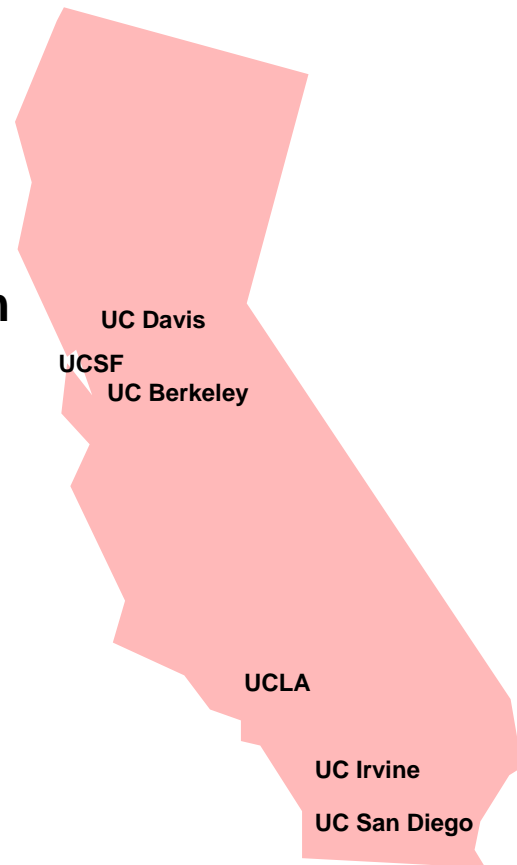
UC Davis
UC San Diego

Medical Effectiveness Team

UC San Diego
UC San Francisco
UC Davis

Cost Team

UC Los Angeles
UC Davis
UC San Francisco



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 desks, 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 on the left 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 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 with a tweet from "California Health Officials and Journalists" posted "about 6 days ago".

CALIFORNIA
HEALTH BENEFITS REVIEW PROGRAM
Providing Objective Legislative Analysis

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BENEFITS.
Contract will

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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

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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.

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Latest Tweets

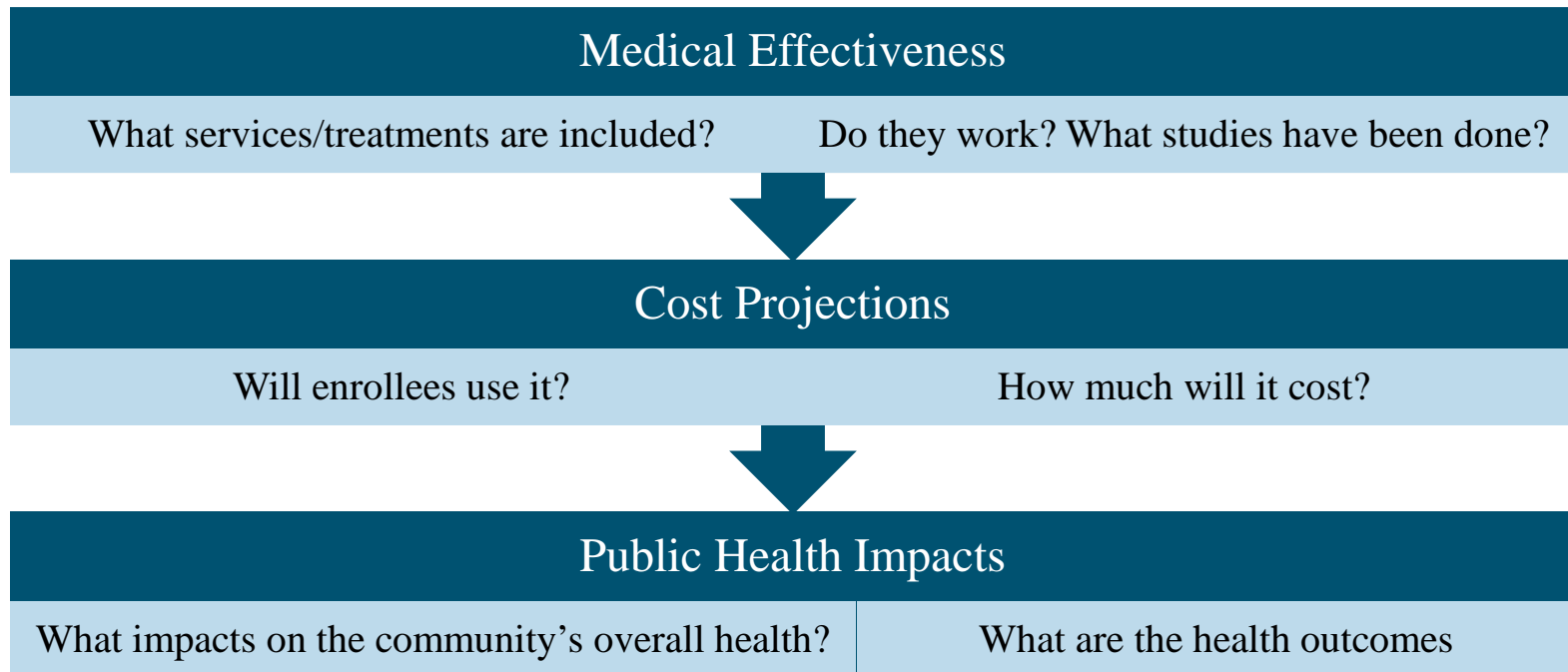
about 6 days ago California Health Officials and Journalists

