California Health Benefits Review Program

Implementation of Senate Bill 125: Analysis of Legislation Mandating or Repealing Health Care Benefits and Related Topics

A Report to the California State Governor and Legislature December 20, 2016

CALIFORNIA
HEALTH BENEFITS REVIEW PROGRAM

OVERVIEW

The California Health Benefits Review Program (CHBRP) was established by legislation in 2002 and is charged with responding to requests from the California Legislature for independent analysis of the medical, financial, and public health impacts of introduced health insurance benefit bills. The program has since been successively reauthorized, most recently in 2015 by Senate Bill (SB) 125 (Hernandez). As requested by SB 125, this report documents implementation of CHBRP's most recent reauthorization.

CHBRP's authorizing statute[1] requests that the University of California, through CHBRP, analyze introduced health insurance benefit bills, including benefit mandate and benefit mandate repeal bills. CHBRP's authorizing statute defines a benefit mandate as a law that requires a health care service plan or health insurer to: (1) permit enrollees to obtain health care treatment or services from a particular type of health care provider; (2) offer or provide coverage for the screening, diagnosis, or treatment of a particular disease or condition; (3) offer or provide coverage of a particular type of health care treatment or service, or of medical equipment, medical supplies, or drugs used in connection with a health care treatment or service; and/or (4) specify benefit design (limits, time frames, copayments, deductibles, coinsurance, etc.) for any of the other categories.

CHBRP consists of an analytic staff in the University of California's Office of the President managing and supporting a Task Force of faculty and researchers drawn from multiple University of California campuses, and a contracted actuarial firm. At the request of the Legislature, CHBRP forms teams to complete analyses within a 60-day period, usually before the Legislature begins formal consideration of a bill during the first policy committee hearing. Content experts, recruited for their subject matter knowledge, assist each team and the certified, independent actuary helps estimate the bill's impacts on benefit coverage, utilization, and cost. A strict conflict of interest policy ensures that all analyses are undertaken without financial or other interests that could bias the results. A National Advisory Council (drawn from experts from outside California so as to avoid conflicts of interest but still provide balanced representation for health insurance stakeholders in the analytic process) reviews drafts to ensure quality before each analysis is submitted to the Legislature. Each analysis summarizes relevant scientific evidence but makes no recommendations, deferring all policy decision making to the Legislature.

The State funds CHBRP's work through an annual assessment on health plans and insurers in California, with funding capped at $2 million per year (about $0.0066 per member per month, in 2016 dollars).

All CHBRP analyses and other products (as well as information about any current requests from the California Legislature) are available on the CHBRP website, www.chbrp.org.

[1] Available at www.chbrp.org/faqs.php.

A Report to the 2015–2016 California State Governor and Legislature

Implementation of Senate Bill 125: Analysis of Legislation Mandating or Repealing Health Care Benefits and Related Topics

December 20, 2016

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EXECUTIVE SUMMARY

Since 2002, the California Health Benefits Review Program (CHBRP) has supported consideration of introduced health insurance benefit bills through independent, academically rigorous, and unbiased analysis. Stakeholders have consistently reported that CHBRP's rigorous analyses inform and elevate discourse by bringing an objective and widely respected, evidence-based perspective to the policymaking process.

Currently set to sunset on December 31, 2017 (with funding through June 30, 2017), CHBRP was established by Assembly Bill (AB) 1996 (Thomson, 2002), which requested the University of California (UC) to assess bills proposing to mandate health benefits. In California, more than 40 health insurance benefit mandates had been enacted by the close of 2001. By the end of 2002, in response to concerns about benefit mandates serving their intended purposes without creating unintended consequences (including, but not limited to, large premium increases), California and 16 other states passed laws requiring benefit mandate evaluation. Since then, at least 12 additional states have formalized benefit mandate evaluation, bringing the current total to approximately 29.[2]

As noted in Table 1, since initial authorization, CHBRP has been continuously reauthorized by the California Legislature.

Table 1. Legislation Authorizing and Reauthorizing CHBRP

Signed Into Law	Bill	Purpose Related to CHBRP
2002—September 22	AB 1996 (Thomson)	Initial authorization requesting analysis of health insurance benefit mandate bills
2006—September 29	SB 1704 (Kuehl)	Reauthorization and broadening of scope to include analysis of proposed mandate repeal bills
2009—October 11	AB 1540 (Assembly Health Committee)	Reauthorization
2014—September 18	SB 1465 (Senate Health Committee)	Extension of sunset date (from July to December)
2015—June 17	SB 125 (Hernandez)	Reauthorization and broadening of scope to include analysis of other* health insurance benefit bills

Source: California Health Benefits Review Program, 2016.
Note: *The initial version of CHBRP's authorizing statute provided definitions for "health insurance benefit mandate" bills. The most recent version also consider bills relevant to benefit design, cost sharing, and other topics.
Key: AB = Assembly Bill; CHBRP = California Health Benefits Review Program; SB = Senate Bill.

The number of health benefit bills introduced in California's Legislature and referred to CHBRP per year, an average of about 10, remained steady between 2002 and the passage of the Affordable Care Act (ACA) in 2010.[3] Perhaps in response to the ACA, the number of bills

[2] For further details on other states' benefit mandate review programs, see Appendix 22.
[3] Although jointly referred to as the Affordable Care Act, the law is actually a product of the Patient Protection and Affordable Care Act (P.L.111-148) and the Health Care and Education Reconciliation Act (H.R. 4872), both passed in 2010.

referred to CHBRP swelled to 15 in 2011, then went through a period of variation (3 in 2012, 8 in 2013, 6 in 2014, and 9 in 2015) before swelling again to 14 in 2016.

Since it was established, CHBRP has responded to the Legislature's requests with analyses that have been consistently utilized by legislators and committee staff, as well as bill advocates and opponents, providing all parties with an objective resource intended to serve as a reliable basis for consideration.

CHBRP's most recent reauthorization, SB 125, requested a report be submitted to the Governor and the Legislature by January 1, 2017, describing implementation of the bill as enacted. This report is provided in response to that request, and describes how CHBRP has fulfilled the mission outlined in the current version of the authorizing statute[4] during the years 2014 through 2016.[5]

Academic Rigor on Demand

Per its authorizing statue, CHBRP utilizes its allocated funds to secure relevant data and faculty time in advance. CHBRP is then able to act immediately upon requests from the Legislature to organize robust and timely analyses for introduced health insurance benefit bills. This arrangement is unique among states that have organized programs for reviewing benefit bills in that it both analyzes the bill while it is under consideration and also harnesses the expertise and effort of multidisciplinary faculty, staff, actuaries, and content experts. This combination of academic rigor with sufficient speed to inform the Legislature's deliberation makes CHBRP's efforts unique, as well as objective, evidence-based, and timely.

Operating support for CHBRP is provided through a non-General Fund source, specifically, fees levied by the California Department of Managed Health Care (DMHC) on health care service plans and the California Department of Insurance (CDI) on health insurers. The total annual amount of funding for CHBRP has remained capped at $2 million annually, or about $0.0066 per member per month (in 2016 dollars) throughout CHBRP's 14 years of active service. Additional in-kind support has also been provided by UC.

Adapting to a New National and State Policy Context: The Affordable Care Act

The continuing introduction of health insurance benefit bills by legislators, as well as ongoing changes in both health care delivery and in California's health insurance markets, has shaped the context within which CHBRP performs its work. To be effective in meeting the Legislature's charge, CHBRP has continuously adapted its analytic efforts to the changing health care landscape. Arguably the most challenging has been the 2010 passage of the ACA and the subsequent need to refine CHBRP's methods, including the need to account for the possibility of interaction between state-level benefit mandates and the federal law. To accommodate these

[4] The current version of CHBRP's authorizing statute is included in Appendix 1.
[5] Because CHBRP's reauthorizations request implementation reports at the end of a calendar year—even though authorization runs through June (and so funds work during one more legislative cycle)—each of CHBRP's implementation reports includes all of the work accomplished after submission of its predecessor.

changes and to provide the most complete, accurate, and relevant information possible to the Legislature and other health insurance stakeholders, among other efforts, CHBRP has:

- Adapted the method of projecting baseline enrollment and premiums that support CBHRP's bill-specific analyses to address ongoing implementation of the ACA.
- Adapted the approach to bill-specific analyses to consider possible interaction with either of the two benefit coverage floors required by the ACA.
- Provided an analysis of the interaction of the ACA's federally specified preventive services mandate with California's state mandates.[6]
- Worked with CHBRP's contracted actuary to provide the Legislature with an analysis of options for the 2015 selection of the benchmark plan that would influence California EHBs as of 2017.[7]

California Cost and Coverage Model

A significant challenge posed by health reform has been the need to update CHBRP's California Cost and Coverage Model (CCM) to accommodate ACA-influenced changes in baseline enrollments and premiums. The CCM is an actuarial model that CHBRP updates annually with information from multiple sources, including data gathered through surveys of the largest (by enrollment) health plans and insurers in California (whose combined enrollment represents more than 90% of persons with privately funded health insurance that may be subject to state-level mandates). After considering multiple options, CHBRP chose to adapt the CCM by incorporating enrollment projections developed by the California Simulation of Health Insurance Markets (CalSIM). CalSIM is the most California-specific of available projections and is used by Covered California, the state's health insurance marketplace. Incorporation of the CalSIM projections allowed CHBRP to provide quantitative estimates of the impact of health reform on premiums and enrollment and to assess the marginal impacts of health insurance benefit bills (which, if passed into law, would typically take effect in the year following introduction). CHBRP's future annual updates of the CCM will reflect the continuing impacts of the ACA as various portions of the law are implemented and as more evidence on its impact becomes available.

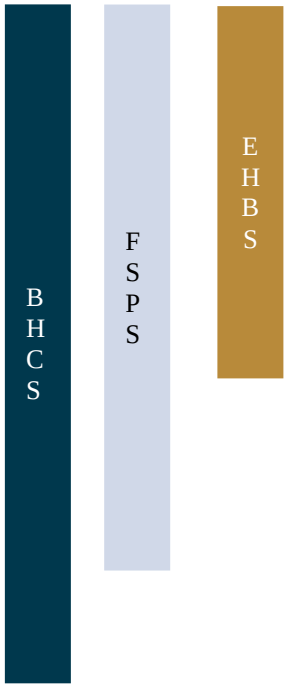
Benefit Floors and Essential Health Benefits

As noted in Figure 1, CHBRP's analyses always consider a bill's possible interactions with numerous benefit floors. Benefit floors are established by laws and/or regulations, and result in some or all health insurance products having to meet a standard, such as inclusion of coverage for a set of treatment, or comply with a prohibition, such as avoiding cost sharing for category of services). In addition to the specific requirements established by benefit-specific mandates already in law, CHBRP considers interactions with the broad benefit floor represented by "basic health care services," a mix of law and regulation applicable to health care service plans

[6] See *The Federal Preventive Services Health Insurance Benefit Mandate and California's Health Insurance Benefit Mandates*, available at www.chbrp.org/other_publications/index.php.
[7] See *California's Essential Health Benefit Base Benchmark Options Effective January 1, 2017*, available at www.chbrp.org/other_publications/index.php.

regulated by the California Department of Managed Health Care (DMHC). [8] CHBRP also considers possible interactions with benefit floors established by the ACA. One such floor is the ACA's requirement that some DMHC-regulated health care service plans, and insurance policies regulated by the California Department of Insurance (CDI) cover essential health benefits (EHBs).[9,10] Separate from the EHB coverage requirement, the ACA also requires a number of DMHC-regulated plans and CDI-regulated policies to meet another benefit floor, by covering federally specified preventive services (FSPS) without cost sharing.[11] CHBRP includes consideration of a bill's possible interactions with all applicable benefit floors in each analysis.

Figure 1. Bills and Benefit Floors Relevant to the Analysis



Year Analyzed*	Analyzed Bills	California Bill Topics (Partial List)
2016	14	Autism, Colorectal Cancer, Contraceptives, Hearing Aids, HIV Specialists, Mammography, Telehealth
2015	9	Abuse-Deterrent Opioids, Acquired Brain Injury, Dental Hygienists, Prescription Drugs, Step Therapy
2014	6	Autism, Contraceptives, Prescription Drugs, School Nurses, Telehealth
2013	8	Acquired Brain Injury, Colorectal Cancer & Genetic Testing, Fertility Preservation, Wellness Programs
2012	3	Cancer Treatment, Immunizations for Children, Prescription Drugs, Tobacco Cessation
2011	15	Acupuncture, Autism, Breast Cancer, Mammography, Maternity Services, Tobacco Cessation
2010	9	Chemotherapy, Diabetes, Durable Medical Equipment, Mammography, Mental Health Services

Source: California Health Benefits Review Program, 2016.
Notes: *Analyzed bills would generally be in effect the following calendar year, so a 2013 bill analysis takes into account benefit floors that would be applicable in 2014.
Key: BHCS = Basic Health Care Services; EHBS = Essential Health Benefits; FSPS = Federally Specified Preventive Services.

[8] CHBRP maintains a list of mandates applicable in California, available at: www.chbrp.org/other_publications/index.php.
[9] Through additional legislation, California requires some small group and individual market plans that are not associated with Covered California to also cover EHBs, see H&SC § 1357.500.
[10] For more discussion of EHBs and relevant markets, see additional resources available at: www.chbrp.org/other_publications/index.php.
[11] Affordable Care Act Section 1001, modifying Section 2713 of the Public Health Service Act; California Health and Safety Code 1367.002; and California Insurance Code Section 10112.2.

Adapting to the ACA implementation, CHBRP also developed an approach to evaluate whether a proposed state-level benefit mandate might exceed EHBs, a situation that could require California to defray related costs for enrollees in health insurance products available through Covered California. For this purpose, CHBRP reviewed for each bill the federal law and regulation (pending, as well as final); state law and regulation; and the benefit coverage offered by California's EHB benchmark plan. For benefit mandate bills analyzed during the period 2014 through 2016, CHBRP reached the following conclusions:

- Appear not to exceed EHBs: 23 analyzed bills.
- Would have an unknown interaction with EHBs: 4 analyzed bills
- Might exceed EHBs: 2 analyzed bills

Although not conclusive due to ambiguous federal guidance, these evaluations sought to provide policymakers with as much relevant context as possible.

CHBRP's Charge: Analyses and Approach

CHBRP carries out impartial analyses of the medical effectiveness of treatments and services relevant to a health insurance benefits bill and estimates the likely impact of the bill on benefit coverage, utilization, cost, and public health. In response to requests from the Legislature, CHBRP has analyzed 123 bills in total, including 29 during the period from 2014 through 2016. Upon completion, each analysis is posted to CHBRP's website, [12] where it is posted indefinitely for the Legislature and other interested parties.

CHBRP Analyses During the Legislative Process

CHBRP analyses support and help inform decision making throughout the Legislature's deliberative process regarding health insurance benefit bills.

- Legislative Committee Staff consistently draw findings and data from CHBRP reports for inclusion in the policy and fiscal committee analyses.
- Legislators in Committees and Bill Authors routinely quote from CHBRP reports during hearing remarks and testimony.
- Health Insurance Stakeholders, both bill advocates and opponents, including advocacy organizations, health plans/insurers, trade associations, select state agencies and regulators, and consumer groups, regularly use CHBRP reports to make cases in support of, or in opposition to, the passage of mandate bills.

Consistently, those involved with the Legislature's consideration of health insurance benefit bills report that they rely on CHBRP's analyses because they are useful, comprehensive, rigorous, and impartial. Stakeholders frequently state that CHBRP analyses serve as the baseline for discussion around benefit bills, particularly around fiscal impacts. Additionally, legislative and agency staff have indicated that the analyses aid them in their internal consideration of whether a bill avoids unintended consequences and whether it adequately addresses the problem it seeks to resolve.

[12] See CHBRP's website at www.chbrp.org/completed_analyses/index.php.

CHBRP Analyses Beyond the Legislative Cycle

Highlighting the strength of CHBRP's contributions, the analyses remain relevant even beyond the legislative process. For example, health insurers and regulators report using CHBRP analyses in discussion of appropriate rate increases when analyzed bills are signed into law, and health plans also report using CHBRP's medical effectiveness analysis to evaluate their benefit coverage offerings. Outside of California, a report by the Center for Consumer Information and Insurance Oversight (CCIIO) cited a CHBRP analysis' estimate regarding the marginal cost of covering applied behavioral analysis as an EHB,[13] and the Institute of Medicine (IOM) recommended that CHBRP's approach serve as a guide for further defining EHBs in the future.[14] Academics in California and beyond, as well as state governments across the country, the media, and others often cite CHBRP analyses when considering health insurance benefit legislation.[15]

Consideration of Multifaceted Requirements of Health Insurance Benefit Bills

CHBRP analyses also provide value with their careful consideration of multifaceted requirements of health benefits bills. Benefit bills referred to CHBRP for analysis may require DMHC-regulated plans or CDI-regulated policies to comply with any (or all) of the following:

- Disease or Condition: cover screening, diagnosis, and/or treatment of a specific disease or condition;
- Treatments or Services: cover one or more health care treatments or services—which may be relevant to multiple diseases and/or conditions;
- Providers: cover services by one or more specific types of health care providers—which may be relevant to multiple treatments and/or services that address multiple diseases and/or conditions;
- Benefit Design: comply with specified benefit design when a benefit is covered (i.e., include no prior authorization requirements or establish limits on cost sharing)—which may be relevant to the multiple treatments and services delivered by multiple types of providers in order to address multiple diseases and conditions.

