

California Health Benefits Review Program

CHBRP Implementation Report of AB 114: 2017-2019

A Report to the California State Governor and Legislature

December 20, 2019



OVERVIEW

The California Health Benefits Review Program (CHBRP) was established by legislation in 2002 to respond to requests from the California Legislature for independent analysis of the medical, financial, and public health impacts of introduced health insurance benefit legislation and health insurance-related topics. The program has since been subsequently reauthorized, most recently in 2017 by Assembly Bill (AB) 114 (Assembly Committee on Budget). This report documents implementation of CHBRP's most recent reauthorization.

CHBRP's authorizing statute¹ requests that the University of California, through CHBRP, analyze introduced health insurance benefit legislation, including benefit mandate and benefit mandate repeal bills.²

CHBRP consists of an analytic staff at the University of California, Berkeley campus, and supports 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 a 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. CHBRP's National Advisory Council of experts 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 \$0.0068 per member per month, in 2019 dollars).

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

¹ Available in Appendix A of this document.

² 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.



A Report to the 2019–2020 California State Governor and Legislature

**CHBRP Implementation Report of Assembly Bill 114:
2017-2019**

December 20, 2019

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

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EXECUTIVE SUMMARY

Since 2003, the California Health Benefits Review Program (CHBRP) has supported consideration of introduced health insurance benefit legislation in the state legislature through independent, academically rigorous, and unbiased analysis. Stakeholders have consistently reported that CHBRP analyses inform and elevate discourse by bringing an objective and widely respected, evidence-based perspective to the policymaking process.

Currently scheduled to sunset on January 1, 2021 (with funding through June 30, 2020), CHBRP was established by Assembly Bill (AB) 1996 (Thomson, 2002), which requested that the University of California (UC) assess legislation proposing health insurance benefit mandates.³ California and 28 other states have passed laws requiring benefit mandate evaluation.⁴

Since the program was established, CHBRP has been continuously reauthorized by the California Legislature. CHBRP was initially authorized by the passage of Assembly Bill 1996 (Chapter 795, Statutes of 2002). The program was reauthorized by the passage of Senate Bill 1704 (Chapter 684, Statutes of 2006), Assembly Bill 1540 (Chapter 298, Statutes of 2009), Senate Bill 1465 (Chapter 442, Statutes of 2014), and then reauthorized through Senate Bill 125 (Chapter 9, Statutes of 2015). CHBRP's sunset was extended to December 31, 2020 by Assembly Bill 114 (Chapter 38, Statutes of 2017).

As of November 2019, CHBRP has conducted 161 bill analyses. Between 2017 and 2019, CHBRP completed a total of 38 analyses, averaging almost 13 bills per session, with 16 completed analyses in 2019. CHBRP's analyses 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 of health insurance-related legislation.

This report describes how CHBRP has fulfilled its charge outlined in the current version of the authorizing statute during the years 2017 through 2019.

Thorough and Rigorous Multidisciplinary Expertise

In order to fulfill the requirements of its authorizing statute, CHBRP staff work in partnership with faculty and researchers drawn from across the University of California system to create reports that detail medical effectiveness, public health, and cost impacts. This structure allows us to work with a team of committed faculty and researchers who hold expertise in their fields, from medicine to public health, economics and library science, and beyond. This multidisciplinary expertise contributes to the thoroughness and sophistication of CHBRP reports, and provides the expertise to meet the wide array of requested topics.

³ The text of CHBRP's most recent authorizing statute can be found in Appendix A.

⁴ For further details on other states' benefit mandate review programs, see CHBRP's publication "Survey and Analysis of Other States' Health Benefit Review Programs (January 2015)" on our website: http://chbrp.org/other_publications/index.php. Click "Additional Publications."

Consideration of Multifaceted Requirements of Health Insurance Benefit Legislation

Because of the breadth of topics that CHBRP analyses cover, staff and faculty must act as knowledgeable health policy generalists with the ability to quickly assemble an analytic framework on legislation with diverse subjects. A proposed benefit mandate that is referred to CHBRP for analysis may require plans regulated by the Department of Managed Health Care or policies regulated by the California Department of Insurance to comply with any (or all) of the following:⁵

- **Disease or condition:** Requiring health insurance coverage of screening, diagnosis, and/or treatment of a specific disease or condition;
- **Tests, treatments, or services:** Requiring coverage of a type of treatment or service;
- **Providers:** Requiring services provided by a specific type of health care provider; and/or
- **Benefit design:** Specifications for benefit design when a benefit is covered (i.e., including no prior authorization requirements, or establishing limits on cost sharing).