CHBRP Reports Enhance Understanding of Health Insurance

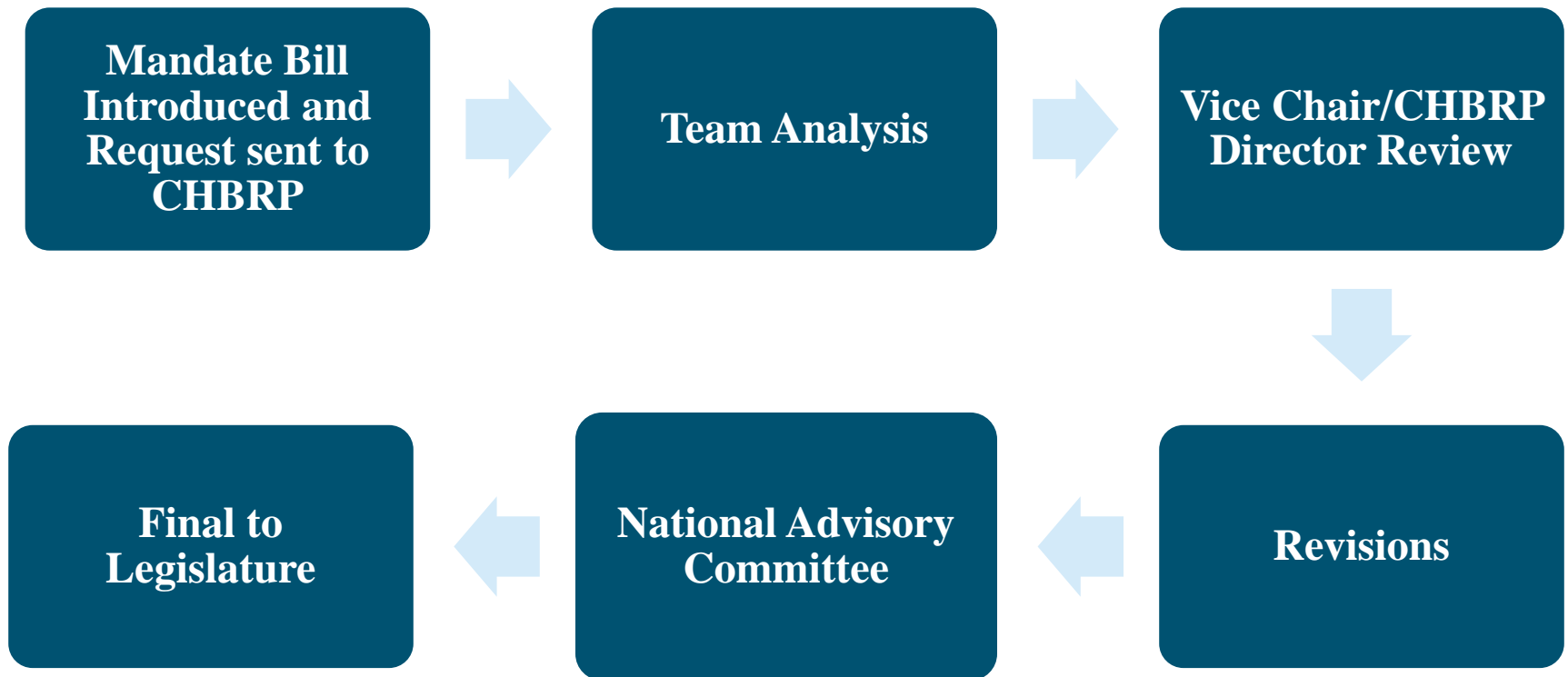
- Health Insurance Benefits:
 - Benefits are tests/treatments/services appropriate for one or more conditions/diseases
- Health Insurance Benefit Mandates may pertain to:
 - Type of health care provider
 - Screening, diagnosis or treatment of disease/condition
 - Coverage for particular type of treatment, 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:



CHBRP's 60-Day or Less Timeline



California Health Benefits Review Program

What Will You Find in a CHBRP Report?

