



Appendix 22: Other States' Health Benefit Review Programs, 2009

During the spring and summer months of 2009, CHBRP staff contacted every state and the District of Columbia to determine what organizations, processes, or requirements other states had in place to evaluate health insurance benefit mandates. CHBRP initially conducted this review in 2004; the 2009 update ensures that CHBRP's information is current. This document presents the project's objectives, methods, and key findings.

OBJECTIVES

The objective of this project is to gather and synthesize information about other states' programs that analyze health insurance benefit mandates. Information collected will update the findings compiled in 2004.

This information is to be used for three main, primarily operational, purposes:

1. To establish ongoing relationships with similar organizations in other states
2. To identify other states' analyses of benefit mandates
3. To provide an overview of other states' activities to analyze health insurance benefit mandates
4. To better understand the gaps between authorizing legislation and the implementation of benefit review processes.

METHODS

Overview

- CHBRP used "key informant interviews" to update 2004 information. The lack of published analytical literature about the activities related to mandate evaluation programs necessitated this method.
- Several states' programs have comprehensive Web sites; where available, CHBRP drew information from these sources to update 2004 information.
- Where available, staff conducted a review of examples of completed mandate evaluations.
- While the 2004 survey methods included data gathering via review of programs' enabling statutes and other information voluntarily provided by the state, the 2009 process did not review such documents.

Identifying Key Informants

- CHBRP contacted key informants interviewed in 2004.
- In many cases, 2004 key informants had left their roles or organizations. In this case, staff contacted their successor. If no successor could be located, staff identified a key informant by contacting:
 - The state department/bureau of insurance (generally, first)
 - Other state agencies (e.g. department of health)
 - Interest groups that appeared to track health insurance mandates within their state (e.g., small business associations, chambers of commerce) to see whether they knew of an existing program and which state agency or office we should contact
- If the initial contact was not knowledgeable, staff pursued other sources as listed above.

Interview Design

- Interview questions were designed to update specific information about each state's systems or processes to conduct mandate evaluations, including:
 - whether a particular state had a systematic evaluation process or formal program in place;
 - how each program came into being;
 - the institutional structure of existing programs;
 - the scope, process, report format, and dissemination methods for completed analysis.
- Interview questions consisted of a subset of CHBRP's 2004 interview questions; emphasis was placed on examining mandate evaluation programs' analytical process and content.

TABLE 1: INTERVIEW QUESTIONS TO KEY INFORMANTS IN OTHER STATES

<i>Basic contact</i>	
1	Organization name, Contact's name, address, phone numbers, email, website
<i>History</i>	
2	How were you established (e.g. legislation? charged by Governor? charged by State Insurance Commissioner?)
<i>Organizational Structure</i>	
3	What is your charge/mission/organizational goal (with respect to benefit mandates)?
4	Where does the organization fit within the state's governmental framework? (related: Is it independent?)
<i>Analytical Content</i>	
5	What type of analyses do you perform (i.e. actuarial, public health, medical effectiveness, other)? Do you have specific criteria for assessing the effectiveness and/or a process for determining the hierarchy of evidence?
6	Do you study proposed legislation and/or passed legislation? Do you examine cumulative impacts?
7	Do you make recommendations? (related: Are there any constraints on reporting of findings?)
8	Are you required to examine mandates' effects on other state programs such as Medicaid, SCHIP, etc.? Do you examine transfer or secondary effects (e.g. private sector to Medicaid or private sector to uninsured?)
9	How many assessments have been completed to date?
10	For which current legislation are you working on analyses? (List current topics that CHBRP has issued reports on -- HPV, CNM, Oral Chemo, Mental Health, etc.)
<i>Analytical Process</i>	
11	What are the steps involved in completing the analysis? a. What fields of expertise do you have represented on staff? Do you employ independent consultants? b. Do you use assessments performed by other groups or organizations?
12	What is the trigger to perform an assessment? Is it only by request? If by request, when does this have to be received?
13	What is your analysis review process? Is it sent to external parties (e.g. non-authors and/or those who do not have a direct stake in the outcome of the mandate)?
14	What is the format of your output? (e.g. reports, testimony)
15	Are the findings of your assessments publicly available? Is there a Web location where they are housed?
16	How are your assessments used and by whom?
<i>Other</i>	
17	Have you heard of the California Health Benefits Review Program (CHBRP)? If so, have you used or referenced any of its publications?
18	If there have been other changes to your organization's structure, scope of work, or analytical process that we have not yet addressed, please discuss.