In practice, legislation that CHBRP is requested to analyze generally includes more than one of the requirements listed above. Additional complexity can arise because legislation may:

- Apply to multiple diseases/conditions;
- Include numerous tests, treatments, or services;
- Be relevant to multiple types of providers;
- Pertain only to particular market segments (e.g., excluding the large-group market); and/or
- Exempt coverage requirements for enrollees in particular types of plans (such as enrollees in CalPERS health plans or Medi-Cal beneficiaries).

Because of these complexities, CHBRP's analytic approach must consider detailed information on premiums, covered benefits, and benefit design for market subsegments.

CHBRP's analytic approach must also consider possible interactions with one or more benefit floors, other state and federal benefit mandates, the current state of relevant benefit coverage in state-regulated health insurance products, and the current health of enrollees in health insurance that would be subject to the proposed legislation.

CHBRP Analyses During and Beyond the Legislative Session

Stakeholders, including Legislative members and staff, health plans and associations, provider groups, and advocates report relying on CHBRP analyses for fact-based, thoroughly researched information. CHBRP analyses provide in-depth information for Legislative members and staff

⁵ For examples of bills with the following components, refer to the "CHBRP's Charge: Analyses and Approach" section of the main report.

during the Legislative process, and contribute to thoughtful deliberation as the Legislature considers proposed health insurance benefit bills.

The strength of CHBRP's contributions to health benefit mandate conversations is also evident in the continued utility of analyses even beyond the legislative process. Health insurers and regulators report using CHBRP analyses in discussion of appropriate rate increases when analyzed legislation is signed into law, and health insurers also report using CHBRP's medical effectiveness analysis to evaluate 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, and the Institute of Medicine recommended that CHBRP's approach serve as a guide for further defining EHBs in the future. 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.⁶

Increased Complexity

As noted above, CHBRP analyses are conducted on complex and technical subjects. As analyses have become more expensive due to complexity, interactions with possible changes to federal law, inflation, and the price of access to data, CHBRP's authorized funding has remained flat.

Fulfilling CHBRP's Mission

For 17 years, CHBRP's Faculty Task Force and staff have provided rigorous and impartial analysis of health insurance benefit legislation, with efforts to continuously evolve and meet the changing needs of the Legislature and primary readers. The program has adapted to changing circumstances, revisions to our 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. During the period of 2017 through 2019, 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 analyses and other products to support policy decision-making, and have found our efforts to enhance the readability and accessibility of key information in our reports to be helpful and effective. During the most recent reauthorization by Assembly Bill 114 (Chapter 38, Statutes of 2017), as before, CHBRP has provided timely, objective, thorough, and high-quality work—thus effectively fulfilling the mandate outlined in CHBRP's authorizing statute.

⁶ For more information on media mentions and published literature or other citations of CHBRP or its work, see Appendices I and J.

CHBRP'S CHARGE: ANALYSES AND APPROACH

At the request of the Legislature, CHBRP conducts rapid analyses of health insurance benefit legislation, including benefit mandates, assessing their medical effectiveness; cost to consumers, plans, and the state; and potential public health impacts. To date, CHBRP has conducted 161 analyses, including 38 in years 2017–2019. When analyses are completed, they are posted to CHBRP's website,⁷ and remain accessible to the Legislature and other interested parties.⁸

CHBRP's Objectives and Charge

CHBRP's authorizing statute⁹ outlines the program's objectives and charge. Due to the Legislature's enduring concern about health insurance benefit legislation and its potential impacts on health outcomes and on cost and affordability, the Legislature has continued to request that the University of California (UC), through CHBRP, conduct systematic analyses of proposed health insurance benefit legislation.

CHBRP's authorizing statute specifies the content to be addressed in its analyses. In addition, the 2006 and 2015 reauthorizations (SB 1704 and SB 125) added the analysis of benefit mandate repeals and analysis of other benefit legislation to CHBRP's charge. In 2017, AB 2893 requested a two-year cost projection where appropriate. The following lists the provisions currently in CHBRP's authorizing 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 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

⁷ Completed analyses can be found at: http://chbrp.org/completed_analyses/index.php.

⁸ Upon completion, CHBRP analyses are also sent directly to committees, bill authors, and leadership in the legislature, as well as over 1,000 people on CHBRP's email listserv.

⁹ A copy of CHBRP's authorizing statute can be found in Appendix A.

(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. The “sunset date” for the program is January 1, 2021 (with funding through June 30, 2020), 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 estimating the likely impact of the bill on benefit coverage, utilization, cost, and public health. Since the program’s inception, CHBRP has analyzed 161 bills and produced numerous policy briefs and related resources. All CHBRP publications are available at www.chbrp.org.