In practice, bills referred to CHBRP generally include more than one of the requirements listed above—and are sometimes made even more complex because the bill exempts from compliance the health insurance of particular enrollees (such as the health insurance of enrollees associated with CalPERS or Medi-Cal) or specifies applicability only to particular market segments (such as the large-group market). Detailed information on premiums, covered benefits, and benefit design for market subsegments are required in order to analyze these bills.

CHBRP's analytic approach also includes the ability to identify possible interactions with one or more benefit floors, the current state of relevant benefit coverage in state-regulated health

[13] See *Essential Health Benefits Bulletin*, available at: www.cms.gov/CCIIO/Resources/Files/Downloads/essential_health_benefits_bulletin.pdf.
[14] See *Essential Health Benefits: Balancing Coverage and Cost*, available at: www.chbrp.org/other_publications/index.php.
[15] See Appendices 20 and 21 for lists of references to CHBRP or its work that appeared during the period 2014 through 2016.

insurance products, and the current health of enrollees in health insurance that would be subject to the proposed legislation.

Considering the bills CHBRP analyzed during the period 2014 through 2016, Table 2 demonstrates the range of requirements that analyzed bills would impose—and the frequency with which particular bills would impose a complex set of requirements.

Table 2. CHBRP Analyzed Bills: Multiple Requirements, 2014–2016

Bills Analyzed	Bill Requirements					
	Benefit Coverage				Limits	
	Specified Disease or Condition	Specified Treatments or Services	Specified Providers	Specified Benefit Design	Specified Market Segments	Specified Enrollees
2016						
AB 533 (Bonta) Out-of-Network Coverage				X	X	
AB 796 (Nazarian) Autism	X	X	X			X
AB 1763 (Gipson) Colorectal Cancer Screening	X	X		X	X	X
AB 1831 (Low) Topical Ophthalmic Refills				X		
AB 1954 (Burke) Reproductive Services				X	X	
AB 2004 (Bloom) Hearing Aids		X				X
AB 2050 (Steinorth) Prescription Refill Synchronization				X		
AB 2084 (Wood) Comprehensive Medication Management		X	X			X
AB 2209 (Bonilla) Clinical Pathways				X		
AB 2372 (Burke) HIV Specialists				X		
AB 2507 (Gordon) Telehealth				X		
AB 2764 (Bonilla) Mammography		X				
SB 999 (Pavley) Contraceptives: Annual Supply				X		
SB 1034 (Mitchell) Autism		X	X	X		X
2015						
AB 339 (Gordon) Outpatient Prescription Drugs				X		X
AB 374 (Nazarian) Step Therapy				X		

Bills Analyzed	Bill Requirements					
	Benefit Coverage				Limits	
	Specified Disease or Condition	Specified Treatments or Services	Specified Providers	Specified Benefit Design	Specified Market Segments	Specified Enrollees
AB 502 (Chau) Dental Hygienists			X			
AB 623 (Wood) Abuse-deterrent Opioid Analgesics		X		X		
AB 796 (Nazarian) Autism	X	X	X			X
AB 1102 (Santiago) Special Enrollment Periods	X				X	
AB 1305 (Bonta) Cost Sharing: Family Health Coverage				X		
SB 190 (Beall) Acquired Brain Injury	X	X		X	X	
SB 289 (Mitchell) Telehealth				X		
2014						
AB 1771 (Pérez) Telehealth				X		
AB 1917 (Gordon) Outpatient Prescription Drugs: Cost Sharing				X	X	
AB 2041 (Jones) Autism	X	X	X			X
AB 2418 (Bonilla & Skinner) Prescription Drug Refills	X			X		
SB 1053 (Mitchell) Contraceptives		X		X		X
SB 1239 (Wolk) School Nurses			X	X		

Source: California Health Benefits Review Program, 2016.

Broad Multidisciplinary Expertise

For each bill analysis, CHBRP assembles analytic teams with expertise in medical effectiveness, health economics, public health, and policy analysis. The analytic teams work with actuaries, librarians, content experts, and editors to collaboratively develop and complete a cohesive analysis within the 60-day (and occasionally shorter) time period, usually while completing multiple other analysis requests subject to equally short time frames.

CHBRP's work achieves its standard academic rigor through the involvement of faculty, researchers, and staff within the UC system. This includes individuals with expertise in medicine, health economics, actuarial science, public health, and medical effectiveness evaluation. CHBRP's multidisciplinary Faculty Task Force (FTF) and contributors are drawn from:

- University of California, Berkeley;
- University of California, Davis;
- University of California, Los Angeles;
- University of California, San Diego; and
- University of California, San Francisco.

In addition to its FTF, CHBRP is administered by a small team of staff at the UC Office of the President (UCOP). CHBRP staff provide overall guidance, policy analysis expertise, project management for the analytic process, and liaison services for CHBRP's communications with the Legislature and other stakeholders. CHBRP staff also ensures that reports and the supporting methodology are transparent and broadly accessible to all health insurance stakeholders.

To meet CHBRP's statutory requirement to include actuarial analysis in its reports, CHBRP has periodically re-bid its actuarial services contract. In 2014 and 2015, CHBRP contracted with Milliman, Inc. However, starting in 2016, CHBRP awarded the contract to a new actuary, PricewaterhouseCoopers (PwC).

Unbiased and Neutral Analyses

CHBRP analyses are highly utilized because they are independent, unbiased, and accurate analyses. It is important to note that although CHBRP is administered by UC, the program functions independently from UC's institutional policy and program interests. At all times, and especially throughout an analysis, CHBRP is careful to avoid any conflict of interest or appearance of such. CHBRP faculty and potential content experts are rigorously vetted for potential conflicts. Participation in the analyses by a person with a material financial interest or a history of advocacy (for or against whatever action the bill would require) is prohibited, and final analyses express solely the findings of the multidisciplinary analytic team.

Prior to submission to the Legislature, each analysis is subject to internal peer review by members of CHBRP's FTF and CHBRP's Director and is subject to external review by members of CHBRP's National Advisory Council (NAC). The NAC consists of experts from outside California, selected to provide balanced representation among groups generally considered to be stakeholders in issues related to health insurance benefits, including providers, purchasers, consumers, and health plans, as well as health policy experts. The NAC is an advisory body rather than a governance board, and a subset of the NAC reviews each draft bill analysis for accuracy, balance, clarity, and responsiveness to the Legislature's request.

CHBRP also typically retains content experts for each analytic team. Content experts are individuals with specialized clinical, health services research, or other expertise pertaining to the specific benefits or topics addressed by the health insurance benefits bill. These individuals are generally drawn from the UC system or from other reputable educational or research institutions.

Unique Information in a CHBRP Report

CHBRP's annually updated Cost and Coverage Model (CCM) provides the baseline from which a bill's incremental impacts on utilization and cost can be estimated, and also provides a number of unique data points for policymakers' consideration. For CHBRP analyses, the CCM provides:

- Enrollment estimates of the sources of health insurance for all Californians
- Estimates of annualized premiums paid by Californians enrolled in health insurance products subject to regulation by CDI or DMHC, including estimates for DMHC-regulated plans associated with:
  - CalPERS
  - DHCS on behalf of Medi-Cal beneficiaries
  - Covered California, the state's health insurance marketplace
- Estimates of the age and sex distribution of Californians enrolled in health insurance market segments subject to regulation by DMHC or CDI

All of CHBRP's analyses are informed by regularly updated lists of applicable health insurance benefit mandates already in state or federal law that are relevant to DMHC-regulated plans and CDI-regulated policies.[16] CHBRP's list of current benefit mandate laws is important in establishing benefit floors relevant to particular bills. It is also useful to health insurance stakeholders throughout the year, as it is the only comprehensive list of benefit mandates applicable to plans and policies regulated by DMHC or CDI.

In addition to the review of the relevant policy context (including possible interactions with EHBs, other benefit floors, and existing mandates in California law), CHBRP analyses also provide the Legislature with other unique information, including:

- Identification of which health insurance market segments would be subject to the requirements the bill would establish, as well as current, California-specific estimates of enrollment in those segments.
- Identification of bill-relevant conditions and disorders and background on prevalence and incidence, as well as estimates of the number of enrollees whose health insurance would be subject to the requirements the bill would establish.
- Identification of bill-relevant tests, treatments, and services and analysis of their effect on health outcomes.
- California-specific baseline estimates as well as the bill's likely marginal impacts on:
  - Benefit coverage and utilization of bill-relevant treatments and services;
  - Costs (estimated as premiums and related enrollee expenses); and
  - Public health (estimated as morbidity, mortality, health behaviors, person-level financial obligation, and other measures significant to the bill being analyzed), as well

[16] For the full list of applicable mandates current in California and federal law, see Appendix 19.

as discussion of relevant disparities and disproportionalities connected to social determinants of health.

Summary of CHBRP Report Findings

Considering the bills CHBRP analyzed during the period 2014 through 2016, approximately 61% of analyses found the relevant treatments or services were generally considered effective. Approximately 88% of analyses estimated an incremental increase in total health care expenditures should the bill become law. The remaining analyses estimated no increase, usually because the benefit was already widely covered or because utilization was unlikely to be affected. Additionally, 39% of analyses estimated a positive public health impact should the bill become law.

Fulfilling CHBRP's Mission

For 14 years, CHBRP's Taskforce and staff have provided rigorous and impartial analysis of health insurance benefit bills, with efforts to continuously improve the quality and readability of our work, and enhance our approach, methods, and process. Since 2002, the program has adapted to changing circumstances and needs of policymakers, including revisions to its authorizing statute and charge, changes to state health programs, and larger reforms of the health care system (such as those enacted by the ACA). The timely, rigorous effort CHBRP provides directly to the Legislature through a multidisciplinary set of academic experts is unique to California Through the period 2014 through 2016, as well as during the prior cycles of CHBRP's authorization, legislators, committee and member staff, and health insurance stakeholders have reported that they rely on CHBRP's analyses and other products to support policy decision making. During the most recent reauthorization by SB 125, as before, CHBRP has provided timely, objective, thorough, and high-quality work—thus effectively fulfilling the mandate outlined in CHBRP's authorizing statue.

INTRODUCTION

Since initial authorization in 2002, the California Health Benefits Review Program (CHBRP) has supported consideration of health insurance benefit bills through independent, academically rigorous, and unbiased analysis. Health insurance stakeholders have consistently reported that CHBRP's analyses inform and elevate discourse by bringing an objective and widely respected analytical perspective to the policymaking process.

Currently set to sunset on December 31, 2017 (with funding through June 30, 2017), CHBRP was established by Assembly Bill (AB) 1996 (Thomson, 2002) which requested the University of California (UC), through CHBRP, assess bills proposing to mandate that health insurance benefits to be provided by health care service plans and health insurers. The provisions of AB 1996, originally set to sunset on January 1, 2007, were extended by Senate Bill (SB) 1704 (Kuehl, 2006) and further extended by AB 1540 (Assembly Health Committee, 2009), SB 1465 (Semate Health Committee, 2014) and SB 125 (Hernandez, 2015). The Legislature has twice broadened CHBRP's scope.SB 1704 added a provision that requested CHBRP analyze bills that would repeal existing benefit mandates and SB 125 added a provision that requested analysis of other[17] bills related to health insurance benefits. As did previous reauthorizations, SB 125 also requested that CHBRP submit a report to the Governor and the Legislature describing the implementation of the program's authorizing statute by January 1, 2017.[18] This implementation report is written in response to that request, and describes how the program has fulfilled the mission outlined in its authorizing statute during the years 20014 through 2016.[19]

History and Trends in Health Insurance Benefit Legislation

A period of increased passage of health insurance benefit mandate laws led to the establishment of CHBRP, and the continued introduction of bills related to health insurance benefits by legislators has led to multiple subsequent reauthorizations of the program. In addition, interest in repeal bills and in the possibility of interaction between state-level benefit mandates and the Affordable Care Act (ACA) [20] have added to CHBRP's analytic responsibilities over the past several years.

In the late 1990s, state-level health insurance benefit mandate benefit laws were proliferating in states across the nation. Researchers attribute the proliferation of such laws to several factors. First, these laws were a product of the managed care "backlash" of the 1990s. Specifically, the rise of managed care ("health maintenance organizations" in many places and Knox-Keene licensed "health care service plans" in California), and these health plans' willingness to use utilization and network controls led interest groups and elected officials to begin using

[17] The initial version of CHBRP's authorizing statute provided definitions for "health insurance benefit mandate" bills. The most recent version also consider bills relevant to benefit design, cost sharing, and other topics.
[18] CHBRP previously provided multiple similar reports to the Legislature and Governor, each regarding an earlier cycles of authorization. All are available at www.chbrp.org/other_publications/index.php.
[19] The current version of CHBRP's authorizing statute is included in Appendix 1.
[20] Although jointly referred to as the Affordable Care Act, the law is actually a product of the Patient Protection and Affordable Care Act (P.L.111-148) and the Health Care and Education Reconciliation Act (H.R. 4872), both passed in 2010.

legislation to limit health plans' ability to deny services or limit access to certain provider types (Blendon et al., 1998; Laugesen et al., 2006). Second, political factors combined to make health insurance benefit mandate bills more likely to be enacted because the costs are relatively small and diffused over a large population, whereas the benefits are concentrated on a small group of stakeholders who have a strong interest in actively advocating for the legislation (Oliver and Singer, 2006; Schauffler, 2000; Wilson, 1980).

In California, more than 40 mandated benefits had been enacted into state law by the close of 2001, and during the 2001 to 2002 session, 10 benefit mandate bills were introduced. At that time, concerns arose regarding cost containment and whether well-intended laws actually served their intended purposes. In response, 16 states, including California, passed laws requiring the evaluation of health insurance benefit mandate bills during 2001 to 2002. Since then, at least 12 additional states have formalized benefit mandate evaluation, bringing the current total to approximately 29.[21]

During this period, CHBRP has been recognized as an acknowledged model for benefit mandate review programs in other states. In 2006, the Virginia General Assembly directed their Joint Legislative Audit and Review Commission (JLARC), the investigative arm of the General Assembly, to provide staff assistance to Virginia's Special Advisory Commission on Mandated Health Insurance Benefits (SACMHIB). In particular, JLARC's charge was to assess, analyze, and evaluate the social and economic costs and benefits of any proposed mandated health insurance benefit or mandated provider. In developing JLARC's methods to fulfill its new charge, their staff interviewed CHBRP staff and reviewed CHBRP's analytic approach and processes. Although the law authorizing Virginia's SACHMHIB has been repealed, the benefit mandate review program has been merged into Virginia's Health Insurance Reform Commission (HIRC), which is charged with establishing the state's health insurance exchange, deciding Virginia's essential health benefits (EHB) package, and providing assessments of existing and proposed mandate legislation.

Another notable example of CHBRP serving as a model occurred in Connecticut. In 2009, the Connecticut General Assembly passed legislation establishing a mandate evaluation program similar both in structure and analytic focus to CHBRP. According to key staff involved in the policymaking process, legislators modeled the new program largely on CHBRP and California's experience. The legislation directs the Commissioner of Insurance to contract with the University of Connecticut's Center for Public Health and Health Policy (CPHHP) to analyze bills annually upon request. The program evaluates the social and financial impacts of benefit mandates along a number of discrete lines, including an analysis of medical effectiveness in addition to utilization and premium impacts. Similar to CHBRP, CPHHP is funded through a tax on health plans and insurers.

Since 2002, legislatures across the country have continued to consider benefit mandate bills, and many have become law (BCBSA, 2015). In 2014, 2015, and 2016, eight more health benefit bills were signed into law in California. The presence of programs dedicated to analysis of benefit mandates may have diminished both the number of bills introduced and the number passed into law. Certainly, over time, more state legislatures have become interested in having close analysis

[21] See Appendix 22 for more information on evaluation efforts in other states.

of health insurance benefit bills. As noted, as many as 29 states now have systematic programs or processes in place to analyze benefit bills, but many of these are not independent of their state government, and they generally require more than 60 days to produce their analyses.

Between 2002 and 2006, the number of benefit mandate bills annually introduced in the California Legislature and referred to CHBRP for analyses remained steady, at about 10 per year. Given this stability, the California Legislature deemed it valuable to continue the evaluations of such legislative proposals (SBFI Committee, 2006). In addition, CHBRP analyses provided in 2005 were deemed useful by a variety of health insurance stakeholders, including stakeholder groups who were generally either proponents or opponents of benefit mandate bills. Such stakeholders included CDI, the California Medical Association (CMA), Health Access, and California Association of Health Underwriters (CAHU) (Senate Rules Committee, 2006). According to the SB 1704 bill author, the analyses produced by CHBRP provided "a valuable resource to the Legislature and other policymakers by providing objective information about the real-world impact of health benefit mandates." In addition, the author and supporters wrote that there was "broad agreement among consumer groups, plans, insurers, and other observers that the CHBRP process has successfully brought objective, quantitative analysis to benefit mandate proposals," and that CHBRP's analyses had "helped inform the debate over the costs and health advantages of particular mandates" (SBFI Committee, 2006).