Adara Citron, MPH, and Erin Shigekawa, MPH
Principal Analysts

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

CHBRP Reports have been used to inform:

- Legislative Committee Analyses & Reports
- Advocates
- Opponents
- Hearing Discussion
- Insurance Companies and Regulators

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.

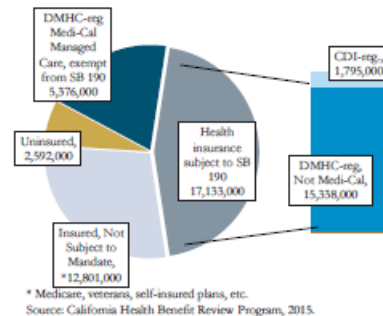
ACQUIRED BRAIN INJURY

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.

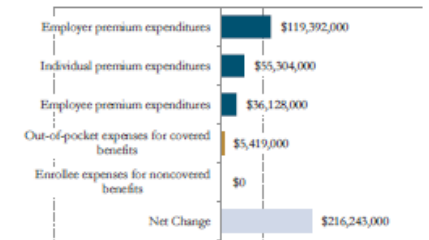
CHBRP found that coverage of PARTRS is not universal among persons with health insurance subject to SB 190 and so projects that 83% of these enrollees would gain benefit coverage. Because these enrollees already have coverage for other post-acute rehabilitation services (outpatient and SNF-based), CHBRP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

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?

SB 999 (PAVLEY)

CONTRACEPTIVES: ANNUAL SUPPLY, 2016

- Mandates insurance coverage of a 12-month supply of FDA-approved, self-administered hormonal contraceptives dispensed at one time to an enrollee.
- Includes oral contraceptives, the vaginal ring, and the contraceptive patch.
- Dispense up to 12-month supply either at the enrollee's request or in accordance with the prescription (unless specifically stated otherwise).

SB 999 (PAVLEY)

CONTRACEPTIVES: ANNUAL SUPPLY, 2016

- **ACA:** Requires non-grandfathered plans sold on the individual and group markets to cover FDA approved contraceptives without cost-sharing.
- **CA Existing Laws:** SB 1053 (passed in 2014) requires all DMHC and CDI regulated plans and policies to provide coverage for at least one form of contraception from each of the 18 FDA-approved contraception types. Medi-Cal enrollees and eligible Family PACT recipients are able to receive up to a 12-month supply of oral contraceptives.
- **Other States:** Oregon and DC have similar laws in effect currently. Several other states were considering similar legislation at the time the analysis was conducted.

Background



BACKGROUND

- Bills CHBRP analyzes are generally focus on:
 - Insurance coverage for screening, diagnosis or treatment of disease/condition;
 - Insurance 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 (as of late 2015).
- What is the disease/condition?
- How widespread is the disease/condition?
- What is the impact on different populations?

BACKGROUND ON CONTRACEPTION

- In California, nearly half of the estimated 818,700 pregnancies per year are unintended.
- Younger women ages 15-24 are more likely to use self-administered hormonal contraceptives than older women. Unintended pregnancy rates are also highest among younger women.
- Women with higher levels of education and with higher incomes are more likely to use the contraceptive pill, ring, or patch than women with lower education levels and incomes.

Sources: Kost K. *Unintended Pregnancy Rates at the State Level: Estimates for 2010 and Trends Since 2002*. New York: Guttmacher Institute; 2015 Available at: <https://www.guttmacher.org/pubs/StateUP10.pdf>. Accessed March 18, 2016.