Topics of Legislation Analyzed

Because of the breadth of topics that CHBRP analyses must cover, staff and faculty must act as sophisticated generalists with the ability to quickly assemble an analytic framework on legislation with diverse subjects. A health insurance benefit bill that is 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:** Requiring health insurance coverage of screening, diagnosis, and/or treatment of a specific disease or condition;
- **Tests, treatments, or services:** Requiring coverage of a type of treatment or service;
- **Providers:** Requiring services provided by a specific type of health care provider; and/or
- **Benefit design:** Specifications for benefit design when a benefit is covered (i.e., including no prior authorization requirements, or establishing limits on cost sharing).

In practice, legislation that CHBRP is asked to analyze generally includes more than one of the requirements listed above. Additional complexity can arise because legislation may:

- Apply to multiple diseases/conditions;
- Include numerous tests, treatments, or services;
- Be relevant to multiple types of providers;
- Pertain only to particular market segments (e.g., excluding the large-group market); and/or
- Exempt coverage requirements for enrollees in particular types of plans (such as enrollees in CalPERS health plans or Medi-Cal beneficiaries).

Because of these complexities, CHBRP’s analytic approach must consider detailed information on premiums, covered benefits, and benefit design for market subsegments.

CHBRP’s analytic approach must also consider possible interactions with one or more benefit floors, other state and federal benefit mandates, the current state of relevant benefit coverage in state-regulated health insurance products, and the current health of enrollees in health insurance that would be subject to the proposed legislation.

Tables 1-4 demonstrate the range of requirements included in legislation that CHBRP analyzed from 2017-2019, and notes where complex requirements have applied.

Table 1. Health Insurance Benefit Bill Components, 2017-2019

Bills Analyzed	Bill Requirements				
	<i>Disease or Condition</i>	<i>Benefit Coverage Specifies: Treatments or Services</i>	<i>Providers</i>	<i>Benefit Design</i>	<i>Limited Market Segments or Enrollees</i>
All bills, 2017-2019	14	27	14	16	16

Table 2. Health Insurance Benefit Bill Components, 2017

Bills Analyzed	Bill Requirements				Limited Market Segments or Enrollees
	<i>Disease or Condition</i>	<i>Treatments or Services</i>	<i>Providers</i>	<i>Benefit Design</i>	
AB 391 (Chiu) Asthma Preventive Services	X	X	X		X
AB 477 (Gray) Continuous Glucose Monitors	X	X			X
AB 1074 (Maienschein) Pervasive Developmental Disorders and Autism	X	X	X		X
AB 1107 (Nazarian) Oncology Clinical Pathway Act				X	
AB 1316 (Quirk) Childhood Lead Poisoning Prevention		X			
AB 1353 (Waldron) Drug Utilization Management Exceptions				X	
AB 1534 (Nazarian) HIV Specialists			X		
AB 1601 (Bloom) Hearing Aids: Minors		X		X	X
SB 172 (Portantino) Fertility Preservation	X	X			
SB 221 (Wiener) HIV Associated Lipodystrophy	X	X			
SB 399 (Portantino) Pervasive Developmental Disorders and Autism	X	X	X	X	

Table 3. Health Insurance Benefit Bill Components, 2018

Bills Analyzed	Bill Requirements				Limited Market Segments or Enrollees
	<i>Disease or Condition</i>	<i>Treatments or Services</i>	<i>Providers</i>	<i>Benefit Design</i>	
AB 1860 (Limon) Cancer Treatment				X	
AB 2193 (Maienschein) Maternal Mental Health		X			
AB 2342 (Burke and Waldron) BRCA Gene Mutations: Screening, Counseling, and Testing		X			
AB 2384 (Arambula) Medication-Assisted Treatment	X	X		X	
AB 2643 (Irwin) Dentistry: General Anesthesia		X		X	
AB 2861 (Salas) Medi-Cal: Telehealth Substance Use Disorder Services	X	X	X		X
SB 399 (Portantino) Pervasive Development Disorder or Autism	X	X	X	X	
SB 1021 (Wiener) Prescription Drugs	X			X	
SB 1034 (Mitchell) Mammograms		X			
SB 1285 (Stone) Advanced Practice Pharmacist			X		X
SB 1322 (Stone) Medi-Cal: Comprehensive Medication Management		X	X		X

Table 4. Health Insurance Benefit Bill Components, 2019

Bills Analyzed	Bill Requirements				Limited Market Segments or Enrollees
	Disease or Condition	Benefit Coverage Specifies: Treatments or Services	Providers	Benefit Design	
AB 78 (Assembly Budget Committee) Health: Actuarial Value				X	X
AB 166 (Gabriel) Violence Preventive Services		X	X		X
AB 598 (Bloom) Hearing Aids		X			X
AB 651 (Grayson) Air Ambulance Services			X	X	X
AB 744 (Aguiar-Curry) Telehealth		X		X	
AB 767 (Wicks) Infertility	X	X			X
AB 993 (Nazarian) HIV Specialists			X		
AB 1246 (Limon) Basic Health Care Services		X			X
AB 1611 (Chiu) Emergency Hospital Services: Costs				X	
AB 1676 (Maienschein) Mental Health			X		X
SB 11 (Beall) Mental Health Parity and Substance Use Medications	X	X		X	
SB 159 (Wiener) HIV: Prophylaxis		X	X		X
SB 163 (Portantino) Autism	X	X	X	X	
SB 583 (Jackson) Clinical Trials		X		X	X
SB 600 (Portantino) Fertility Preservation	X	X			
SB 746 (Bates) Anticancer Medical Devices		X			

Use of CHBRP’s Analyses

CHBRP analyses are used by stakeholders throughout and beyond the Legislative cycle. Stakeholders report relying on our analyses for many different types of information.