At the time of CHBRP's first reauthorization, the California Legislature deemed it valuable to evaluate the potential impacts of bills that would repeal health insurance benefit mandate legislation, and so included this additional scope in CHBRP's charge under SB 1704. Between 2007 and 2009, the average number of introduced benefit bills considered by the California Legislature and referred to CHBRP again remained steady, which led to CHBRP's second reauthorization in 2009 by AB 1540, which extended the program's sunset date to June 30, 2015.

From 2009 until after passage of the ACA, the average number of introduced benefit mandate bills in California referred to CHBRP for analysis remained steady, at about 10 per year. However, the legislative periods since 2011 have deviated from the norm. Perhaps in response to the ACA, the number of introduced benefit mandate bills referred to CHBRP swelled to 15 in 2011, fell to 3 in 2012, rose back to 8 in 2013, fell to 6 in 2014, rose back to 9 in 2015, and has now swelled again to 14 in 2016. Two considerations suggest that the 2016 figure may be the most indicative of future years: (1) CHBRP's most recent discussions with stakeholders suggest continued interest in state-level benefit legislation on the part of the Legislature; and (2) that only 1 of the 14 bills CHBRP analyzed in 2016 had the possibility of exceeding EHBs, which suggests that the Legislature has studied the issue and is focused on proposing bills that would not create the extra financial burden for the state that a mandate exceeding EHBs would produce.

During the most recent period of reauthorization, as in prior years, CHBRP has responded to requests with analyses that have been consistently utilized by Legislators and committee staff, as well as bill advocates and opponents, providing all parties with a reliable basis for discussion of health benefit bills. In response to requests from the Legislature, CHBRP has analyzed a total of 123 bills, including 29 during the 2014 to 2016 period.

Adapting to a New National and State Policy Context: The Affordable Care Act

In March 2010, the federal government passed the ACA, [22] enacting health care reform laws that dramatically impacted California's health insurance markets and their regulatory environment. The ACA included a number of provisions, such as the expansion of Medicaid, the establishment of states' health insurance marketplaces, the requirement for some plans and policies to cover federally specified preventive services (FSPS) without cost sharing, and the requirement for some to cover EHBs. These changes directly and indirectly prompted changes to health care delivery and finance.

CHBRP has also seen its work impacted by these changes, and its faculty and staff have adapted the program's analytic approach to address the new health care landscape. Since 2010, CHBRP has focused on understanding how changes initiated by the ACA would influence the state-regulated health insurance markets. Some examples of this include ACA requirements related to medical-loss ratios for health insurers, new cost-sharing limits on health plans, and the division of health plans/policies into grandfathered and nongrandfathered categories. All of these changes have been incorporated into CHBRP's analytic approach starting in 2011. Since the passage of the ACA, the CHBRP has also focused on understanding how subsequent federal regulations and state laws that provide clarity on aspects of the ACA would impact CHBRP's work, such as California's selection of a benchmark plan to clarify the state's definition of EHBs and the continuing issuance of federal guidance related all states' EHB definitions. CHBRP engaged in these efforts in order to adapt its model and analytic approach to provide the most complete, accurate, and relevant information possible to the Legislature and other stakeholders as they consider health benefit bills.

Amid these changes, a particular topic of interest to the Legislature and other stakeholders has been the question of how EHBs might interact with state-level benefit mandates. To address this concern, for both CHBRP's bill analyses and through supplemental issue briefs, CHBRP has conducted a thorough analysis of the interaction of proposed health benefit bills with EHBs. Beginning in 2013, CHBRP developed an approach to evaluating whether a state level benefit mandate might exceed EHBs, a situation which would require California to defray related costs for enrollees in products sold through Covered California. To do so, CHBRP reviews, for each bill, federal law and regulation (pending as well as final), state law and regulation, and the benefit coverage offered by California's benchmark plan. The results of this approach are illustrated in Table 3 below. Although not conclusive, these evaluations provide more clarity for the discussion of mandate bills by indicating whether a mandate probably would not exceed EHBs, might exceed EHBs, or would have an unclear interaction with EHBs.

[22] Although jointly referred to as the Affordable Care Act, the law is actually a product of the Patient Protection and Affordable Care Act (P.L.111-148) and the Health Care and Education Reconciliation Act (H.R. 4872), both passed in 2010.

Table 3. CHBRP Analyzed Bills: Interaction With Essential Health Benefits, 2014–2016

Bill	Proposed Benefit Mandate	EHB Interaction	Discussion
2016			
AB 533 (Bonta) Out-of-Network (OON) Coverage	Would define OON "surprise medical bills"	Would not exceed	Requirements in AB 533, related to enrollee expenses and plan/insurer payments, appear not to exceed EHBs.
AB 796 (Nazarian) Autism	Would broaden qualified autism services	Would not exceed	First, AB 796 alters the terms and conditions of an existing benefit mandate but does not require benefit coverage. Second, the current law that AB 796 would alter expressly indicates that it ceases to function if it exceeds EHBs.
AB 1763 (Gipson) Colorectal Cancer Screening	Would require colorectal cancer screenings/tests coverage	Would not exceed	AB 1763 requires coverage for preventive screening tests for colorectal cancer given a grade of A or B by the USPSTF and coverage for tests recommended by treating physicians for high-risk individuals. Additionally, the bill eliminates cost sharing for persons aged 50 and older. Therefore, AB 1763 does not exceed EHBs.
AB 1831 (Low) Topical Ophthalmic Refills	Would prohibit topical ophthalmic products refill denial	Would not exceed	Because AB 1831 specifies terms of existing benefit coverage, it appears that AB 1831 would not exceed EHBs.
AB 1954 (Burke) Reproductive Services	Would require OON reproductive and sexual health services coverage	Would not exceed	Requirements in AB 1954, related to enrollee expenses and plan/insurer payments, appear not to exceed EHBs.
AB 2004 (Bloom) Hearing Aids	Would require hearing aid coverage	May exceed	Coverage of hearing aids for children younger than 18 years and associated services, as mandated by AB 2004, would require coverage for a new benefit that appears to exceed EHBs in California.
AB 2050 (Steinorth) Prescription Refill Synchronization	Would require synchronization of multiple prescription refills	Would not exceed	Because the refill synchronization provision would specify a condition on the terms of existing benefit coverage (but not require new benefit coverage), it would not directly exceed EHBs.
AB 2084 (Wood) Comprehensive Medication Management (CCM)	Would require Medi-Cal CMM services coverage	Unknown	CHBRP analysis of AB 2084 did not include EHB interaction.
AB 2209 (Bonilla) Clinical Pathways	Would prohibit clinical care pathways implementation by providers	Unknown	CHBRP analysis of AB 2209 did not include EHB interaction.
AB 2372 (Burke) HIV Specialists	Would require HIV specialists as primary care providers	Would not exceed	AB 2372 allows certain physicians to be designated as primary care physicians, expanding the providers eligible to provide EHBs but does not mandate coverage of additional benefits. Therefore, the provisions of AB 2372 do not appear to exceed EHBs.

Bill	Proposed Benefit Mandate	EHB Interaction	Discussion
AB 2507 (Gordon) Telehealth	Would recognize telehealth modalities	Would not exceed	AB 2507 would require reimbursement for services already included in the current required EHB benchmark but provided in a different setting. Therefore, AB 2507 does not appear to exceed EHBs.
AB 2764 (Bonilla) Mammography	Would alter mammography coverage	Would not exceed	AB 276 would require coverage for digital breast tomosynthesis (DBT). However, because DBT would be considered part of mammography coverage, which is an EHB, it would not trigger the requirement that the state pay for benefits beyond EHBs.
SB 999 (Pavley) Contraceptives: Annual Supply	Would require annual, contraceptive supply coverage	Would not exceed	SB 999's requirements regarding 12-month supply of FDA-approved, self-administered hormonal contraceptives would not alter the benefit coverage requirements; only the permitted supply dispensed at one time. Therefore, SB 999 does not exceed EHBs.
SB 1034 (Mitchell) Autism	Would alter autism behavioral health treatment coverage	Would not exceed	First, SB 1034 alters the terms and conditions of an existing benefit mandate but does not require an additional benefit to be covered. Second, the current law that SB 1034 would alter expressly indicates that it ceases to function if it exceeds EHBs, and SB 1034 does not eliminate this clause of the current law (so neither the current law nor the version SB 1034 would create functions if they are deemed to exceed EHBs).
2015			
AB 339 (Gordon) Outpatient Prescription Drugs	Would restrict cost sharing	Would not exceed	Requirements that would be mandated by AB 339 appear not to exceed EHBs.
AB 374 (Nazarian) Step Therapy	Would require overrides for step therapy	Would not exceed	AB 374's requirements regarding step therapy protocol overrides would alter the terms and conditions of benefit coverage but would not alter benefit coverage requirements. Therefore, AB 374 would not exceed EHBs.
AB 502 (Chau) Dental Hygienists	Would require OON hygienist coverage reimbursement	Would not exceed	Requirements that would be mandated by AB 502 will not impact EHBs coverage. Furthermore, AB 502 would not change the EHB pediatric dental coverage requirement for children nor extend it to adults.
AB 623 (Wood) Abuse-deterrent Opioid Analgesics	Would require opioid analgesic utilization management coverage	Would not exceed	AB 623 would alter the terms and conditions of benefit coverage for opioid analgesics but would not alter benefit coverage requirements. Therefore, AB 623 would not exceed EHBs.
AB 796 (Nazarian) Autism	Would broaden definition of qualified autism services professionals and paraprofessionals	Would not exceed	First, AB 796 alters the terms and conditions of an existing benefit mandate but does not require benefit coverage. Second, the current law that AB 796 would alter expressly indicates that it ceases to function if it exceeds EHBs.

Bill	Proposed Benefit Mandate	EHB Interaction	Discussion
AB 1102 (Santiago) Special Enrollment Periods	Would include pregnancy as "qualifying event"	Unknown	CHBRP analysis of AB 1102 did not include EHB interaction.
AB 1305 (Bonta) Cost Sharing: Family Health Coverage	Would standardize family cost sharing	Would not exceed	Because AB 1305 would not mandate the coverage of any specific services, it would not exceed federally and state-mandated EHBs.
SB 190 (Beall) Acquired Brain Injury	Would require PARTRS coverage	Unknown	It is unclear whether the PARTRS coverage SB 190 would mandate would exceed EHBs. The language of SB 190 is complex, but at least three elements (definition of PARTRS as "residential," inclusion in PARTRS of "rehabilitation nursing," and "prosthetic and orthotic services") seem to make interaction with EHBs unclear.
SB 289 (Mitchell) Telehealth	Would require reimbursement for telehealth services	Would not exceed	SB 289 would require reimbursement for services already included in the current required EHB benchmark but provided in a different setting. Therefore, SB 289 does not appear to exceed or alter EHBs.
2014			
AB 1771 (Pérez) Telehealth	Would require coverage for telehealth services	Would not exceed	In the case of AB 1771, E/M services would simply be delivered in a different way rather than be considered a new benefit; therefore, these telehealth services would not trigger the ACA requirement that the state defray the cost of additional benefit coverage for enrollees in QHPs.
AB 1917 (Gordon) Outpatient Prescription Drugs: Cost Sharing	Would restrict cost sharing	Would not exceed	AB 1917 modifies the cost sharing. As state rules related to cost sharing do not meet the definition of state benefit mandates that could exceed EHBs, AB 1917 would not exceed EHBs.
AB 2041 (Jones) Developmental Services: Regional Centers: Behavioral Health Treatment	Would redefine behavior management personnel	Would not exceed	The existing behavioral treatment mandate was enacted prior to December 31, 2011, thus it is already included in California's definition of EHBs. AB 2041 does not modify the existing behavioral health treatment mandate in a manner that would exceed EHBs.
AB 2418 (Bonilla & Skinner) Prescription Drug Refills	Would require prescription drug coverage in state-regulated plans/insurance	Would not exceed	Since AB 2418 specifies terms for existing benefit coverage but does not require new benefit coverage, it would not directly interact with EHBs.
SB 1053 (Mitchell) Contraceptives	Would require contraceptive coverage in state-regulated plans/insurance	May exceed	Because the requirements of SB 1053 could be interpreted as broader than what is currently required in the EHB benefit package in California, the bill could exceed EHBs due to its requirement to cover all FDA-approved contraceptive drugs, devices, products, and voluntary sterilization procedures. SB 1053 would likely exceed EHBs due to its requirement for plans and insurers to provide coverage for male condoms, which are not currently required by EHBs as defined by California law.

Bill	Proposed Benefit Mandate	EHB Interaction	Discussion
SB 1239 (Wolk) School Nurses	Would require school nurse services coverage in state-regulated plans/insurance	Would not exceed	The language of SB 1239 explicitly requires reimbursement for health care services provided by school nurses that "would otherwise be covered by" an enrollee's health plan contract or insurance policy. For this reason, CHBRP does not believe that the requirements in SB 1239 would interact with EHBs because such services are currently within the scope of EHBs.

Source: California Health Benefits Review Program, 2016.
Key: CCM = comprehensive medication management; DBT = digital breast tomosynthesis; EHB = essential health benefits; FDA = Food and Drug Administration; HIV = human immunodeficiency virus; OON = out-of-network; PARTRS = post-acute residential transitional rehabilitation services; USPSTF = United States Preventive Services Task Force.

CHBRP'S CHARGE: ANALYSES AND APPROACH

The California Health Benefits Review Program (CHBRP) provides the Legislature with a standardized, impartial approach for evaluating health insurance benefit bills in an ever changing health policy landscape. This section summarizes CHBRP analyses' findings, provides an overview of supplemental publications, reviews CHBRP's continuous quality improvement efforts and responsiveness to legislative requests, and briefly describes some challenges to CHBRP's analytic approach. Many of CHBRP's supplemental publications have focused on initial and continuing implementation of the ACA. As noted earlier in this report, CHBRP's scientific expertise and rigorous analysis of health insurance benefit bills continues to provide value and insight into the interaction between the ACA and state law and regulation. In order to provide maximum value to the Legislature and other stakeholders, CHBRP has disseminated information on how these two sets of laws and regulations interact through its analyses, supplemental products, and through briefings and presentations at the State Capitol.

CHBRP's Objectives and Charge

CHBRP's authorizing statute[23] outlines the program's objectives and charge. Due to the Legislature's continuing concern about health insurance benefit legislation bills, their potential impacts on health outcomes, and their potential impacts on cost and affordability, the Legislature has continued to commission the University of California (UC), through CHBRP, to conduct systematic analyses of proposed health insurance benefit bills.

CHBRP's authorizing statute specifies the questions to be addressed in CHBRP's analyses. In addition, as previously noted, the 2006 and 2015 reauthorizations (SB 1704 and SB 125) added the analysis of benefit mandate repeals and analysis of other benefit bills to CHBRP's charge. The following lists the provisions current in CHBRP's enabling statute:

1. UC is requested to establish CHBRP.
2. Legislation proposing to mandate coverage for a benefit is defined as a proposed statute that requires a health care service plan and/or health insurer to:
    a. Permit an enrollee to obtain health care treatment or services from a particular type of health care provider;
    b. Offer or provide coverage for the screening, diagnosis, or treatment of a particular disease or condition; or
    c. Offer or provide coverage of a particular type of health care treatment or service, or of medical equipment, medical supplies, or drugs used in connection with a health care treatment or service.
3. All legislation proposing or repealing health insurance benefit mandates and any legislation that would impact benefit design, cost sharing, premiums, or other health insurance topics, is to be analyzed by CHBRP and a written analysis is to be prepared

[23] For a full description of CHBRP's Authorizing Statue, see Appendix 1.

with relevant data on the legislation's public health, medical, and financial impacts, as defined in the authorizing statute.

4. Support for CHBRP to conduct these analyses is to be provided through a non-General Fund source, specifically fees levied by the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI) on health care service plans and health insurers, respectively, the total annual amount of which shall not exceed $2 million.
5. Legislative requests to CHBRP are to be made by an appropriate policy or fiscal committee chairperson or legislative leadership.
6. CHBRP is to submit analyses of proposed health insurance mandate bills to the appropriate committee no later than 60 days after receiving a request from the Legislature.
7. CHBRP is to develop and implement conflict-of-interest provisions to prohibit participation in the analyses by a person with a material financial conflict of interest, including a person who has a consulting or other agreement with an entity that would be affected by the legislation.
8. CHBRP is to use a certified actuary or other person with relevant knowledge and expertise to determine the financial impact of a given bill.
9. CHBRP is to post all analyses on the Internet and make them available to the public on request.
10. CHBRP is to provide the Governor and Legislature with a report on the implementation of SB 125 (CHBRP's most recent reauthorization) by January 1, 2017.
11. The "sunset date" for the program is December 31, 2017 (with funding through June 30, 2017), unless a later enacted statute extends or repeals that date.