Medical Effectiveness

MEDICAL EFFECTIVENESS

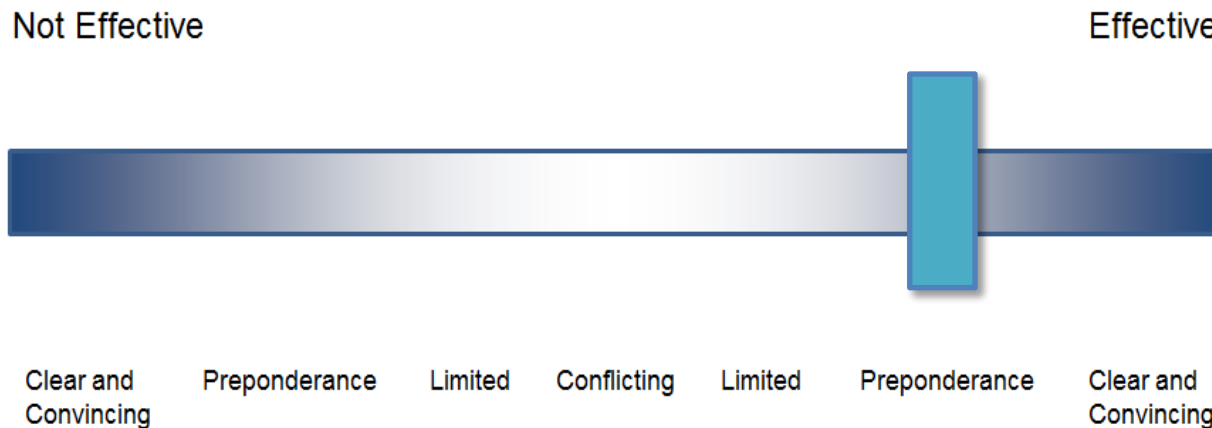
- Based on scientific evidence, is the treatment or service effective?
 - Sources include:
 - Peer-reviewed publications (e.g., randomized controlled trials, etc.);
 - Other published information (e.g., clinical guidelines and best practices); and
 - Expert opinion.

MEDICAL EFFECTIVENESS: CATEGORIES OF EFFECTIVENESS

Clear & Convincing	Preponderance of Evidence	Limited Evidence	Conflicting Evidence	Insufficient Evidence
It works. OR It doesn't work.	It seems to work. OR It seems not to work.	Number of studies is small. OR Studies have weak comparison groups.	The evidence cuts both ways.	There is not enough evidence to determine whether it does or does not work.

MEDICAL EFFECTIVENESS GRAPHIC

Figure 1. Summary of Findings related to the effect of dispensing patterns of oral contraceptives on adherence and pregnancy outcomes



Conclusion: *There is a preponderance of evidence from studies with moderate research designs that conclude that dispensing oral contraceptives in larger quantities leads to a reduction in unintended pregnancy and related outcomes.*

MEDICAL EFFECTIVENESS OF SELF-ADMINISTERED HORMONAL CONTRACEPTIVES AND THE IMPACT OF DISPENSING QUANTITIES

- Self-administered hormonal contraception is effective in preventing pregnancy.
- Dispensing oral contraceptives in larger quantities leads to a reduction in unintended pregnancy and related outcomes.
- Anticipated pill-wastage due to increased dispensing amounts.
- Women with unintended pregnancies have lower utilization of certain services and may experience poorer maternal health outcomes.

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 insurance 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 SELF-ADMINISTERED HORMONAL CONTRACEPTIVES

- Postmandate, of the 744,000 insured women with active prescriptions, CHBRP estimated that the share of women receiving 12 months of their contraceptives at one time would increase from 0.6% to 47%.
- Coverage of a 12-month supply would result in estimated \$122M in avoided costs within the first 12 months.
- Estimated premium changes per member per month (PMPM) vary by market segment from no change in premium to a \$0.26 decrease in total premiums.

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 SB 999

- Obtaining a 12-month supply at one time reduces potential for delays in refills between cycles.
- Postmandate dispensing patterns would result in 15,000 fewer unintended pregnancies among the 744,000 enrollees. Specifically, this will equate to 6,000 fewer live births, 2,000 fewer miscarriages, and 7,000 fewer abortions.
- The reduction in unintended pregnancies will result in a reduction of negative health outcomes related to unintended pregnancy.

THE SOCIAL DETERMINANTS OF HEALTH

- 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.
- CHBRP considers the full range of SDoH that are relevant to the bill and where evidence is available.

SB 999'S IMPACT ON THE SOCIAL DETERMINANTS OF HEALTH

- Disparities exist regarding utilization of self-administered hormonal contraceptives and unintended pregnancy rates.
- Will likely reduce the unintended pregnancy rate among women who are more likely to use self-administered hormonal contraceptives.
- Due to lack of data, CHBRP is unable to estimate the magnitude by which this mandate will address these disparities.

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 not become apparent until years after the first year of implementation (e.g., vaccine coverage).

LONG-TERM IMPACTS OF DISPENSING A 12-MONTH SUPPLY OF CONTRACEPTIVES

- The availability of a consistent supply of self-administered hormonal contraceptives will likely encourage higher utilization of this effective method.
- Reduction in the unintended pregnancy and abortion rates will continue over time, leading to additional cost savings along with reduced complications from potential adverse postpartum outcomes.

Wrap-up

What Will You Find in a CHBRP Report?

- Key Findings
- Six major sections:
 1. Policy Context
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