CHBRP analyses during the legislative process

CHBRP analyses support informed decision-making throughout the Legislature’s deliberative process on health insurance benefit mandate 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, including bill advocates and opponents, 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 health insurance benefit mandate bills.

Those involved with the Legislature’s consideration of health insurance benefit mandate bills report relying on CHBRP’s analyses because of their impartiality, comprehensiveness,

usefulness, and rigor. Stakeholders, including legislative staff, frequently state that CHBRP analyses serve as the baseline for discussion of health insurance benefit mandate bills. Additionally, legislative and agency staff have indicated that analyses aid them in their internal consideration of whether a bill avoids unintended consequences, impacts social determinants of health, and adequately addresses the issue it seeks to resolve.

CHBRP analyses beyond the legislative cycle

The strength of CHBRP's contributions to health insurance benefit conversations is evident in the continued usefulness of analyses even beyond the legislative process. Health insurers and regulators report using CHBRP analyses in discussion of appropriate rate increases when analyzed legislation is signed into law, and health insurers also report using CHBRP's medical effectiveness analysis to evaluate 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, and the Institute of Medicine recommended that CHBRP's approach serve as a guide for further defining EHBs in the future. 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.¹⁰

Other Publications

CHBRP also releases background resources on federal and state benefit mandates, documents on the sources of health insurance for each year, policy context reports, and more. Additionally, CHBRP work has periodically been published in peer-reviewed journals, including *Health Affairs*, *American Journal of Public Health*, and *Health Services Research*.¹¹

Legislative Outreach and Briefings

In order to promote better understanding of CHBRP's role and the nature of health insurance benefit mandate bills, CHBRP has regularly provided pre-session briefings for legislative staff and other health insurance stakeholders. Early each year, before the bill introduction deadline, CHBRP 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.¹²

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

¹⁰ For more information on media mentions and published literature or other citations of CHBRP or its work, see Appendices I and J.

¹¹ See these publications on our website, under "External Publications": http://chbrp.org/other_publications/index.php.

¹² Presentations given by CHBRP staff and faculty are available online: http://chbrp.org/recent_presentations/index.php.

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 health committee members to further explain report details and analytic approaches.

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, is responsive to legislative requests, and is making continuous quality improvements.

On an annual basis, CHBRP interviews 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 legislative mandate. These meetings ensure that stakeholders have the opportunity to voice comments and concerns directly to CHBRP staff, so that feedback can be incorporated into CHBRP's analyses 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 Assemblymembers who served as the primary bill authors for health insurance benefit mandate bills are also contacted;
- Agency staff, including individuals at DMHC, CDI, the 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).

In 2019, CHBRP completed meetings with more than 25 stakeholder groups.

The following sections summarize the relevant concerns discussed in CHBRP's stakeholder process, how CHBRP has responded to these issues, and how CHBRP continues to evaluate ways in which we can be responsive to demands related to our analyses while staying within our 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 we have accomplished this are by including summary boxes that provide the main points of each section of the report, and by providing a concise “Key Findings” section that makes the salient report findings easier to digest for CHBRP’s stakeholders. Because CHBRP’s report structure has remained consistent over the years, stakeholders remark that the reports are easy to navigate, allowing them to locate the precise information they are looking for. Stakeholders also appreciate CHBRP’s ability to adapt the report structure when appropriate.

Legislative staff, agency staff, and stakeholder groups consider CHBRP’s products to be both reliable and impartial. Stakeholders often remark that CHBRP analyses serve as the “baseline” for discussion of the fiscal impact of health insurance benefit mandate bills. CHBRP analyses enable stakeholders to have conversations beyond whether a test, treatment, or service is effective and how much coverage would cost, and instead discuss the language of the proposed bill and whether the impacts are as intended. Legislative staff report that they utilize CHBRP analyses and find them responsive, comprehensive, and useful. Committee staff have stated that CHBRP analyses provide the essential technical information that the Legislature needs to make decisions regarding health insurance benefit mandate bills, and particularly appreciate the “Key Findings” sections, which are helpful in locating essential data for legislative analysis.

Consumer groups and sponsors or proponents of health insurance benefit mandate 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 various levels of impact, 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.”