CHBRP Analyses

As described in statute above, CHBRP is charged with supporting the California Legislature through independent, academically rigorous, and unbiased analysis of the medical effectiveness of treatments and services relevant to a proposed health insurance benefits bill; and estimate the likely impact of the bill on benefit coverage, utilization, cost, and public health. Since the program's inception, CHBRP has analyzed 123 bills and issued numerous policy briefs and related resources. All CHBRP publications are available at www.chbrp.org.

Topics of Bills Analyzed

The list of bills CHBRP analyzed during the 2014 through 2016 period, their relevant topics, and their final status are included in Table 4. Because of the range of issues addressed by health insurance benefit bills, CHBRP faculty and staff must be sophisticated generalists, capable of obtaining the knowledge base necessary to effectively develop an appropriate bill-specific analytic approach quickly. For a further discussion of the complexity of the bills CHBRP has analyzed, see Table 2 in the Executive Summary of this document. CHBRP also retains a content expert for each analysis who serves as subject matter experts and helps to identify key literature.

CHBRP has developed an analytic approach that is attuned to the breadth of possible questions and aims to deliver robust analyses that provide the Legislature with answers to aid in its deliberation.

Table 4. CHBRP Analyzed Bills: Status, 2014–2016[24]

Analyzed Bill	Status
2016	
AB 533 (Bonta) Out-of-Network Coverage	Failed passage out of Legislature
AB 796 (Nazarian) Autism	Signed into law
AB 1763 (Gipson) Colorectal Cancer Screening	Failed passage out of Legislature
AB 1831 (Low) Topical Ophthalmic Refills	Vetoed by Governor
AB 1954 (Burke) Reproductive Services	Signed into law
AB 2004 (Bloom) Hearing Aids	Failed passage out of Legislature
AB 2050 (Steinorth) Prescription Refill Synchronization	Failed passage out of Legislature
AB 2084 (Wood) Comprehensive Medication Management	Failed passage out of Legislature
AB 2209 (Bonilla) Clinical Pathways	Failed passage out of Legislature
AB 2372 (Burke) HIV Specialists	Failed passage out of Legislature
AB 2507 (Gordon) Telehealth	Failed passage out of Legislature
AB 2764 (Bonilla) Mammography	Failed passage out of Legislature
SB 999 (Pavley) Contraceptives: Annual Supply	Signed into law
SB 1034 (Mitchell) Autism	Failed passage out of Legislature
2015	
AB 339 (Gordon) Outpatient Prescription Drugs	Signed into law
AB 374 (Nazarian) Step Therapy	Signed into law
AB 502 (Chau) Dental Hygienists	Signed into law
AB 623 (Wood) Abuse-Deterrent Opioid Analgesics	Failed passage out of Legislature
AB 796 (Nazarian) Autism	Active, referred to committee suspense file
AB 1102 (Santiago) Special Enrollment Periods	Ceased being a benefit mandate bill
AB 1305 (Bonta) Cost Sharing: Family Health Coverage	Signed into law
SB 190 (Beall) Acquired Brain Injury	Failed passage out of Legislature
SB 289 (Mitchell) Telehealth	Failed passage out of Legislature
2014	
AB 1771 (Pérez) Telehealth	Failed passage out of Legislature
AB 1917 (Gordon) Outpatient Prescription Drugs: Cost Sharing	Failed passage out of Legislature
AB 2041 (Jones) Autism	Failed passage out of Legislature
AB 2418 (Bonilla & Skinner) Prescription Drug Refills	Vetoed by Governor
SB 1053 (Mitchell) Contraceptives	Signed into law
SB 1239 (Wolk) School Nurses	Failed passage out of Legislature

Source: California Health Benefits Review Program, 2016.

Summary of CHBRP Bill Analyses

CHBRP analyses generally consider: (1) the medical effectiveness of relevant treatments and services in terms of health outcomes; (2) the projected cost impacts in terms of per member per month premiums and enrollee expenses (cost sharing and any out-of-pocket expenses for noncovered benefits); and (3) the estimated public health impacts for the population in terms of health outcomes.[25] CHBRP's issue analyses are less uniform in approach, instead providing a

[24] For full details on each of the bills CHBRP analyzed during this period, please see Appendix 9.
[25] For full details on the analytic methods used for CHBRP's medical effectiveness, cost, and public health impacts analyses, see Appendices 10, 11, and 12, respectively.

summarization of key policy considerations when the language of a bill is too ambiguous for CHBRP's standard analytic process to be feasible or when insufficient time is available for a fill analysis to be completed.

During the years 2014 through 2016, at the request of the California Legislature, CHBRP analyzed 29 bills. Below is a summary of some of the key findings from the period's analyses.

Medical effectiveness

- 61% of medical effectiveness analyses determined that the bills were addressing coverage for treatments or services considered to be effective.
- 39% of medical effectiveness analyses concluded that the evidence was either mixed or insufficient to deem the relevant treatment or service effective.

Cost impact

- 88% of cost impact analyses estimated that the bill would incrementally increase total costs, defined as the combination of per member per month premiums and enrollee expenses (cost sharing and any out-of-pocket expenses for noncovered benefits).
- 12% of cost impact analyses estimated no overall increase in expenditures as a result of the bill, usually because the benefit was widely covered or there was no estimated increase in utilization associated with the mandate.

Public health impacts

- 39% of public health impact analyses estimated a positive impact on public health as a result of the bill, due either to improved health outcomes or decreased financial burdens for enrollees utilizing the benefit.
- 35% of public health impact analyses estimated no impact on the public's health, generally where the benefit was widely covered or there was no estimated increase in utilization associated with the bill.
- 26% of public health impact analyses concluded that due to incomplete, inconclusive, or mixed evidence, the impact of the bill on the health of the public was unknown.

Use of CHBRP's Analyses

Consistently, those involved with the Legislature's consideration of health insurance benefit bills report that they rely on CHBRP's analyses because they are useful, comprehensive, rigorous, and impartial. Stakeholders frequently repot that CHBRP analyses serve as the baseline for discussion around benefit mandate bills, particularly around fiscal impacts. Additionally, legislative and agency staff have frequently indicated that the analyses aid them in their internal consideration of whether a bill avoids unintended consequences and whether it adequately addresses the problem it seeks to resolve.

CHBRP analyses during the legislative process

CHBRP's analyses are widely used to support decision making throughout the Legislature's deliberative process regarding benefit mandate bills.

- Legislative Committee Staff consistently draw on findings and data from CHBRP analyses for inclusion in the policy and fiscal committee analyses.
- Legislators on Committees and Bill Authors routinely quote from CHBRP analyses during hearing remarks and testimony.
- Health Insurance Stakeholders, both bill advocates and bill opponents, including advocacy organizations, health plans/insurers, trade associations, and consumer groups, regularly use CHBRP analyses to make cases in support of, or in opposition to, the passage of mandate bills.

CHBRP analyses beyond the legislative cycle

CHBRP's analyses remain relevant as references even beyond the legislative process. For example, insurance regulators report having used CHBRP analyses in discussion of appropriate rate increases when analyzed bills have passed into law. Health plans also report using CHBRP's medical effectiveness analysis to evaluate their benefit coverage offerings.

Outside of California, a federal report[26] cited a CHBRP analysis's estimate regarding the marginal cost of covering applied behavioral analysis as an EHB, and the Institute of Medicine (IOM) also recommended that CHBRP's approach serve as a guide for further defining EHBs in the future.[27]

In addition, other states considering their own benefit mandate bills have also utilized CHBRP's analyses, a variety of health insurance stakeholder groups inside and outside the state have referenced CHBRP's analyses and other products, a number of references have been made to CHBRP's work in published literature, and CHBRP's work has been quoted in frequently in the popular media. During the period 2014 through 2016, CHBRP is aware of 58 such examples,[28] but this figure is likely to be an undercount for two reasons: (1) CHBRP is not always made aware of references to its work; and (2) references to CHBRP's work are often made for many years after publication, so efforts just completed at the end of this period, in 2016, will likely have further use in future years.

Other Publications

In addition to analyzing benefit mandate bills, CHBRP utilizes faculty and staff expertise to generate a number of other publications that provide value to the Legislature. These products generally address issues that are broadly relevant to benefit mandates or aspects of initial and

[26] Center for Medicare & Medicaid Services, Center for Consumer Information and Insurance Oversight, *Essential Health Benefits Bulletin*. December 16, 2011. Available at: www.cms.gov/CCIIO/Resources/Files/Downloads/essential_health_benefits_bulletin.pdf.
[27] IOM, 2011. *Essential Health Benefits: Balancing Coverage and Cost.* Available at: www.iom.edu/Reports/2011/Essential-Health-Benefits-Balancing-Coverage-and-Cost.aspx.
[28] See Appendices 20 and 21 for complete lists of references.

continuing implementation of the ACA that are relevant to CHBRP's work. A description of each publication is provided below.

Resources

Estimates of the Sources of Health Insurance

This annually updated resource presents projections of health insurance enrollment for California's population that may be subject to state-level health insurance benefit laws—DMHC-regulated plans and CDI-regulated policies—as well as the number enrolled in other types of health insurance. The resource also estimates the portion of enrollees in DMHC regulated plans associated with the CalPERS or with Medi-Cal and the portion of the enrollees associated with grandfathered plans (and so not subject to some ACA requirements).

Health Insurance Benefit Mandates in California State Law

This annually updated resource provides a comprehensive list of the existing health insurance benefit mandates that are currently in law in California, including both the laws that are enforced by DMHC and CDI, as well as applicable federal law. This resource alerts CHBRP's stakeholders of existing laws that may interact with a proposed health insurance benefit bill.

Federal Preventive Services Benefit Mandate and California Benefit Mandates

This resource identifies potential overlap between the ACA requirement for some DMHC-regulated plans and CDI-regulated policies to cover federally selected preventive services (FSPS), without cost sharing, and California's state benefit mandates. The resource provides a comprehensive list of relevant preventive services through analysis of the sources referenced by the ACA, including: the United States Preventive Services Task Force (USPSTF) A and B recommendations; guidelines supported by the Health Resources and Services Administration (HRSA) for women, children, and newborns; and Advisory Committee on Immunization Practices (ACIP) recommendations.

Analysis: California's EHB Base Benchmark Options

This resource analyzed and compared the health services covered by the ten plans indicated by the ACA as available to California as options for the state's EHB base benchmark plan, to inform the state's definitions of EHBs in 2017 and beyond.

Background on Cost Sharing for Outpatient Prescription Drugs

Intended as a supplement to CHBRP's analyses of bills related to prescription drugs, this resource offers general information on relevant cost sharing.

Outpatient Prescription Drug Coverage 101

Intended as a supplement to CHBRP's analyses of bills related to prescription drugs, this resource offers general information about coverage for outpatient use of prescription drugs.

What Is Cost Sharing in Health Insurance?

Intended as a supplement to CHBRP analyses related to cost sharing, this resource offers general information on the subject.

Policy and Issue Briefs

California's State Benefit Mandates and the Affordable Care Act's "Essential Health Benefits"

The focus of this issue brief is on the ACA's requirement of coverage of EHBs, which is relevant to significant portions of health insurance products sold in California's individual and small-group markets, including, but not limited to,[29] health insurance associated with Covered California, the state's health insurance exchange. The brief provides background on federal EHB requirements, as well as context for potential interaction effects between those requirements and state-level health insurance benefit bills.

Immunization Mandates, Benchmark Plan Choices, and Essential Health Benefits

This brief provides a detailed analysis of California's immunization benefit mandates as an example of how state benefit mandates could exceed EHBs and how evidence-based analysis may inform discussions of whether to keep or repeal state benefit mandates that exceed EHBs.

Mammography Mandates, Benchmark Plan Choices, and Essential Health Benefits

This brief provides a detailed analysis of California's mammography benefit mandates to illustrate how state benefit mandates could exceed EHBs and how evidence-based analysis may inform discussions of whether to keep or repeal state benefit mandates that exceed EHBs.

Pediatric Dental and Pediatric Vision Essential Health Benefits

This brief raises a number of unresolved policy and technical questions related to the ACA's requirement of coverage for pediatric dental and vision benefits. All of the questions posed analytic challenges for CHBRP, even when considering bills unrelated to the subject matter, so the brief was issued to begin raising those questions with external policymakers and stakeholders. Since its publication, the brief was revised to address ways in which some of these questions have been answered by subsequent federal and state law and regulation.

Policy Snapshot: Primer on Insurer Provider Networks

This brief gives background on provider networks and discusses changes relevant to on-going implementation of the ACA.

Legislative Outreach and Briefings

In order to promote better understanding of CHBRP's role and the nature of health insurance benefit bills, CHBRP has regularly provided pre-session briefings for legislative staff and other health insurance stakeholders. Each January, before the bill introduction deadline, CHBRP

[29] Through additional legislation, California requires some small-group and Individual market plans that are not associated with Covered California to also cover EHBs; see H&SC § 1357.500.

provides a briefing that outlines the program's process and analytic approach, as well as providing a "health insurance 101" for persons new to the subject and information on the continuing implementation of the ACA.

CHBRP has also consistently taken steps to ensure that analyses are understood by legislators and staff from author's offices and policy committees throughout the legislative process. Immediately after an analysis is submitted, CHBRP schedules calls with staff from the requesting health committee, with calls also offered to the bill author's office and to the staff of each health committee that considers the bill. CHBRP staff members remain available to answer the questions of any interested party throughout the legislative process, and routinely attend health committee hearings as well as appropriations hearings. At hearings, CHBRP staff members have occasionally been called upon by committee members to further explain report details and analytic approach.

In addition, in March of 2015, CHBRP partnered with the University of California, Davis, to provide a briefing in Sacramento, "Lessons From Massachusetts for the Next Phase of Health Care Reform," an open event that brought experts from the state that led the country in health care reform to discuss implementation issues with California stakeholders.

Continuous Quality Improvement

CHBRP continuously evaluates its products, processes, and policies to ensure that the program is in compliance with the requirements of its authorizing statute, that it is responsive to legislative requests, and that it is making continuous quality improvements.

On an annual basis, CHBRP interviews legislative staff, agency staff, and health insurance stakeholder groups to understand how CHBRP products were used, how they can be improved, and how CHBRP's process can continue to be responsive to its own legislative mandate. These meetings ensures that stakeholders have the opportunity to voice comments and concerns directly to CHBRP staff, so that feedback can be incorporated into the CHBRP's analytic approach for the next legislative cycle.

As part of CHBRP's annual stakeholder process, many groups are contacted, including the following:

- Legislative staff, including the Health and Appropriations Committee chairs, leadership in both houses, staff from the Republican caucus in both chambers, and staff at both the Legislative Analyst's Office and the Senate Office of Research. Personal staff of Senators or Assembly Members who served as the primary bill authors for health insurance benefit bills are also contacted;
- Agency staff, including individuals at DMHC, CDI, Department of Health Care Services (DHCS), Covered California, and CalPERS;
- Health plans, insurers, and their trade associations, including the California Association of Health Plans (CAHP), the Association of California Life & Health Insurance Companies (ACLHIC), and Local Health Plans of California (LHPC);

- Advocacy groups such as Consumers Union and Health Access;
- Labor groups such as the AFL-CIO and the California Federation of Labor;
- Business groups, such as the California Chamber of Commerce; and
- Provider groups such as the California Medical Association (CMA), the California Association of Provider Groups (CAP-G), the California Hospital Association (CHA), and the American College of Obstetrics and Gynecology (ACOG).

The following sections summarize the relevant concerns discussed in CHBRP's stakeholder process, how CHBRP has responded to these issue areas, and how CHBRP continues to evaluate ways in which it can be responsive to demands related to its analyses while staying within its legislative mandate.

Readability, Reliability, and Content of the Analyses and Other Products

Overall, CHBRP has received a great deal of positive feedback on its analyses, and has focused on trying to present findings with greater clarity and brevity. Some ways in which this has been done is to include summary boxes that provide the main points of each section of the report, and a shorter "Key Findings" section, generally two to four pages, that makes the salient report findings easier to digest for CHBRP's stakeholders.

Legislative staff, agency staff, and stakeholder groups consider CHBRP's products to be both reliable and impartial. Stakeholders often remark that CHBRP's analyses serve as the "baseline" for discussion of the fiscal impact of mandate bills. Legislative staff report that they utilize CHBRP's analyses and find the analyses responsive, comprehensive, and useful. Committee staff have stated that CHBRP analyses provide the essential technical information the Legislature needs to make decisions regarding health insurance benefit bills, and particularly appreciate that the "Key Findings" sections are helpful in locating essential data for the legislative analyses.