Interviews and information collection

- The key information interview format was a conversation between the CHBRP staff and the state representative identified as a knowledgeable source. The interview questions acted as conversation guides.
- Key informants in states with any form of established program were asked the complete set of interview questions with probing questions as necessary (e.g. Analysis that was publicly available.)
- Those in states with no program were asked additional probing questions about proposals that were to set up mandate evaluation programs or process.
- Staff documented interview responses in a database.
- A contact tracking log was maintained during the scheduling and interview phases.

FINDINGS

In the summer and fall of 2009, CHBRP contacted all of the 49 other states and the District of Columbia to update records on their processes for evaluating health insurance benefit mandates. These are the findings (inclusive of California):

1. 27 states have some form of systematic process or program in place, defined as follows:
 - a. program/process must at least evaluate the financial (beyond fiscal) impact of a mandate. This may include proposed mandates in bill form or retrospective analyses of existing mandates on private insurers and/or insured;
 - b. process must be “regular” in that 1) those who are responsible for conducting the evaluations do so per the provisions of state law (if applicable), 2) the process is automatically triggered by the nature of the legislative process (e.g., when bill is proposed; when bill gets a 2nd hearing; when it is being heard in committee with jurisdiction), or 3) the process is triggered by request of the state legislature or a state agency or 4) the process occurs at some regular interval defined by policies or law (e.g. annually, every 5 years, etc.)
2. 32 states have passed legislation that requires or authorizes some form of systematic process or program in place to evaluate health insurance benefit mandates. The majority of these states has either established a program specifically for this purpose (e.g., a commission) or has assigned the responsibility to existing staff. A few require the bills’ sponsors to submit an evaluation of the mandate’s probable impact as part of the analysis for legislative hearings (See Table 2 for a summary of these programs and where they are housed in each state).
3. Differences between laws that authorize mandate evaluation processes and programs and the actual processes implemented occur frequently because:
 - a. The laws do not always explicitly dictate the criteria and steps for mandate evaluations. Therefore the implementation of such laws and policies are subject to interpretation and can vary (for example, with changes in administration).

- b. State governments and their various departments do not always uniformly implement laws related to mandate evaluation programs or processes even when criteria and steps for evaluations may be explicitly defined. This may occur for several reasons, including limits on data availability, limits on staff and funding resources, or the political climate in the state.
 - c. When the mandate evaluation law places the onus of conducting the evaluation on the sponsor of the legislation, it is difficult for any one state entity to enforce—the responsibility to enforce the law becomes diffuse.
- 4. Two states – Connecticut and Oklahoma – passed legislation in 2009 to establish mandate review processes that would constitute formal programs under our criteria. However, because these programs have not been fully established, they are excluded from the counts to maintain consistency with the definition of a “formal program” as currently operational in practice, and not merely in statute. The counter-example is New York, whose program legislated in 2007 has not been established to meet our criteria. CT and OK are included in Table 2 for illustrative purposes.
- 5. The steps involved in performing the analyses vary considerably in 2 main regards:
 - a. Independent research, contracted services, information from interested parties
 - b. Nature of questions addressed
- 6. 9 states are permitted or requested to make recommendations.
- 7. The following fall within the scope of states’ analysis:
 - a. 27 (all states with a systematic process/program) analyze cost impact: defined as analyzing impact on the private health insurance sector, as opposed to the fiscal impact on state budget
 - b. 5 analyze public health: defined as reporting on the impact of the mandate on the health of the population
 - c. 15 analyze medical effectiveness: defined broadly as reviewing and reporting on the medical literature
 - d. 17 analyze “social impact”: defined impacts on coverage and utilization levels (See Table 3 for further detail)
- 8. Observations on Cost:
 - a. Defined as analyzing impact on the private health insurance sector, as opposed to the fiscal impact on state budget
 - i. For example, if a state were to estimate only the cost impact of mandates on insurance provided to state employees then this would be excluded
 - b. Many appear to analyze the total cost of the benefit versus the marginal cost of mandating the benefit.
 - c. Focus of most states’ cost analysis tends to emphasize the mandate’s potential effect on premiums and costs to the state.
 - d. Most states analyze the mandate’s potential effect on coverage and utilization levels (which is also sometimes called “social impact”).