Health plans, 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 health insurance 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 discussed in CHBRP reports, especially for legislation that would primarily shift costs from the enrollee using the treatment or service to the insurer.

Medical effectiveness visual grading system: One key feature of CHBRP analyses is the medical effectiveness visual grading system. This visual display quickly and clearly conveys to readers the key findings of the medical effectiveness analysis. More information about how CHBRP conducts the medical effectiveness review and the figures included in each analysis is included in the Analytic Methods section of this report.

These figures have evolved as CHBRP has refined the evidence grading system, becoming clearer, easier to read, and more recognizable. The current figures resulted from a concerted effort to redesign and professionalize the images, and were finalized in the summer of 2018.

Stakeholders have commented that the Medical Effectiveness sections are easy to read and have become clearer over time. Using stakeholder feedback, CHBRP continues to evaluate the ways in which information is conveyed.

Analyzing impacts by race and/or ethnicity: CHBRP’s statute requires examination of the public health impacts of a bill by race. Each analytic team examines the literature for evidence of disparities and disparate impacts by race and/or ethnicity. As the conversations in the larger health policy community have shifted regarding the discussion of race and/or ethnicity, so has CHBRP’s approach. One notable change to CHBRP’s approach is the inclusion of discussion of whether a bill may exacerbate disparities by race and/or ethnicity. CHBRP released updated methodology in the fall of 2018 that shows the racial and ethnic distribution of Californians by insurance status.¹³ While there are more individuals of racial and ethnic minorities with commercial insurance, there is a higher proportion of individuals of racial and ethnic minorities enrolled in Medi-Cal. This distribution by race/ethnicity is an important factor in whether a bill may impact disparities.

CHBRP’s analytic and research translation process

Committee and bill author staff appreciate having a dialogue with CHBRP staff. For each analysis, CHBRP staff communicate with the bill author and sponsors to understand the key background issues as well as the intended impacts of the bill. CHBRP staff discuss any issues related to bill language in terms of its potential interpretation with committee staff; after the analysis has been submitted to the Legislature, the CHBRP staff lead provides a verbal briefing of the conclusions and caveats presented in the analysis to committee and bill author staff. CHBRP remains available to bill and committee staff throughout the legislative process to continue to answer questions about the analysis, even as legislation is amended and provisions may change. 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 members and 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 an evidence-based, 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 mandate bills in time for CHBRP analysis and ensuring smooth workflow. Some of CHBRP’s other 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 mandate 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 mandate bills that might be referred to CHBRP for analysis. On an annual basis, both the

¹³ CHBRP’s approach to Benefit Mandate Structure and Unequal Racial/Ethnic Health Impacts is available online here: http://chbrp.com/analysis_methodology/public_health_impact_analysis.php.

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-related legislation early in the process.

The second year of each 2-year legislative session presents additional challenges due to an accelerated hearing calendar. To allow CHBRP the full statutory 60-day period to complete analyses before legislation is heard in policy committee, CHBRP works with committee staff to be notified of bills and receive requests before the bill introduction deadline. These deadlines are communicated with Assembly and Senate offices at the beginning of the legislative session.

In years past, committee staff were sometimes alerted to a health insurance benefit mandate bill before formal introduction, or worked with the author to introduce the bill ahead of the bill introduction deadline. More recently, committee staff have not been informed of these bills until they are introduced by the bill author, and the bills are introduced on or very near the bill deadline introduction. This poses a particular challenge to committee staff and CHBRP, who must work to make final determinations about which bills are referred to CHBRP with incomplete or last-minute information. If bills are not introduced until the bill introduction deadline, CHBRP may have far fewer than 60 days to complete the analysis. CHBRP communicates with committee staff and other stakeholders who may be alerted to whether health insurance benefit mandate bills may be introduced to attempt to stay abreast of potential topics.

Workflow and training

CHBRP must have sufficient capacity to do multiple analyses (as many as 16, if 2019 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 modified analytic team structure and built additional seasonal capacity among CHBRP librarians, faculty, and research staff, within budgetary constraints.

Limited funding

CHBRP is funded through an annual assessment on health plans in California and receives up to \$2 million each fiscal year. At the inception of CHBRP in 2002, the \$2 million maximum provided ample funding to contract with actuaries, faculty, researchers, and librarians, and to support a small CHBRP staff. Over time, the cost to adequately fund CHBRP's faculty, staff, and operations have grown with inflation. Over the last few years, CHBRP has neared spending the full \$2 million allotment.