Consumer groups and sponsors or proponents of health insurance benefit bills have also expressed high regard for CHBRP's work. They appreciate the fact that cost impacts are broken down by out-of- pocket expenditures and employee/employer premiums, and have stated that such information is useful to communicate all sides of the story, and particularly valuable in discussions regarding the overall affordability of health insurance. One provider group representative stated that the reports "do a good job of outlining the key issues, a feature especially important for new legislators." Another provider group representative noted that the quantitative data are sometimes difficult to parse out if one does not have an actuarial background. They emphasized the need to "translate" the figures presented in the tables into useful bulleted points, and since then, CHBRP has provided abbreviated bulleted explanations to help clarify understanding of these often complex figures in the "Key Findings" section.

Health plans and insurer representatives and their associations echo the sentiment that CHBRP is seen as a "credible source" for information. One plan stated that it conducts an internal analysis for some benefit mandate bills, and its findings are generally consistent with CHBRP's premium impact analysis. Insurers have also stated they appreciated that administrative costs are also

discussed in CHBRP reports, especially for those bills that would primarily shift costs from the enrollee using the treatment or service to the insurer.

CHBRP's Analytic and Research Translation Process

Committee and bill author staff appreciate having a dialogue with CHBRP staff to understand the key background issues a bill author may identify, any issues related to bill language (in terms of its potential interpretation), and the verbal briefing of the analysis by the CHBRP staff lead, after the analysis has been submitted to the Legislature. To better draw readers to conclusions and caveats presented in the medical effectiveness, cost, and public health impacts sections, CHBRP staff has routinely followed up with legislative staff to provide detailed briefings. In addition, the analyses have been revised to more clearly state the overall conclusions in terms of medical effectiveness. CHBRP is committed to addressing any concerns and taking further strides to ensure that its analytic work is even more accessible and useful to busy legislative staff operating under tight timelines.

Challenges Inherent to CHBRP's Analytic Process

The overarching challenge CHBRP faces in its analytic process is the delivery of a scientific, rigorous, high-quality analysis within the constraints posed by the 60-day time frame (or less) required by statute. More specifically, key process challenges include identifying health insurance benefit bills in time for CHBRP analysis and ensuring smooth workflow. Some of CHBRP's analytic challenges include projecting public health impacts with data limitations, and dealing with the applicability and limitations of the medical literature. More detail on each of these challenges is provided below.

Identifying Health Insurance Benefit Bills

The Assembly Health Committee and the Senate Health Committee play an active role in communicating with members' offices so that they are notified of potential health insurance benefit bills that might be referred to CHBRP for analysis. On an annual basis, both the Assembly Health Committee and the Senate Health Committee send a memorandum to all Assembly Members and Senators discussing CHBRP's process, the deadlines for the legislative year, and the requirement for a CHBRP analysis. CHBRP's briefings and workshops have also helped bill authors to become aware of the timelines and to notify committee staff of potential benefit bills early in the process.

The second year of each 2-year legislative session presents additional challenges due to an accelerated hearing calendar. Approximately 30 days are allotted from the point of bill introduction to the time it must pass out of the policy committees in the house of origin. To address this issue and provide CHBRP the statutory 60-day time period, CHBRP works with committee staff to be notified of bills and receive requests before the bill introduction deadline. These deadlines are communicated with Assembly Member and Senators offices at the beginning of the legislative session.

Workflow and Timing

CHBRP must have sufficient capacity to do multiple analyses (as many as 14, if 2016 is indicative of the future) on near-simultaneous 60-day timelines with the heaviest period of overlap occurring during the months February through April, just before bills are heard in initial health committee hearings. CHBRP faculty, actuaries, librarians, reviewers, and staff must produce and review multiple drafts on multiple bills in a very compressed time frame. To address this concern, CHBRP has built additional seasonal capacity among CHBRP librarians, and with faculty and research staff, within budgetary constraints.

When the Legislature is not in session, CHBRP undertakes numerous projects to meet the workload of the coming year, and improve the quality and transparency of its process and products. For example, CHBRP's medical effectiveness and public health teams may develop guidelines or criteria to address specific research questions that are likely to be presented by future bills. CHBRP updates its Cost and Coverage Model (CCM) annually, during the fourth quarter of the calendar year. The cost team supplies updated California Health Insurance Survey (CHIS) and California Health Care Foundation/National Opinion Research Center (CHCF/NORC) data, as described later in the "Analytic Methods" section of this report. CHBRP's public health team has considered ways to address bill-relevant social determinants of health.

Estimating Public Health Projections With Data Limitations

CHBRP has responded to requests from legislative staff, agency staff, and other stakeholders to provide quantitative estimates of public health benefits where possible. In an effort to provide more information about impact on health disparities and social determinants of health, CHBRP has done preliminary analyses examining the distribution of gender, age, and race/ethnicity in different insurance markets. As appropriate for particular analyses, CHBRP considers additional issues, such as education, income, and the differences between rural and urban populations. Because health insurance benefit mandates sometimes have differential impacts on different elements of the health insurance market, understanding such issues, as well as possible impacts, can provide some information about the potential for laws related to health insurance benefits to enhance access to certain kinds of care. In addition, because most public health impacts occur in a longer time frame than the typical 1 year CHBRP typically estimates, staff and faculty have developed an additional section that focuses on the potential long-term health impacts of health benefit laws and have incorporated it into to reports submitted during the 2014 through 2016 period.

Applicability and Limitations of the Medical Literature

CHBRP's medical effectiveness team has encountered three specific challenges in conducting its analysis. First, some mandate bills address topics for which few (or no) well-designed studies have been completed. Secondly, for medical effectiveness analyses, some mandate bills would require coverage for multiple interventions or services, such as bills regarding coverage for maternity services, diabetes-related treatments, or durable medical equipment. Many studies focus on a single intervention or service, and their findings are not applicable to all of the interventions or services proposed in a bill. Studies that examine multiple services often do not

compare the same bundle of interventions or services, which makes it difficult to compare findings across studies. The third challenge arises with the bills that address parity in coverage for treatment of a disease or condition rather than coverage of specific services, such as bills on parity in coverage for mental health and substance abuse services. Such bills are difficult to analyze because they implicitly assume that parity in coverage will remove financial barriers for accessing services which will, in turn, increase use of appropriate and effective services and thus improve health outcomes. Barriers experienced by some enrollees, but not others (such as limited knowledge of the health care system, difficulties in meeting any cost-sharing requirements, or transportation issues), may limit overall utilization despite increased parity in benefit coverage. The available medical literature often does not enable the medical effectiveness team to make these causal links. In each of these cases, CHBRP reports on both what the literature is able to convey and its limitations.

ACADEMIC RIGOR ON DEMAND

As per its authorizing statue, the California Health Benefits Review Program (CHBRP) utilizes the funds made available to it to secure key data and faculty time in advance, and is then able to act instantly upon requests from the Legislature to organize robust and credible analyses for introduced benefit mandate and repeal bills. This arrangement is unique among states that have organized programs for reviewing benefit mandates in that it both analyzes while the bill is under consideration, and also harnesses the expertise and effort of teams of faculty, staff, actuaries, and content experts. This combination of academic rigor with sufficient speed to inform deliberation makes CHBRP's efforts unique, robust, and timely.

Overall Structure

Operating support for CHBRP is provided through a non-General Fund source, specifically, fees levied by the California Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI) on health care service plans and health insurers, the total annual amount of which has been capped at $2 million annually, or about $0.0066 per member per month (in 2016 dollars).[30] Additional in-kind support has also been provided by UC.

Broad Multidisciplinary Expertise

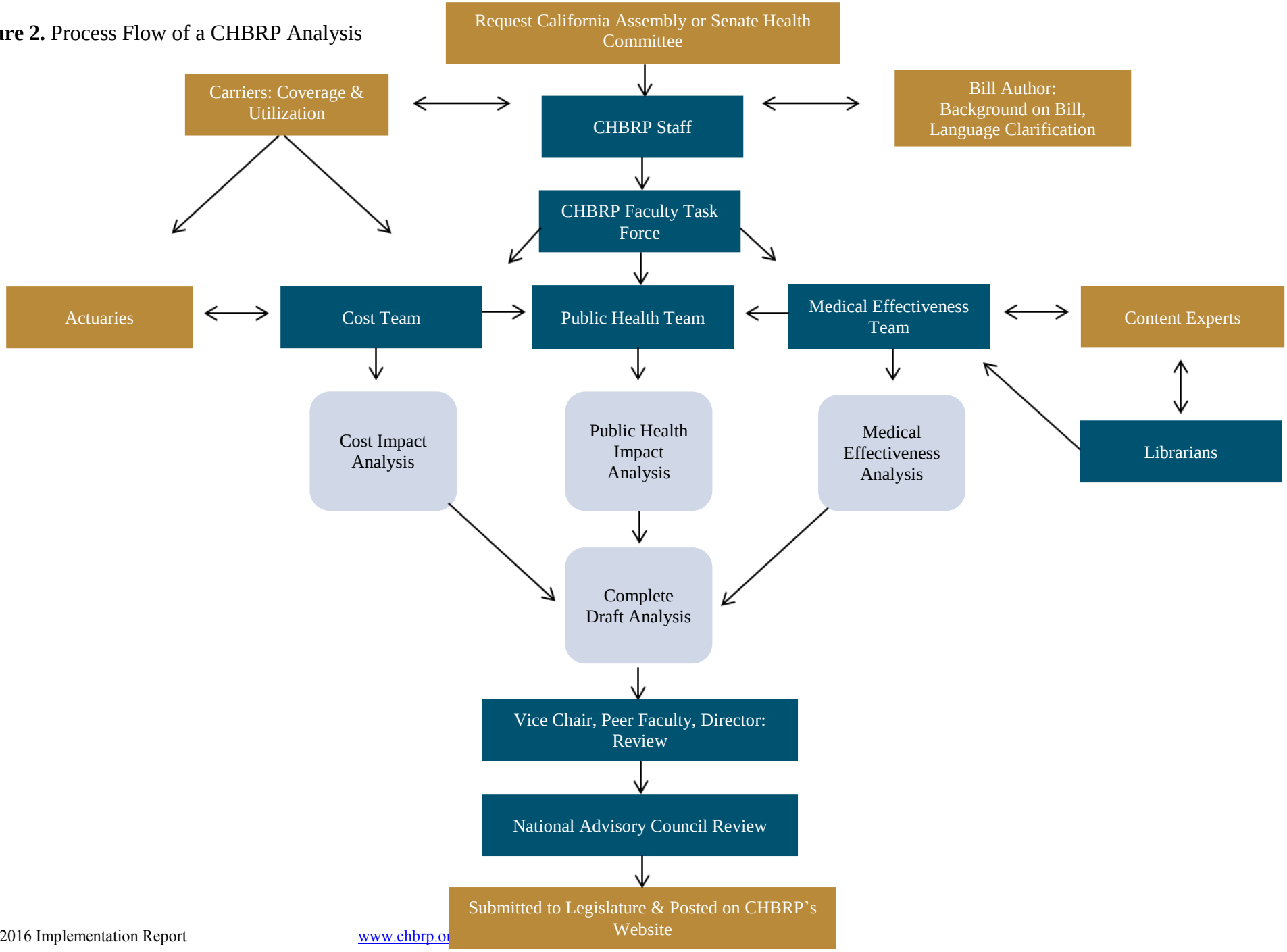
CHBRP reports provide academically rigorous analysis utilizing broad, multidisciplinary expertise. CHBRP's work achieves its standard academic rigor through the involvement of faculty, researchers and staff attached to the UC system. This includes individuals with expertise in medicine, health economics, actuarial science, public health, and medical effectiveness evaluation. CHBRP's multidisciplinary contributors are drawn from:

- University of California, Berkeley;
- University of California, Davis;
- University of California, Los Angeles;
- University of California, San Diego; and
- University of California, San Francisco.

The analytic teams work with librarians, content experts, and editors to collaboratively develop and complete a cohesive analysis within the 60-day time period. As demonstrated in Figure 2 below, the work is interdependent and cumulative.

[30] Additional information about CHBRP's funding process can be found in Appendix 7.

Figure 2. Process Flow of a CHBRP Analysis



Full descriptions of all of CHBRP's contributors follow in the sections below.

Research capacity and expertise: faculty task force

During the years following the passage of AB 1996, UC considered various structural options for building the program. After consideration and discussions with faculty from various campuses, UC decided to implement a hybrid model in which the administration and some analytic work would occur at the UC Office of the President (UCOP), but the bulk of the writing and analysis would fall to the designated campuses. This model has proven to be an effective approach from UC's perspective because: (1) the quality of CHBRP reports is enhanced by an internal peer-review process; (2) the quality of CHBRP reports is enhanced by using faculty who are experts in their field; and (3) faculty, junior faculty, researchers, and graduate students derive benefits in terms of collaborative research opportunities.

Prominent researchers have been selected periodically from various campuses to serve as CHBRP's vice chairs. The vice chairs coordinate the three statutorily required components of each bill analysis. As of 2016, the University of California at San Francisco (UCSF), the University of California at Davis (UC Davis), and the University of California at San Diego (UCSD) lead the medical effectiveness reviews and public health impacts (UCSF focuses only on medical effectiveness), while the University of California at Los Angeles (UCLA) leads analysis of benefit coverage, utilization, and cost impacts A handful of other prominent researchers from these and other UC campuses, including the University of Berkeley (UC Berkeley) also serve as members of the Faculty Task Force (FTF) to ensure broad expertise (for example, a clinical pharmacist out of UCSF). The FTF's expertise reflects the evaluation criteria set forth in CHBRP's authorizing statute—the inclusion of experts in health services research and health policy, public health, economics, pharmacology, political science, and clinical medicine. Appointments on the FTF have remained fairly stable over time, but have changed periodically based on availability and the needs of the program.[31]

One of the ongoing challenges of ensuring adequate analytic capacity is the uncertainty of the workload from year to year. In addition, because the legislative calendar dictates the workflow, multiple bills need to be analyzed simultaneously, often during the same 60-day time period. To address these issues as well as the workload challenges previously discussed, CHBRP has built additional capacity at specific campuses to handle overflow. All four of the campuses that lead analytic efforts, UCSF, UCLA, UC Davis, and UCSD have regularly brought on additional faculty and staff to handle the spikes in the number of mandate bills that may arise from year to year and to take on a specific analysis if another researcher has a potential conflict of interest.

CHBRP also makes a concerted effort to enhance its analytic model by periodically incorporating new faculty to provide fresh, unique perspectives and understanding of new research approaches. In the past, CHBRP has also had prominent academics "audit" its analytic approach, in order to gain insight into changes and improvements that might be made from an academic perspective so that all salient information is captured in the bill analysis reports submitted to the Legislature.

[31] For a complete list of current FTF members, see Appendix 3.

Additionally, many of CHBRP's faculty and researchers work at public research centers throughout the UC system as health policy experts, producing cutting edge research for policymakers throughout California. Participation in CHBRP provides these contributors with indirect funding opportunities as well as ongoing expertise in changes to state and federal law, which helps support their wider research efforts.

Professional analytic and administrative staff

In addition to its FTF, CHBRP is administered by a small group of staff at UCOP. The staff provides overall management, policy analysis expertise, project management for the analytic process, and liaison services for CHBRP's communications with the Legislature and other stakeholders. The staff also ensures that reports and the supporting methodology are transparent and accessible to all stakeholders via CHBRP's website. CHBRP staff currently consists of a director, an associate director, two analysts, summer interns, and an administrative/program specialist.[32]

Actuarial analysis

To meet CHBRP's statutory requirement to include actuarial analysis in its reports, CHBRP contracted with Milliman, Inc. after a competitive bidding process in 2003. Milliman's senior actuaries have been heavily involved in developing and annually updating CHBRP's Cost and Coverage Model (CCM). The program has periodically re-bid the actuarial contract since that time, but Milliman successfully re-bid for the contract through 2015.

In 2015, CHBRP again rebid the actuarial contract, which was awarded, late in the year to PricewaterhouseCoopers (PwC). PwC became the contracted actuary, beginning with the 2016 bill analysis season. PwC will also help support CHBRP's efforts in updating the CCM for the next analytic cycle.

The contracted actuaries are deeply engaged in developing the methodological approach for each bill analysis. They support the cost team at UCLA in analyzing coverage, cost, and utilization impacts, and support the public health teams at UC Davis and UC San Diego by providing utilization data analyses for specific populations when available. The contracted actuaries' access to proprietary aggregate claims data enables CHBRP to obtain baseline cost and utilization data and project financial impacts that would result from enactment of a mandated benefit.[33]

National Advisory Council: internal review

CHBRP's NAC consists of experts from outside California selected to provide balanced representation among groups with an interest in health insurance benefit mandates and repeals. The NAC is an advisory body rather than a governance board. Its membership changes based on availability and program needs, with a focus on maintaining a balanced group of stakeholders from key constituencies, including providers, purchasers, consumers, and health plans, as well as health policy experts.[34]

[32] For a full list of CHBRP's current staff, see Appendix 2.
[33] Further information regarding CHBRP's contracting actuaries is included in Appendix 5.
[34] For a full list of the current National Advisory Council membership, see Appendix 4.