9. Observations on Medical Effectiveness:
 - a. Defined broadly as reviewing and reporting on the medical literature.
 - b. Wide variation in whether/how states routinely analyze medical effectiveness.
 - c. No states report having express criteria for analyzing the literature. Note: As some contract for medical analytic services, the systematic nature of their approach is difficult to assess.
 - d. Some states noted the difficulty of conducting such analyses without appropriate content expertise represented on staff.

10. Observations on Public Health:
 - a. Defined broadly as reporting on the impact of the mandate on the health of the population. None appear to systematically quantify public health outcomes based on the medical literature and analysis on changes in utilization.
 - b. “Social impacts” typically include coverage and utilization criteria.
 - c. Very few states perform public health impact analysis; only 5 were identified at the time of this update.

11. All states with a systematic process/program for performing mandate evaluations said that their records are publicly available. The manner of availability varies widely from “available upon request” to posting on public Web sites.
 - a. One state reported that its findings had to be released by the Committee chair to become public, but also noted this was consistently done.

12. Significant changes in states’ processes/programs since 2004:
 - a. Key informants’ dominant perspective was that their states’ mandate evaluation processes/programs had not changed substantively in the past 5 years. This represents a shift in the environment around the health insurance benefit mandate evaluation issue in 2004, when a significant number of states had just recently established mandate evaluation processes and programs.
 - b. Four cases stand as notable exceptions:
 - i. *Arkansas*: A 2003 law that established the Arkansas Advisory Commission on Mandated Health Insurance Benefits was repealed in 2007. The state now lacks a systematic mandate evaluation process.
 - ii. *New York*: In 2007, the state legislature passed a law creating the New York State Health Care Quality and Cost Containment Commission. While this body has among its responsibilities the analysis of the costs and quality of health insurance mandates, several Commission seats remain vacant and has not yet met as of June, 2009.
 - iii. *Connecticut*: In 2009, the Connecticut General Assembly passed into law the establishment of a program modeled partly on California’s experience. The Insurance Commissioner is to contract with the University of Connecticut, and the program is funded by a fee assessed on the insurance industry. By the end of 2009, the program is tasked with producing both a retrospective analysis as well an evaluation of current proposals.

- iv. *South Carolina*: In 2002, the state established a Task Force to retrospectively analyze all mandates to date, in combination with a moratorium on new mandates. Despite a final recommendation to continue the moratorium, both the Task Force and the moratorium sunsetted in 2005. Now, ad-hoc analyses are conducted by the Department of Insurance.
- c. Of the states lacking a systematic mandate evaluation process/program, several (such as Rhode Island and Idaho) report that legislation to create such a system is routinely introduced, but that it “consistently dies” in the legislative process.

2004 Survey Notes

This section presents notes on methods and conclusions from the initial 2004 survey which were not used or updated in this iteration of the survey.

- When possible, information collected and documented in 2004 was emailed to the interviewee for review prior to the interview; staff also used information provided in 2004 as a tool to guide the conversation.
- Following the 2004 interviews, CHBRP conducted a validation process in which staff compared responses to other sources and key informants verified CHBRP’s documentation of their responses.
- Nearly all programs were funded by the respective state’s general funds as of 2004. California and Colorado were unique in that the programs are funded through assessing fees on health insurers.
- No other states appeared to expressly address conflict of interest issues, however, most did not consider this question applicable since analyses are conducted by state employees or their contractors (and are thereby bound by state codes). Programs that are commission-based were generally designed to represent various and balanced interest of stakeholders.