To ensure CHBRP is able to deliver comprehensive and well-resourced analyses to the Legislature each year, CHBRP has experimented with adapting the analytic team structure to spread resources where most needed. However, the legislation sent by the Legislature to CHBRP is increasingly complex and requires full analytic teams to comprehensively and successfully deliver analysis. While CHBRP has been creative during the last few years in order to adequately fund the actuaries, faculty, and researchers, CHBRP recognizes that these contributors deserve to

be compensated fairly for their time and hard work, and the funding limitations will make that harder over time. Should CHBRP be unable to meet the funding needs of the actuaries, faculty, and researchers, it is possible that analytic capacity and quality may diminish.

Adapting to a New National and State Policy Context

Of historic importance, the Affordable Care Act (ACA) enacted 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 Essential Health Benefits (EHBs). These changes directly and indirectly prompted changes to health care delivery and financing. CHBRP worked in the years immediately following the passage and implementation of the ACA to adapt CHBRP's cost model and analytic approach to respond to these substantial changes in the health insurance market. More information about the changes CHBRP made to its analytic approach are available in previous implementation reports.¹⁴

Future changes made at the federal and state level may present challenges to CHBRP's analytic approach. CHBRP is closely monitoring the following areas of interest and is ready to adapt its analytic approach should more information become available or an official ruling be made:

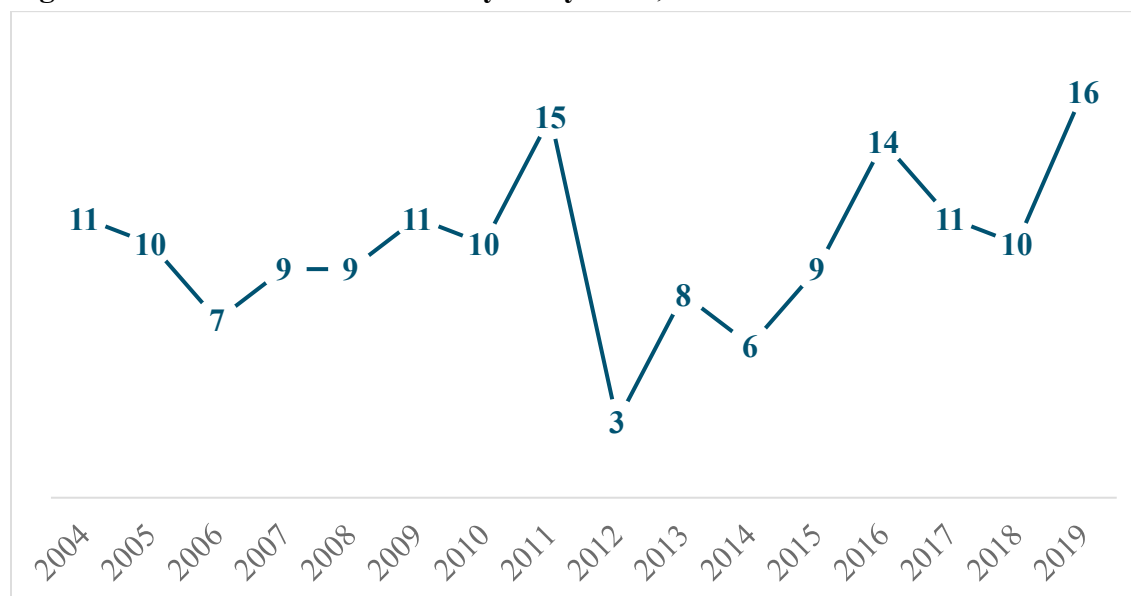
- *Texas v. Azar*: On December 18, 2019, the Fifth Circuit Court of Appeals ruled that the ACA's individual mandate is unconstitutional. The Court did not make a determination about whether the rest of the ACA is constitutional, and at the time of this writing, the future implications of this decision are unknown.
- *Single payer/Medicare for All*: The upcoming Presidential election may usher in further changes to federal health insurance regulations by expanding health insurance offerings. California policy makers, including Governor Gavin Newsom and California Insurance Commissioner Ricardo Lara, have voiced their support for a single payer system in California. While changes to California regulation will take years to implement, CHBRP will be ready to adapt to these possible reforms.
- *Bulk purchasing of prescription drugs*: One of Governor Gavin Newsom's first actions was signing Executive Order Number 01-19. This Executive Order transitions prescription drugs out of Medi-Cal Managed Care Plans and instead places prescription drugs on a fee-for-service benefit in order to pool the purchasing power of all Californians receiving health insurance through Medi-Cal and therefore reduce prescription drug costs. A handful of counties and cities have joined this effort. As details about the implementation of this Executive Order emerge, CHBRP will adapt its analytic approach as warranted.

¹⁴ Previous implementation reports are available on CHBRP's website under "Reports on Implementing CHBRP's Authorizing Statute" at http://chbrp.org/other_publications/index.php.

Trends in Health Insurance Benefit Legislation

An aforementioned 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, bills that would extend or eliminate a sunset date, bills that address social determinants of health, and in the possibility of interaction between state-level benefit mandates and the Affordable Care Act (ACA) have added to CHBRP's analytic responsibilities over the past several years.