The NAC reviews CHBRP's draft bill analyses for accuracy, balance, clarity, and responsiveness to the Legislature's request before the reports are transmitted to the Legislature.[35] During the 60-day time period, NAC reviews occur over 3 days within the final 2 weeks. The NAC review enhances CHBRP's ability to produce balanced, impartial analyses by providing feedback on early draft analyses from different stakeholder groups. For each analysis, CHBRP staff selects a subcommittee—generally three to five members—of the NAC membership to serve as reviewers. NAC reviewers provide input when a particular draft explanation, method, or underlying assumption may be perceived as leading to biased results. In addition, the NAC members' input enhances the overall quality of the product by: (1) reviewing and providing comments on the methods, assumptions, and data sources used in the analyses; (2) identifying sections that warrant further explanation, clarification, or citation; and (3) noting text that may need to be reworded to be more accessible to a lay audience. During the period between 2014 through 2016, NAC members completed a total of 88 separate reviews. In addition to its annual meeting (which focuses on broader strategic and analytic issues) and review of draft reports, individual NAC members have also provided advice to CHBRP staff on particular issues as they have arisen.

Content experts: timely guidance to identify key literature and data sources

Within days of beginning an analysis, CHBRP also retains content experts for each analytic team.[36] Content experts are individuals with specialized clinical, health services research, or other expertise pertaining to the specific benefits and topics addressed by the mandate or repeal bill. These individuals are generally drawn from the UC system or from other reputable educational or research institutions. Content experts are asked to help identify literature and/or data and provide advice to the analytic teams on the following:

- Identification of individual or bundled sets of mandate-relevant tests, treatments, and services and the associated billing codes that allow estimates of utilization;
- Search criteria for the literature review that informs the medical effectiveness analysis (e.g., medical conditions and outcomes) to assure that the team is using the appropriate search terms to identify key articles;
- Expert knowledge regarding:
    - Clinical care management, any controversies in practice, specialty society positions and guidelines;
    - Current and changing technology;
    - Research in progress that could affect the final conclusions of the medical effectiveness analysis;
    - Potential changes in utilization due to coverage for the mandated benefit; and
    - Potential effects of the mandate on clinician practice patterns.

Throughout an analysis, CHBRP is also carefully mindful to avoid any conflict of interest in its use of content experts. Potential content experts are carefully screened by CHBRP's director,

[35] See Appendix 16, NAC Review Criteria and Guidelines.
[36] For full details on the protocol for selecting CHBRP content experts, see Appendix 14.

who is charged with maintaining and implementing conflict-of-interest policies to prohibit participation in the analyses by any person with a material financial conflict of interest or who has advocated for or against the benefit mandate being analyzed. CHBRP applies this prohibition broadly, to content experts as well as to faculty and staff participating on the analytic team, and NAC members reviewing analyses, carefully screening and carefully documenting the absence of any possible conflicts of interest.

Librarians: timely and relevant literature searches

CHBRP's work requires resource-intensive, systematic literature reviews to be conducted within the first 3 weeks of the analytic process. To accomplish this, several librarians with Masters in Library and Information Science from across the UC System are brought in to conduct in-depth literature searches during CHBRP's analytic cycle.[37] Having a team of librarians with expertise in health insurance benefit mandate terminology and search criteria has enhanced the timing of internal deliverables and the development of medical effectiveness analyses. The librarians: (1) develop search strategies specific to the mandated benefit or repeal; (2) conduct the literature search given inclusion/exclusion criteria developed by the medical effectiveness team, the cost team, the public health team, content experts, and CHBRP staff; (3) forward relevant abstracts of peer-reviewed literature to the medical effectiveness team for researchers' review and selection; and (4) conduct literature searches of the grey literature and forward relevant abstracts to the other members of the analytic teams as needed.

Process and Workflow

Since inception, CHBRP has established policies and procedures to streamline activities, to ensure the production of unbiased and thorough analyses, and ensure continuous quality improvement activities are sought out and implemented.

Conflict-of-Interest Policy

CHBRP's authorizing statute specifically requests that UC develop and implement conflict-of-interest provisions to prohibit an individual from participating in an analysis or review in which the individual knows, or has reason to know, that he or she has a material financial interest, including, but not limited to, a consulting or other agreement that would be affected by the mandate benefit proposal or repeal.

To comply with this provision and to systematically review potential conflicts, CHBRP continues to use the process established by UC in 2004. Specifically, CHBRP uses a detailed conflict-of-interest disclosure form for the NAC and all others (faculty, content experts, actuaries, and staff) who contribute to CHBRP analyses.[38] These forms were modeled closely on a background and conflict-of-interest disclosure form designed by the National Academies of Sciences (NAS) for use with respect to studies relating to government regulation.[39]

[37] For a complete list of CHBRP's current librarians, see Appendix 6.
[38] See Appendix 15, CHBRP Conflict-of-Interest Policies, General Disclosure Form, and NAC Disclosure Form.
[39] The UC and CHBRP are grateful to the NAS for extending its permission to use the NAS form.

It is essential that the work of the participants in CHBRP activities not be compromised by any material conflict of interest. All who participate in the development of CHBRP's analyses are required to complete and submit the disclosure form and to update it annually or whenever compelled by a change of circumstance (e.g., a new investment, equity interest, change of employment, or the specific nature of a given item of legislation for review). The completed forms are recorded and reviewed by CHBRP's Director and UCOP administrative personnel who monitor potential conflicts and, as appropriate, request recusals where actual or perceived conflicts of interest arise in relation to a given bill.

FTF members are encouraged to publish their research results in peer-reviewed journals; however, they are expected to avoid legislative testimony or lobbying related to the findings of CHBRP studies while serving on the FTF.

Clarifying Bill Language

Legislative language in benefit mandate and repeal proposals is sometimes vague and difficult to interpret. It is important for CHBRP to interpret bills reasonably and correctly since the interpretation can often alter the scope of an analysis or the accuracy of impact estimates. Examples of potential questions include: (1) whether the mandate applies to all insurance markets (e.g., large group, small group, and individual); (2) whether the mandate applies to all populations (e.g., adults and children); and (3) whether the mandate restricts utilization management or affects physician referral requirements.

CHBRP's general approach is to interpret the bill language by considering only the bill "as written." Regulatory staff from DMHC have told CHBRP that they refer to secondary sources for legislative intent only if the law was not clear on its face or was ambiguous. For this reason, CHBRP focuses on the bill "as written" whenever possible. However, in order to address instances of ambiguous language, CHBRP developed a protocol that allows analytic teams to request clarification of intent directly from the bill author's office. As part of this protocol, CHBRP conducts an interview with the bill author's staff shortly after each bill request is received. Using a standardized questionnaire, CHBRP staff works with the bill author's office (and occasionally the relevant legislative policy committee) to confirm mutual understanding of both the intent of the bill and the likely interpretations of the bill as written.[40] CHBRP's analysis then proceeds based on the agreed upon interpretation of the bill as written.

CHBRP's standard questionnaire allows staff, in plain language, to clarify a number of elements crucial to providing useful reports. The process identifies the issue or problem being addressed and the solution that the bill seeks to create. The process also identifies the populations for which the bill (or repeal) may affect health benefit coverage, and whether any populations are purposefully excluded. It also gives CHBRP staff an opportunity to ask for copies of any studies, standards of care, or other documents that the author's office finds relevant. CHBRP staff also uses this process to ask whether similar bills have been introduced previously in California or in any other state to provide additional context.

[40] For the full questionnaire, see Appendix 17.

Obtaining Data From Health Plans and Insurers

CHBRP must obtain accurate and timely data from health plans and insurers to conduct its cost impact analyses. Since the program's establishment, CHBRP has worked with the California Association of Health Plans (CAHP) and the Association of California Life & Health Insurance Companies (ACLHIC) to obtain contact information from the largest (by enrollment) health plans and insurers in the state. Enrollment in their plans and policies represent more than 90% of persons with privately funded health insurance that can be subject to subject to state mandates.[41] CHBRP has routinely collected data from health plans and insurers to obtain information about what proportion of the insured population has coverage for the mandated benefit.

As noted below, CHBRP conducts an Annual Enrollment and Premium Survey of the largest health plans and insurers and collects analysis-specific data via a coverage survey for each proposed benefit mandate. Details on these surveys are provided below.

Annual Enrollment and Premium Survey

Before the legislative session, CHBRP collects enrollment and premium data through a survey of health plans and insurers. These data are used: (1) to identify the population in health plans and insurance policies subject to state-mandated benefits (i.e., health plans and insurance policies regulated by the DMHC and the CDI); and (2) to categorize enrollment by type of purchaser: small-group (2 to 100 employees), large-group (101+ employees), and individual (non-group) purchasers. In the individual market, the data are further broken down by age and gender. These data are limited to the population enrolled in privately purchased health plans and insurance policies because enrollment and premium data are available from public sources for publicly purchased health insurance.

The Annual Enrollment and Premium Survey has been refined in two ways since 2006. First, the annual survey was expanded to obtain information on enrollment by deductible (i.e., low- or high-deductible), so that the cost analysis could project estimates for bills that specifically address high-deductible health plans. Secondly, in 2012, in anticipation of the 2013 analytic cycle, CHBRP began collecting data breaking out enrollment in terms of grandfathered and nongrandfathered plans as outlined in the ACA. This was necessary because CHBRP anticipated that benefit mandates would have differential impacts on nongrandfathered plans that included EHBs and other ACA compliant features relative to grandfathered plans.

Bill-specific surveys

Following the receipt of a request for bill analysis from the California Legislature, CHBRP sends a bill-specific coverage survey to health plans and insurers that focuses on information necessary for CHBRP to conduct the analysis. Examples of data requested include: (1) existing (baseline) coverage for the proposed mandate; (2) cost sharing; (3) other benefit limits or rules (e.g., prior authorization, limitations based on specific clinical guidelines); (4) changes that might impact administrative costs; and (5) differential impacts between self-insured and fully insured products.

[41] It is important to note that it is CHBRP's policy to mask plan-identifying information and to report data in aggregate in its analyses. For more information about this policy, see Appendix 18.

Obtaining Information From Consumer Groups and Other Stakeholders

CHBRP has established a process for obtaining information from interested parties for bills under analysis. "Interested parties" are defined by CHBRP as any member of the public, such as bill sponsors, disease-specific organizations, consumer advocate organizations, health plans, or health care industry interests. CHBRP announces each new legislative request on its website and via its mailing list.[42] All interested parties who believe they have scientific evidence relevant to CHBRP's analysis of proposed health insurance benefit mandates are encouraged to provide that information to CHBRP's staff. In order for CHBRP to meet its statutory 60-day deadline to complete its analyses, CHBRP requests interested parties to submit information within the first 14 days of the review cycle. Currently there are approximately 740 people signed up to receive such notices, including legislative staff, consumer and interest groups, health plan representatives, and state government agency employees from California and other states.

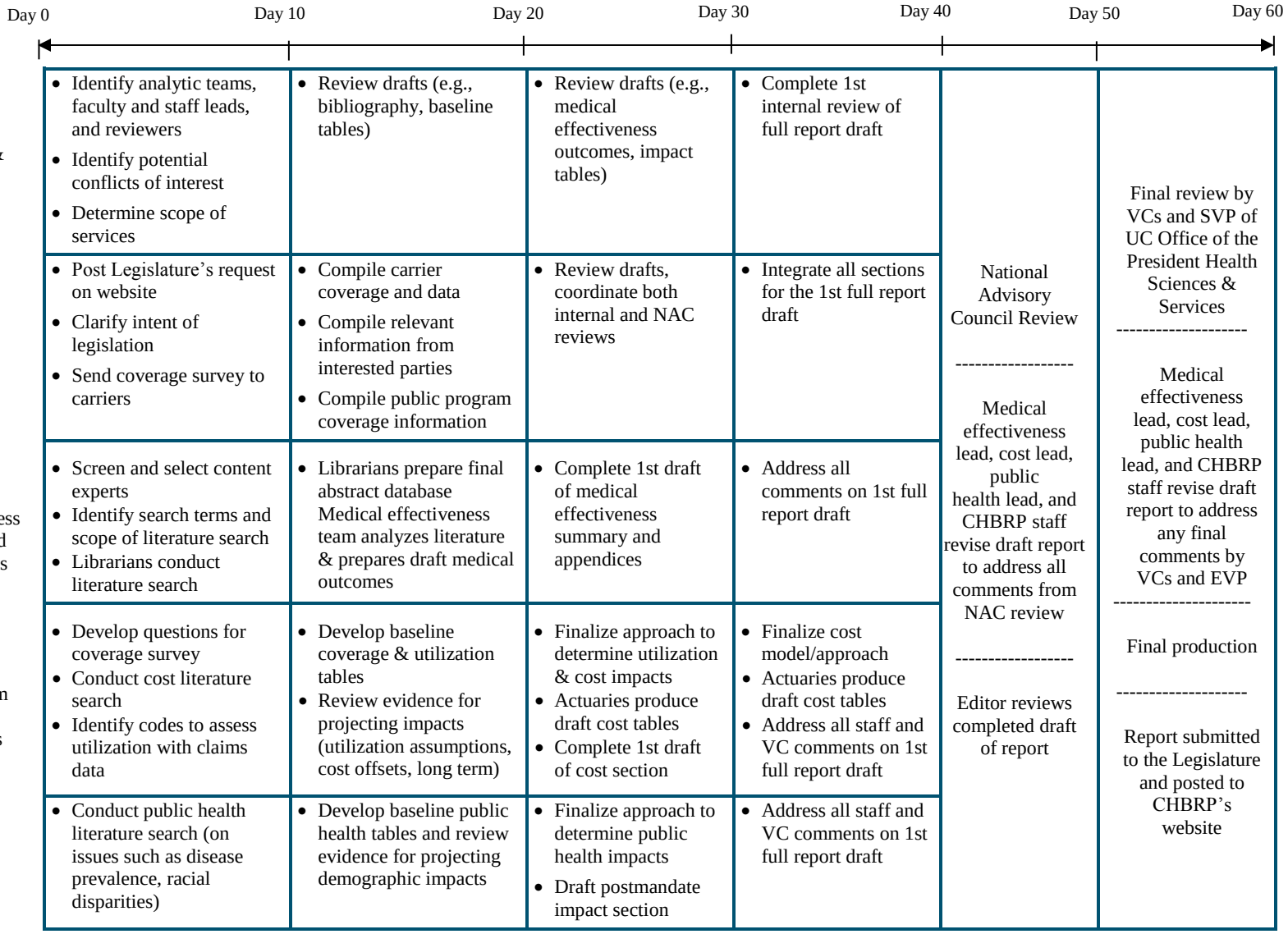
Once CHBRP receives information submitted by the public, that information is disseminated to the analytic teams and the actuaries. The respective teams (medical effectiveness, cost, and public health) then review the information to determine whether the evidence submitted is relevant to the analysis and meets the standard of rigor for inclusion. If the information is relevant and meets the inclusion criteria, the teams decide how to incorporate the information into the analysis. All publically submitted information is listed in an appendix in the relevant analysis.

60-Day Timeline

In order to address the evaluation criteria specified in CHBRP's authorizing statute in a timely, transparent manner, CHBRP uses a 60-day timeline (and on occasion, less) that details which activities occur on what day.[43] The 60-day clock is initiated upon receipt of a request from the Senate Health Committee or the Assembly Health Committee. Figure 3 below provides a broad illustration of the tasks and responsibilities for each of the teams within the 60-day timeline.

[42] Any interested party may request that he or she be added to the mailing list, or may add themselves via the CHBRP website at www.chbrp.org.
[43] For more detail on CHBRP's 60-day timeline, see Appendix 13.

Figure 3. 60-Day Timeline of a CHBRP Analysis



Key: CHBRP = California Health Benefits Review Program; EVP = executive vice president; NAC = National Advisory Council; UC = University of California; VC = vice chair.

Disseminating CHBRP Reports

CHBRP electronically submits reports to the Chairs and Vice Chairs of the Senate and Assembly Health Committees and to other Chairs and Vice Chairs of Committees that are likely to hear CHBRP-analyzed bills (e.g., the Appropriations Committees), and several relevant state agencies, regulators, and the Office of the Governor.

CHBRP's website, www.chbrp.org, provides full access to all CHBRP reports and the legislation analyzed in the reports, as required by statute. The website also announces new requests from the Legislature and provides instructions on how interested parties can provide CHBRP with evidence they believe should be considered in its analyses. Reference documents describing CHBRP's processes and methods are available on the website, as well as lists of individuals associated with CHBRP's work, including CHBRP's staff, FTF members and contributors, and NAC members.[44] Lastly, the website serves as the primary medium for making announcements. In 2012, the CHBRP website was redesigned to promote greater accessibility and ease of use for CHBRP's many stakeholders, and to allow access to CHBRP's materials and analyses by web visitors using mobile web browsers (such as those found on smartphones and tablets). CHBRP is in the process of further improvements and redesign of its website, which will be completed by the end of 2016.

Analytic Methods

Medical Effectiveness Analysis

CHBRP's authorizing statute requires the program to analyze the following with regard to the analyses of medical effectiveness[45]:

- The extent to which the benefit or service is generally recognized by the medical community as being effective in the screening, diagnosis, or treatment of a condition or disease;
- The current availability and utilization of a benefit or service by treating physicians;
- The contribution of the benefit or service to the health status of the population; and
- The extent to which mandating or repealing the benefits or services would not diminish or eliminate access to currently available health care benefits or services.