**TABLE 2: STATES' HEALTH BENEFIT MANDATE REVIEW PROGRAMS,
INSTITUTIONAL STRUCTURE**

STATE (1)	Commission (2)	Department of Insurance (3)	Legislative Services (4)	Sponsors (5)	Other State Agency (6)	University
Arizona				√		
California						√
Colorado (7)	√			√		
Connecticut (8)						√
Florida				√		
Georgia		√				
Hawaii (9)			√			
Indiana (10)	√	√				
Kansas					√	
Kentucky		√				
Louisiana		√	√			
Maine		√				
Maryland	√					
Massachusetts					√	
Minnesota					√	
Nevada			√			
New Hampshire		√				
New Jersey	√					
North Dakota			√			
Ohio			√			
Oklahoma (8)	√					
Oregon				√		
Pennsylvania	√					
Tennessee			√			
Texas		√				
Utah		√				
Virginia	√					
Washington					√	
Wisconsin		√				

Notes:

(1) States listed here have a formal mandate evaluation program or process; or they have a law requiring evaluation of health insurance mandate bills by sponsors of a bill.

(2) Commission-based programs usually consist of individuals appointed by the executive branch, the legislative branch and represent different industry and consumer interests. Commissions that evaluate health insurance benefits often conduct other types of analysis related to health care programs in the state.

(3) "Department of Insurance" programs include the "Insurance Commissioner," "Office of Insurance" or the equivalent agency in that respective state. These are housed in the executive branch of the state government.

(4) "Legislative Services" programs include those that are housed at the departments or agencies designed to support the state legislature.

- (5) The requirement for conducting evaluations falls primarily on the bill sponsors. Sponsors may mean a member of the state legislature but usually mean an outside organization or association advocating for passage of the bill.
- (6) "Other State Agency" programs include those that are housed at another agency under the executive branch besides the Department of Insurance
- (7) Colorado has two separate laws: One creates a mandate evaluation commission that is to sunset in May 2005 and another law requires any sponsor of a legislation to provide a "social" and "financial" impact analysis of the proposal to the legislative committee with jurisdiction.
- (8) Connecticut and Oklahoma passed a law establishing mandate evaluation programs in 2009. Because this survey examined current practice as opposed to statutes, these states have been excluded from the final counts, but are included here for reference.
- (9) Hawaii's mandate evaluation is conducted by the State Auditor, who reports to and is considered part of the legislative branch.
- (10) Indiana has a "Mandate Health Benefit Task Force" whose members are appointed by the Governor and is staffed by the Insurance Commissioner.

**TABLE 3: STATES' HEALTH BENEFIT MANDATE REVIEW PROGRAMS,
ANALYTICAL DIMENSIONS**

STATE (1)	Financial/ Cost Impact	Medical Effectiveness	Social Impact	Public Health Impact
Arizona	√	√	√	
California	√	√	√	√
Colorado	√	√	√	
Connecticut (2)	√	√	√	
Florida	√		√	
Georgia	√			
Hawaii	√		√	
Indiana	√	√	√	
Kansas	√		√	
Kentucky	√			
Louisiana	√			
Maine	√	√	√	
Maryland	√	√	√	√
Massachusetts	√	√		
Minnesota	√	√		√
Nevada	√			
New Hampshire	√	√	√	
New Jersey	√	√	√	
North Dakota	√			
Ohio	√		√	
Oklahoma (2)	√	√		
Oregon	√	√	√	
Pennsylvania	√	√	√	
Tennessee	√			
Texas	√			
Utah	√	√		√
Virginia	√	√	√	
Washington	√	√	√	√
Wisconsin	√			

Notes:

(1) States listed here have a formal mandate evaluation program or process; or they have a law requiring evaluation of health insurance mandate bills by sponsors of a bill.

(2) Connecticut and Oklahoma passed a law establishing mandate evaluation programs in 2009. Because this survey examined current practice as opposed to statutes, these states have been excluded from the final counts, but are included here for reference.