Figure 1. Number of CHBRP Analyses by Year, 2004-2019



Initially, the number of bills referred to CHBRP remained constant, averaging 10 bills per year. However, the legislative periods since 2011 have deviated from earlier years. Perhaps in response to the ACA, the number of introduced benefit mandate bills referred to CHBRP swelled to 15 in 2011, fell to three in 2012, and rose back to 14 in 2016. While the 2017 and 2018 analytic years returned to an average level, CHBRP analyzed a record number of 16 bills in 2019. Two considerations suggest that the recent figures may be the most indicative of future years: (1) CHBRP's most recent discussions with stakeholders suggest continued interest in state-level health insurance benefit legislation on the part of the Legislature; and (2) Only two of the 16 bills CHBRP analyzed in 2019 had the possibility of exceeding EHBs, which suggests that the Legislature has studied the issue and — rather than avoiding proposing benefit mandates — is focused on proposing bills that would not create the extra financial burden for the state that a mandate exceeding EHBs would produce.

Increased Complexity

Legislation sent to CHBRP for analysis and the nature of the requests have evolved over time, and in many cases has grown more complex and multifaceted. CHBRP was established to analyze health insurance benefit mandates, which traditionally, can be defined as a bill that

requires coverage for a test, treatment, or service. While some bills analyzed include one test, treatment, or service, or address one disease or condition, CHBRP more frequently analyzes bills that address a multitude of tests, treatments, or services (such as AB 767 Infertility and SB 11 Mental Health, analyzed in 2019), or includes multiple and sometime loosely related provisions (such as SB 1021 Prescription Drugs, analyzed in 2018).¹⁵ These analyses require more effort to complete than a narrower bill and can lead to increased actuarial expenditures.

Regulatory Ambiguity in California

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 that 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. Although not conclusive, these evaluations provide more clarity for the discussion of mandate bills by indicating whether a mandate would likely not exceed EHBs, might exceed EHBs, or would have an unclear interaction with EHBs.

However, federal regulation is unclear regarding who determines officially whether a benefit mandate exceeds EHBs, simply referring to the "state."¹⁶ As of fall 2019, CHBRP assumes California state regulators, the Department of Managed Health Care, and the California Department of Insurance would make this determination, and the federal Centers for Medicare and Medicaid Services is responsible for monitoring compliance.

¹⁵ All of CHBRP's analyses are available online at http://chbrp.org/completed_analyses/index.php.

¹⁶ 45 CFR §155.170.

ACADEMIC RIGOR ON DEMAND

To fulfill its authorizing statute, CHBRP, which is located within the University of California system, secures key data and faculty time in advance of the legislative session so that we are ready to act instantly upon requests from the Legislature. CHBRP's ability to harness the expertise of faculty, staff, actuaries, and content experts on tight Legislative timelines is unique among those states that have organized programs that review health benefit mandates. The combination of academic rigor with sufficient speed to inform legislative deliberation makes CHBRP's efforts unique, robust, and timely.

Overall Structure

As previously stated, funding for CHBRP is provided through an annual levy 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 \$0.0068 per member per month (in 2019 dollars).¹⁷ CHBRP also receives additional in-kind support from the University of California.