This section presents the current methods used by CHBRP to conduct the medical effectiveness analyses.

CHBRP's approach to medical effectiveness analysis

CHBRP's approach to medical effectiveness analysis is grounded in the principles of evidence-based medicine (EBM). CHBRP applies the principles of EBM to health insurance mandates by

[44] For full lists of CHBRP staff and contributors, see Appendices 2, 3, and 4.
[45] For full details on CHBRP's medical effectiveness approach, see Appendix 10.

systematically reviewing the medical literature to assess the effectiveness of interventions (e.g., preventive services, diagnostic tests, treatments) addressed by proposed mandates.

Once CHBRP receives a request from the State Legislature, the medical effectiveness team defines the parameters for a search of the medical literature in consultation with a medical librarian and an expert on the disease or condition to which the proposed mandate would apply. Once the literature search is completed, the medical effectiveness team selects studies for inclusion in the review based on a hierarchy of evidence that ranks studies by the strength of the evidence they present.

Team members systematically evaluate evidence across five domains, as illustrated in Table 5.

Table 5. Ranking Studies Used in a CHBRP Medical Effectiveness Analysis

Domain	Description
Research design	Studies with strong research designs are more likely to yield accurate information about an intervention's effects.
Statistical significance	Statistical significance indicates whether the association between an intervention and an outcome is stronger than that which might occur by chance.
Direction of effect	The direction of effect reveals whether the intervention is associated with better or poorer outcomes or has no effect on outcomes.
Size of effect	The size of effect suggests whether an intervention's effect is sufficiently large to be clinically meaningful to patients and/or their caregivers.
Generalizability of results	Generalizability concerns the applicability of a study's findings to the population to which a proposed mandate would apply. Many studies, for example, assess populations that are not as racially/ethnically diverse as California's.

Source: California Health Benefits Review Program, 2016.

Conclusions regarding an intervention's effects on outcomes are based on the strength of the evidence across the five domains described above. Medical effectiveness findings may relate to any one of a number of types of outcomes including the following:

- Physiological (e.g., blood pressure);
- Behavioral (e.g., smoking cessation);
- Cognitive (e.g., improved short-term memory);
- Functional status (e.g., activities of daily living, such as bathing and dressing);
- Quality of life (e.g., overall sense of well-being);
- Morbidity (e.g., specific complications, progression of disease, restricted activity days);
- Mortality (e.g., years of life lost); and
- Health care utilization (e.g., emergency department visits).

If the language of a bill references specific outcomes, these outcomes will be included in the review. If the bill does not mention specific outcomes, the team and the content expert will identify the outcomes most relevant to the proposed mandate or repeal.

Content of the medical effectiveness sections of CHBRP reports

The medical effectiveness section of the main text includes information regarding:

- Services covered under the proposed mandate;
- Outcomes of interest;
- Methods used to gather evidence;
- Evidence for each outcome measure assessed; and
- Medical effectiveness team's conclusion regarding the effectiveness of the intervention.

All CHBRP reports contain a qualitative synthesis of the medical literature on the outcomes of interest. In some cases, the effectiveness team also produces quantitative estimates of effectiveness for select outcomes.

The reports also include a graphic figure that summarizes the findings for each outcome with regard to research design, statistical significance, direction of effect, size of effect, and generalizability, as well as CHBRP's conclusion regarding the intervention's effectiveness.

Further information about the effectiveness analysis is presented in two standard appendices in the reports. The first appendix describes the methods used to conduct the literature review. The second appendix consists of a table that lists the studies included in the medical effectiveness analysis and their major characteristics, such as the specific screening test, diagnostic test, or treatment assessed, the research design, the sample size, the population studied, and the location in which the study was conducted.

Enhancing the medical effectiveness analysis

Since CHBRP's reauthorization, the medical effectiveness team has worked to enhance the medical effectiveness analysis in three key areas: (1) developing criteria for using the grey literature; (2) developing criteria for using clinical practice guidelines; and (3) presenting the findings of the literature analysis.

Grey literature

The medical effectiveness team expanded the scope of its literature searches to include the grey literature, which consists of material that is not published commercially or indexed systematically in bibliographic databases. The grey literature is primarily composed of technical reports, working papers, dissertations, theses, business documents, and conference proceedings. The medical effectiveness team decided to incorporate grey literature into CHBRP's literature searches due to delays between the completion of relevant studies and their publication in peer-reviewed sources and concerns that bias could arise if only peer-reviewed sources for literature were evaluated for inclusion in its reviews. For example, medical journals have a subtle bias against publishing negative findings. CHBRP's hierarchy of evidence is applied in a consistent fashion to both the peer-reviewed literature and the grey literature.

Clinical practice guidelines

Clinical practice guidelines are statements about appropriate health care for specific diseases or conditions that are intended to help clinicians and patients make decisions regarding screening, diagnostic testing, or treatment (IOM, 1990). CHBRP developed the following criteria to standardize the use of guidelines in medical effectiveness analyses. In cases where a bill would mandate coverage for an intervention that is "consistent with national guidelines" or where a guideline is specified in a bill or is an obvious source of bill language, the medical effectiveness team constructs a table that summarizes pertinent guidelines and rates the transparency of the guideline's development process and the strength of the evidence on which they are based. In cases where a bill does not reference any guidelines, the medical effectiveness team will apply the hierarchy of evidence and review guidelines only when little information is available from more highly ranked sources of evidence or when the information is conflicting.

Presentation of the findings of the medical effectiveness analysis

CHBRP received feedback that early CHBRP reports' discussions of the findings of the medical effectiveness analysis were sometimes difficult to grasp. The medical effectiveness team therefore developed a method to present an overall conclusion for an outcome that captures all the factors in determining the quality of the available evidence (research design, statistical significance, direction of effect, size of effect, and generalizability). The conclusion is a statement that captures the strength and consistency of the evidence of an intervention's effect on an outcome. The following terms are currently used to characterize the body of evidence regarding an outcome.

- Clear and convincing evidence with
  - Favorable effect
  - No effect
  - Unfavorable effect
- Preponderance of evidence with
  - Favorable effect
  - No effect
  - Unfavorable effect
- Ambiguous/conflicting evidence
- Insufficient evidence

Cost Impact Analysis

CHBRP's authorizing statute requests that CHBRP provide two sets of financial information to assist the Legislature's consideration of benefit proposed health benefit mandates: (1) current

benefit coverage, utilization and cost (premandate); and (2) projected changes in coverage, utilization and costs after the implementation of a mandate (postmandate).[46]

The specific information regarding current coverage requested by the California Legislature for each mandate includes:

- Existing coverage of the service in the current insurance market;
- Current utilization and cost of providing a benefit;
- Public demand for coverage among self-insured plans; and
- Current costs borne by insurers.

The specific information regarding post-mandate effects requested by the Legislature includes:

- Changes in utilization;
- Changes in the per-unit cost of providing the service;
- Administrative costs;
- Impact on total health care costs;
- Costs or savings for different types of insurers; and
- Impact on access and availability of services.

This section presents the current methods used by CHBRP to conduct the cost impact analysis of proposed mandated benefits as required and highlights adjustments that CHBRP has had to make to account for changes resulting from the ACA.

California Cost and Coverage Model

CHBRP developed the CCM to produce baseline and postmandate financial impacts requested by the Legislature. CHBRP's Cost Model is an actuarial forecasting model, using data from the CHBRP's annual enrollment and premium survey, administrative payer data, the California Health Interview Survey and the California Employer Health Benefits Survey. Each year, a team of economists and researchers from a number of UC campuses, along with contracted actuaries and CHBRP staff, update and refine the CCM.

Before CHBRP can measure an incremental change resulting from a proposed mandate, it must first establish a starting point, or baseline. This is a two-step process: first requiring CHBRP to estimate current overall health insurance coverage for California; and then, estimating current coverage for a specific proposed mandate.

Current coverage overall: To establish a baseline, CHBRP determines:

[46] For full detail on CHBRP's cost approach, see Appendix 11.

- Enrollment: Number of Californians currently enrolled in state-regulated health plans in relevant market segments (individual, small group, large group), CalPERS HMO plans, and Medi-Cal Managed Care;
- Premiums: Current premiums by market segment (split by DMHC-regulated or CDI-regulated individual, small group, and large group).

A comprehensive list of CHBRP's sources for coverage and demographic data can be found in Appendix 11, but in short, CHBRP relies on both public administrative data, as well as an annual survey of the state's largest insurance carriers.

Baseline adjustments to account for the ACA: Beginning with the analyses CHBRP completed for the 2013 Legislative cycle and continuing through the present, CHBRP has made adjustments to its cost model in order to account for on-going implementation of the ACA. Key changes were made regarding:

- **Enrollment:** CHBRP began relying on the California Simulation of Health Insurance Markets (CalSIM), a microsimulation model, in addition to its usual sources of enrollment data, to estimate how enrollment would change post-ACA implementation in response to the introduction of a health insurance marketplace, the individual mandate and subsidies, and the expansion of Medi-Cal.
- **Market segments:** The ACA imposes additional requirements on health insurance products created after March 23, 2010. These plans are considered "nongrandfathered." Health insurance that existed before that date is considered "grandfathered" and the ACA has limited authority over those plans. In order to determine enrollment and premium costs associated with enrollees in grandfathered versus nongrandfathered health insurance, since 2012, CHBRP's Annual Enrollment and Premium Survey has asked the state's largest health plans and insurers to include that detail as part of its annual survey instrument. Beyond grandfathered and nongrandfathered plans, the addition of a health insurance marketplace (Covered California),[47] where Californians could purchase federally subsidized insurance, was also included as a market segment in each year's updated Cost Model.
- **Mandate-specific baseline**: Coverage: For each proposed mandate, CHBRP surveys each of the state's largest insurance carriers on specific tests, treatments, and services relevant to the mandate. These surveys provide CHBRP with baseline coverage for a proposed mandate (as opposed to baseline coverage for health insurance generally), which would change based on the details of proposed legislation.
- **Utilization and unit cost**: CHBRP must also determine how frequently a treatment or service is currently used—whether or not an individual has benefit coverage—and how much each unit of the test, treatment, or service costs. This is determined using a variety of sources, including the contracted actuary's private datasets and MarketScan, a database to which the actuaries subscribe for access. In addition, academic literature related to health costs, guidance from content experts, and information from other sources may be needed to estimate utilization, unit cost, or both.

[47] CHBRP estimated Covered California enrollment using CalSIM.

Definitions/components of the Cost and Coverage Model

Cost: Cost is defined as the aggregate expenditures for health care services. (It is not the costs incurred by health care providers.) The rationale for this definition of "cost" is that legislators are ultimately interested in evaluating the financial impact of mandates on the major *payers* for health care services in the state.

In evaluating aggregate expenditures, CHBRP includes:

- Insurance premiums (paid by employers, government, and enrollees);
- Enrollee cost sharing (copayments, deductibles, and coinsurance paid by enrollees using the benefit);
- Enrollee expenses for noncovered health benefits (paid by enrollees using a service who have health insurance, but whose insurance does not cover specified services); and
- Total expenditures for health insurance (premiums, enrollee cost sharing, and enrollee expenses for noncovered benefits).

Utilization: Utilization is defined as the frequency or volume of use of a mandated service.

Coverage: Coverage is defined as the extent to which the mandated services are covered by state-regulated health insurance.

The model includes two types of health insurance plans or policies:

1. "Knox-Keene" plans: These include health maintenance organizations (HMO), point-of-service (POS) health plans, and certain preferred provider organization (PPO) health plans subject to the requirements of the Knox-Keene Health Care Service Plan Act of 1975. These plans are regulated by the Department of Managed Health Care and are included in one category because they are similar in type and regulatory requirements.

2. "Insurance" policies: These include PPOs and fee-for-service (FFS) health insurance products subject to the California Insurance Code, which are regulated by the California Department of Insurance.

These plan types are divided in California into three market segments representing private purchaser categories:

- Large group—101 or more employees (51 or more prior to 2016);
- Small group—2 to 100 employees (2 to 50 prior to 2016); and
- Individual market (direct purchase).

Because some requirements of the ACA do not apply to "grandfathered" health insurance that existed before March 23, 2010, CHBRP's California Cost and Coverage Model also makes a distinction between "grandfathered" and "nongrandfathered" plans.

Coverage and demographic data sources.

The following bullets provide an enumeration of all data sources in California's Cost and Coverage Model:

- The California Simulation of Insurance Markets (CalSIM) is used to estimate health insurance status of Californians aged 64 and under. CalSIM is a microsimulation model that was created to project the effects of the Affordable Care Act on firms and individuals.[48] CalSIM relies on data from the Medical Expenditure Panel Survey (MEPS), the California Health Interview Survey (CHIS), analysis data from the California Employment Development Department, and the most recent California Employer Health Benefits Survey.
- The California Health Interview Survey (CHIS) is used to estimate the number of Californians aged 65 and older, and the number of Californians dually eligible for both Medi-Cal and Medicare coverage.[49] CHIS is a continuous survey collected annually that provides detailed information on demographics, health insurance coverage, health status, and access to care. Prior to 2011, CHIS was conducted every 2 years with a sample of over 40,000 households. Beginning in 2011, the CHIS is collected continuously, surveying over 20,000 households each year, and is conducted in multiple languages by the UCLA Center for Health Policy Research.
- The most recent California Health Care Foundation/National Opinion Research Center (CHCF/NORC) survey of California employers is used to obtain estimates of the characteristics of the employment-based insurance market, including firm size, plan type, self-insured status, and premiums. The CHCF/NORC survey, collected annually since 2000, is based on a representative sample of California's employers.
- CalPERS premiums and enrollment are obtained annually from CalPERS administrative data for active state and local government public employees and their family members who receive their benefits through CalPERS. Enrollment information is provided for fully-funded, Knox-Keene licensed health care service plans covering non-Medicare beneficiaries.
- The California Department of Health Care Services (DHCS) supplies CHBRP with the statewide average premiums negotiated for the Medi-Cal Managed Care Two-Plan Model and generic contracts with health plans participating in Medi-Cal Managed Care program. Administrative data for the Medicare program is obtained online from the federal agency the Centers for Medicare & Medicaid Services (CMS).

[48] UC Berkeley Center for Labor Research and Education and UCLA Center for Health Policy Research. *Methodology & Assumptions, California Simulation of Insurance Markets (CalSIM) Version 1.7,* June 2012. Available at www.healthpolicy.ucla.edu/pubs/files/calsim_methods.pdf. Accessed October 19, 2012.

[49] Although CHIS collects data on Californians of all ages, CHBRP's analysis relies on the survey particularly for information on the population aged 65 years and over.

- CHBRP also conducts a survey of the largest health plans and insurers in California, whose enrollment together represents over 90% of the persons with health insurance subject to state mandates. Although it is important to note that it is CHBRP's policy to mask plan/insurer identifying information and to report data in aggregate in its analyses,[50] the surveyed health plans and insurers are: Aetna, Anthem Blue Cross, Blue Shield of California, CIGNA, Health Net, and Kaiser Permanente. These surveys provide data to determine baseline enrollment in the non-group (individual) market, and distributions between grandfathered and nongrandfathered insurance plans.

Utilization and expenditure data sources. The utilization and expenditure data for the California Cost and Coverage Model are drawn primarily from multiple sources, including the contracted actuaries' private datasets and MarketScan, a database to which the actuaries subscribe for access. In addition, academic literature related to health costs, guidance from content experts, and information from other sources may be needed to estimate utilization, unit cost, or both.

CHBRP's most recent estimates for California's population, divided by health insurance market segments are given in Table 6.

[50] For more information about this policy, see Appendix 18.

Table 6. CHBRP Estimates of Sources of Health Insurance in California, 2017

Publicly Funded	Ages	DMHC Regulated		Other Regulators		Total
Medi-Cal	0–17	3,301,000		174,000		3,475,000
	18–64	3,030,000		159,000		3,189,000
	65+	12,000		23,000		35,000
Medi-Cal COHS	All	—		1,183,000		1,183,000
Dually eligible-Medicare & Medi-Cal	All	549,000		690,000		1,239,000
Medicare (non–Medi-Cal)	All	—		—		4,195,000
CalPERS	All	861,000		297,000		1,158,000
Other public	All	—		—		791,000
Privately Funded	**Ages**	**DMHC Regulated**		**CDI Regulated**		**Total**
		Grand-fathered	**Non-Grand-fathered**	**Grand-fathered**	**Non-Grand-fathered**	
Individual market subsidized	0–17	—	34,000	—	—	34,000
	18–64	—	1,740,000	—	4,000	1,744,000
	65+	—	—	—	—	—
Individual market nonsubsidized	0–17	57,000	305,000	77,000	24,000	396,000
	18–64	266,000	1,432,000	359,000	113,000	1,855,000
	65+	1,000	5,000	1,000	—	6,000
Small group	0–17	110,000	592,000	2,000	181,000	885,000
	18–64	327,000	1,756,000	7,000	536,000	2,626,000
	65+	3,000	17,000	—	5,000	25,000
Large group	0–17	591,000	1,696,000	7,000	71,000	2,365,000
	18–64	1,754,000	5,032,000	20,000	209,000	7,015,000
	65+	17,000	48,000	—	2,000	67,000
Self-insured	All	—	—	—	—	3,236,000
Uninsured	**Ages**					**Total**
	0–17					317,000
	18–64					2,302,000
	65+					44,000
Total population	**All**					**38,566,000**

Source: California Health Benefits Review Program, 2016.
Key: CalPERS = California Public Employees' Retirement System; CDI = California Department of Insurance; COHS = county operated health system; CovCA = Covered California (the state's health insurance marketplace); DMHC = California Department of Managed Health Care.

Public Health Impact Analysis

The public health impact analyses capture the potential value of a proposed health benefit mandate—what health outcomes might be expected from implementation of the mandate. Short-term (1 year) costs and impacts are estimated quantitatively when possible. The analyses focus on the health outcomes of Californians with health insurance that may be subject to a health benefit mandate law passed at the state level.

This section describes the methodology and assumptions that CHBRP developed to conduct public health impact analyses of proposed health benefit mandates, as required by the program's authorizing statute.[51]

Health outcomes and data sources

Prior to collection of baseline public health data, the CHBRP public health team determines the relevant health outcomes related to the proposed health benefit mandate. These decisions are made in consultation with a content expert and the medical effectiveness team. Examples of health outcomes include reductions in morbidity; mortality; disability; days of hospitalization and emergency department visits; changes in self-reported health status; improvements in physiological measures of health such as blood pressure, cholesterol, weight, and forced expiratory volume; changes in health behaviors such as increased physical activity or quitting smoking; and improvements in the quality of life. Also, when possible, CHBRP presents an assessment of potential harms and financial burden related to the mandate. For each defined health outcome, baseline data on the incidence, prevalence, and health services utilization rates of associated conditions are collected. The public health team uses a five-tiered hierarchy of evidence to prioritize sources of incidence and prevalence data:

- Tier 1. Registries with California-specific census counts;
- Tier 2. Surveys with California-specific estimates;
- Tier 3. Surveys with national estimates only, peer-reviewed literature, or grey literature;
- Tier 4. Actuarial contractor database; and
- Tier 5. Content experts.

Examples of data sets used to conduct the public health impact analysis include the California Cancer Registry (Tier 1), the California Health Interview Survey (CHIS) (Tier 2), and California agency reports (Tier 3). Baseline data on prevalence/incidence for the disease/condition and relevant outcomes are presented in each report. This provides context for analyses in the medical effectiveness, cost and utilization, and public health sections.

[51] For more detailed information about CHBRP's public health approach, see Appendix 12.

Impact on public health

The data elements needed to estimate the short-term public health impact on the overall health of Californians with health insurance that may be subject to a health benefit mandate law passed at the state level include:

- Baseline incidence and health outcomes of the relevant condition(s);
- The medical effectiveness of the mandated health benefit; and
- The impact on coverage and utilization due to the mandate.

First, using registry- or survey-based datasets and/or literature, the public health team estimates baseline health status relevant to the health benefit bill. This includes, but is not limited to, rates of morbidity (disease), mortality, premature death, disability, health behaviors, and other risk factors stratified by age, gender, race, and ethnicity. Second, the public health impacts section uses findings from the literature review in the medical effectiveness analysis. The literature review commonly includes meta-analyses and randomized controlled trials, which provide information on the effectiveness of the proposed benefit or service on specific health outcomes. Third, the public health impacts section uses estimated changes in benefit coverage and/or utilization of treatments or services relevant to the proposed legislation from the cost impact analysis section. Estimated changes in benefit coverage include the number of insured Californians who are presently covered for the proposed benefit and the number who would be newly covered if the mandate were enacted. The cost section also estimates changes in utilization rates for insured Californians who are presently covered for the proposed benefit and for those who will be newly covered for the benefit, postmandate. Using these data elements, estimates are made regarding the impact of new utilization of the mandated benefit on specific health outcomes in the affected population (e.g., the effect of asthma self-management training on the reduction of hospitalizations for asthma). The results are compiled by the public health team to produce an overall mean estimate that can be used to calculate the predicted short-term (1 year) health effects of the benefit mandate.

Impact on gender and racial disparities

When possible, CHBRP reports detail differences in disease prevalence, health services utilization, and health outcomes by gender and race/ethnicity, preferably in the insured population. Four steps are used to assess whether disparities exist and whether the proposed mandate will have an impact on gender and/or racial disparities:

- Conduct a literature review;
- Review data sources for prevalence, utilization, and outcome data by race/ethnicity and gender;
- Determine whether a mandate will impact disparities; and
- Determine whether a change in disparities can be quantified.

Impact on premature death and economic loss

In addition, the public health team estimates the extent to which the proposed benefit would reduce premature death and the economic loss associated with conditions affected by the benefit mandate. In order to calculate an expected impact on premature death, mortality must be a relevant health outcome; the treatment or service must be medically effective at reducing mortality; and the mandate must increase coverage or utilization of the benefit. Where premature death is a relevant outcome, the public health team conducts a literature review to determine if societal costs of illness (indirect costs) have been established and uses the evidence to support one of four conclusions: disease/condition is not relevant to economic loss; impact of mandate on economic loss is unknown; mandate is not estimated to affect economic loss; or mandate is estimated to increase economic loss.

Long-term impacts
When the expected benefits may not be realized within the 1-year time frame used in the cost and utilization analyses, the public health team also projects the long-term public health impacts (beyond 12 months) associated with a benefit mandate. In this case, the public health team generally relies on qualitative assessments based on longitudinal studies and other research about the long-term impacts of health interventions affected by the mandate. This type of analysis is especially relevant for preventive care and disease management programs where the benefits accrue over many years.

Analyzing Repeal Bills

As discussed previously, under SB 1704 CHBRP's statutory charge was expanded to include analysis of health benefit mandate repeals. The authorizing statute defines a "repeal" bill as a proposed statute that, if enacted, would repeal an existing requirement that a health care service plan or a health insurer do any of the following:

- Permit a person insured or covered under the policy or contract to obtain health care treatment or services from a particular type of health care provider;
- Offer or provide coverage for the screening, diagnosis, or treatment of a particular disease or condition;
- Offer or provide coverage of a particular type of health care treatment or service, or of medical equipment, medical supplies, or drugs used in connection with a health care treatment or service.

Per discussions with legislative staff, the following types of bills would be considered a "repeal" bill and could trigger a request for CHBRP to conduct an analysis:

- A bill that would relax a mandate to *cover* a service and instead require carriers simply to *offer* that coverage;
- A bill that would allow carriers to develop products for a subset of the market, which would be exempt from a set of mandates, such as limited benefit plans for small employers; and

- A bill that would relax coverage level requirements; for example, repealing requirements to cover a certain set of services at "parity" levels or eliminating coverage requirements altogether.

In developing methodology for analyzing repeal bills, CHBRP considered what analytic questions within its charge were relevant for the Legislature's consideration.

Overall approach

When determining the analytic approach to a repeal bill, CHBRP considers the scope of the benefits that would be affected. In 2007, CHBRP developed methods to anticipate the receipt of the various types of bills that would be considered a "repeal" bill, for example, a bill that would repeal a single benefit mandate or a bill that would affect benefit packages. CHBRP has thus far only received requests to analyze bills that would allow carriers to develop and sell products that are not subject to California benefit mandate laws.

Medical effectiveness analytic questions and approach. The analytic questions for medical effectiveness are essentially the same as for a mandate bill: 1) to what extent is the benefit or service generally recognized by the medical community as being effective; and 2) to what extent is the benefit or service generally available and utilized by treating physicians. However, given that the repeal bills CHBRP has analyzed to date sought to address the full range of benefit mandates authorized in law, the analytic approach applied to medical effectiveness has necessarily been modified.

As an example, AB 1904 (Villines, 2010) would have effectively permitted the waiver of California's current health insurance benefit mandate and mandated offering statutes—statutes that address numerous health care services for a wide range of diseases and conditions. CHBRP reviewed evidence regarding the medical effectiveness of 34 of the mandates that could have been waived under AB 1904. Nine mandates were not analyzed because they would not require coverage for specific diseases or health care services, but instead would require coverage for a vaccination that had yet to be approved by the Food and Drug Administration, or apply to such a large number of diseases that the evidence could not have been summarized briefly. CHBRP examined each of the 34 mandates to determine whether the mandated benefits were considered to be medically effective based on existing evidence. Conclusions were drawn from the U.S. Preventive Services Task Force recommendations, CDC recommendations, NIH guidelines, and other authoritative sources. A number of previous CHBRP reports, especially useful when studies or recommendations are limited or unavailable, were also utilized. For example, the medical effectiveness analysis in CHBRP's report on SB 1634 (Steinberg, 2008) was used regarding the effectiveness of orthodontic services for persons with oral clefts, a relatively rare service for which few studies have been completed. Similarly, the medical effectiveness analysis in CHBRP's report on SB 158 (Wiggins, 2009) was used regarding the effectiveness of immunization against human papillomavirus (HPV), a vaccine that was, at the time of CHBRP's report, still relatively new.

Cost impact analytic questions and approach: The cost impact analytic questions and approach used in analyzing repeal bills differs substantially from those used in the analysis of

mandate bills. Currently, an analysis of mandates assumes that the post-mandate coverage levels would be 100%, essentially full and universal compliance with the bills' requirements. However, it would not be reasonable to assume that *all* coverage would be dropped following the effective date of a repeal bill because: (1) the benefit or service may be considered medically necessary per the professional standard of care; (2) employers and individuals may still demand the benefit; and (3) the associated premium decreases may be so minimal that the cost associated with the perception of taking away a benefit or service may seem more costly to the carrier or the purchaser than simply keeping the existing benefit coverage in place. Timing is also an issue of consideration. With a new mandate, carriers have had to comply by the effective date specified in the bill. With a repeal, carriers have the option to offer the newer products that exclude the repealed benefit mandate(s). Some carriers may respond right away, and others may delay in order to monitor what other carriers do and how the market responds. Collective bargaining and inertia could also delay employer response to new choices that become available in the market.

CHBRP identified a series of analytic questions that would need to be addressed and data elements that would need to identified for CHBRP to produce a reliable post-repeal estimate of premiums and health care expenditures. For example:

- Products available for purchase from carriers:
  - Would carriers continue to include the benefit in the "base" benefit package, move it to a "rider," or not offer it at all?
  - If carriers continue to cover/offer the benefit, then with what levels of cost sharing and to what extent would the premium differential be passed down to the employer/individual?
- Employer/purchaser demand or offer rate:
  - What percentage of employers would demand that the benefit continue to be included in the benefit package they purchase? If employers no longer have to provide coverage for a service, how many will continue to offer that coverage to their employees?
  - How would this vary by market segment—i.e., for large groups, small groups, and individual markets?
- Employee/individual take-up rate:
  - How many employees would opt out of employer-based coverage if the mandate was repealed?
  - How many individual members would purchase a plan without coverage for the previously mandated benefit?

An actual estimate of post-repeal coverage (and utilization of benefits) was not ascertainable due to the significant uncertainties surrounding carriers' responses, purchasers' responses, and the take-up rate by the individual or employee. Therefore, to model cost impacts for repeal bills, CHBRP chose to develop hypothetical scenarios that would provide a range of potential cost impacts, given the range of possible market responses. For example, in its analysis of AB 1904

(Villines, 2010), CHBRP determined that the number of possible combinations of the current benefit mandates that insurers might offer, if they were no longer mandated, was practically limitless. For the cost impact analysis of AB 1904, CHBRP's analysis modeled the possible maximum short-term savings using the following three scenarios:

- **Scenario 1: Maximum Impact.** This extreme hypothetical scenario assumes that limited-mandate plans would be purchased by all (i.e., 100%) currently insured Californians in lieu of their current plans. Buyers in all market segments (large group, small group, and individual) and all insurance products (high-deductible, low-deductible, and no-deductible policies) would respond to the lower premiums offered by limited-mandate policies, and would switch to those policies in response to a lower-cost alternative. This scenario projects the impacts of all currently insured persons purchasing policies that are otherwise identical to their current policies, except without a subset of the benefit mandates. This scenario represents the most extreme possible response and should be considered an absolute upper bound. The probability of this scenario occurring is small; therefore, the report offered two more scenarios.
- **Scenario 2: Low-Income Impact.** Because of evidence that employees in the group market prefer generous benefits, and because there is evidence that those in the individual market are the most price-sensitive, this scenario assumes that limited-mandate policies would only have an impact only on the price-sensitive segment of the individual market. However, in contrast to Scenario 1 where it is assumed that all plan participants will switch over, and based on actuarial experience demonstrating take-up by only part of the considered population, this scenario assumes that only 40% of all those insured in this market segment with incomes below 350% of the 2010 federal poverty level (FPL) would switch; thus this scenario assumes that about 16% of the individual market participants will switch to limited-mandate plans. This scenario falls within the range of possibility should AB 1904 be enacted.
- **Scenario 3: Very Low-Income Impact.** This scenario is similar to Scenario 2, and assumes that limited-mandate policies would only have an impact on the most price-sensitive segment of individual and small-group markets. This scenario also assumes that 40% of all those currently insured in the individual market segment with incomes below 200% of the FPL who currently own DMHC- and CDI-regulated individual policies, and 20% of the small-group segment with incomes below 200% of the FPL, will purchase limited-mandate plans. This scenario also falls within the range of possibility should AB 1904 be enacted.

The multiple scenarios offered in the analysis of AB 1904 were considered useful because they show the maximum short-term savings that might be possible if there was broad acceptance of these policies. In its analysis of AB 1904, CHBRP also estimated the short-term impacts on those currently uninsured in California if AB 1904 were to pass and limited-mandate plans were to become available in the market. Finally, potential long-term impacts on the market, such as risk segmentation and possible interactions with the ACA, were qualitatively addressed.

Public health impact analytic questions and approach: The public health impact analytic questions for repeal analysis are essentially equivalent to CHBRP's standard mandate analysis: (1) what is the impact on the health of community; (2) what is the impact on disparities; and (3) what is the extent to which premature death and economic loss are impacted? Given the scope of repeal bills analyzed to date and the approach necessitated for the cost impact analysis, the public health impact analysis also uses multiple-scenario analysis to determine what the population impacts would be if a specific benefit were to be dropped or certain product types were taken up in the market.

Fulfilling CHBRP's Mission

Since its initial authorization, CHBRP has provided rigorous and impartial analysis of benefit mandate legislation for the Legislature and other interested stakeholders. Throughout that time, the program has adapted to changing circumstances, including revisions to its authorizing statute and charge, changes to state health programs, and larger reforms of the health care system such as the ACA. Amidst these changes, CHBRP's work continues to support the legislative process, and has also been helpful to numerous stakeholders in their internal consideration of the merits of benefit mandate bills. The academic rigor that the program provides directly to the Legislature through its use of multidisciplinary academic experts is unique to California, and provides policymakers with credible, independent analysis on demand.

During the period 2014 through 2016, as well as during the prior cycles of CHBRP's authorization, CHBRP's reports and other products have been regarded by the Legislature and parties involved in health insurance as credible sources of information that support policy decision making, thus effectively and carefully achieving the mission described in its authorizing statue.

With the program's funding ending June 30, 2017, (and full sunset of the program set for December 31, 2017 CHBRP looks forward to working with the Legislature on reauthorization in the coming months, and incorporating enhancements to CHBRP's model that even further strengthen CHBRP's utility and value to the Legislature, as well as to other relevant policymakers and stakeholders. We are most appreciative of the ongoing opportunity to support the policymaking process with independent, objective, and evidence-based analysis.

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The California Health Benefits Review Program is administered by UC Health at the University of California, Office of the President. UC Health is led by John D. Stobo, MD, Executive Vice President. A group of faculty, researchers, and staff complete the analysis that informs California Health Benefits Review Program (CHBRP) analyses. The CHBRP Faculty Task Force comprises rotating senior faculty from University of California (UC) campuses. In addition to these representatives, there are other ongoing contributors to CHBRP from UC that conduct much of the analysis. The CHBRP staff coordinates the efforts of the Task Force and contributors as well as campus-based librarians in preparing parts of the analysis, and manages all external communications, including those with the California Legislature. As required by CHBRP's authorizing legislation, UC contracts with a certified actuary, PricewaterhouseCoopers, to assist in assessing the financial impact of health insurance benefits bills. The National Advisory Council (NAC) provides expert reviews of draft analyses and offers general guidance on the program to CHBRP staff and the Faculty Task Force. Full membership lists of CHBRP's current staff, Task Force, NAC, actuaries, and librarians are included in Appendices 2, 3, 4, 5, and 6, respectively, of this implementation report.

CHBRP gratefully acknowledges all of these contributions but assumes full responsibility for the report and its contents. Please direct any questions concerning this report to my attention, at:

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