Broad Multidisciplinary Expertise

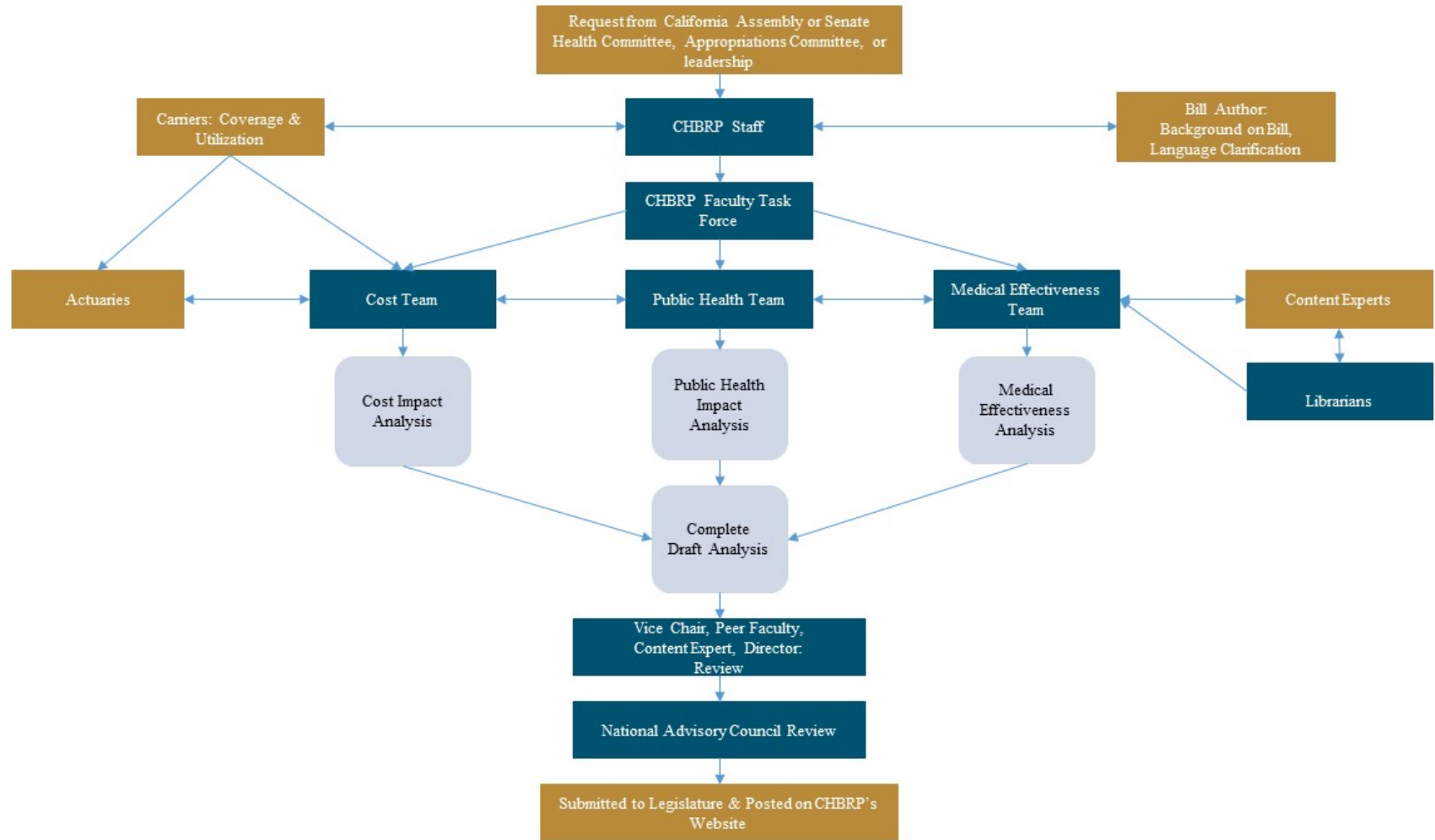
At its inception, after the passage of AB 1996 in 2002, UC considered various options for CHBRP's structure. After consideration and discussions with faculty from several UC campuses, UC decided to implement a hybrid model in which the administration and some analytic work would occur at the UC Office 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 because:

1. The quality of CHBRP reports is enhanced by an internal peer-review process;
2. CHBRP reports benefit from the use of faculty who are experts in their field; and
3. Faculty, junior faculty, researchers, and graduate students derive benefits in terms of collaborative research opportunities.

CHBRP's process flow of analyses is depicted on the following page.

¹⁷ More information on CHBRP's funding process can be found in Appendix G.

Figure 2. Process Flow of CHBRP Analyses



Professional analytic and administrative staff

As of the fall of 2019, the CHBRP staff is comprised of four full-time members with a seasonal part-time contract analyst during the legislative cycle. During legislative session while analyses are being completed, CHBRP staff act as project managers and policy context experts, and guide the direction of faculty work on analyses. Staff must be ready, each session, to respond to requests for analyses on a variety of topics, leaning on the expertise of faculty and content experts while making informed decisions about analysis scope, process, and cohesion. Beyond legislative session, CHBRP staff prepare for the upcoming season, updating background and source documents, preparing templates, troubleshooting any analytic issues that came up during the previous legislative session, and working with faculty to update approaches to various aspects of analyses (e.g., two-year impacts, medical harms). CHBRP staff are also regularly assisted by Graduate Student Interns, and Student Assistants from UC.¹⁸

Research capacity and expertise: Faculty Task Force

CHBRP works with faculty from across several UC campuses to produce our reports. Faculty teams, with the leadership of faculty vice chairs, develop the three statutorily required components of each bill analysis: medical, financial, and public health impacts of proposed benefit mandates. The Faculty Task Force (FTF) ensures broad expertise, and reflects the evaluation criteria set forth in CHBRP's authorizing statute; the FTF includes 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.¹⁹

As of 2019, the University of California, San Francisco (UCSF), the University of California, Davis (UC Davis), and the University of California, San Diego (UCSD), lead the medical effectiveness reviews and public health impacts (USCF focuses only on medical effectiveness). The University of California, Los Angeles (UCLA), leads analysis of benefit coverage, utilization, and cost impacts with the assistance of contract actuaries (as described in the section below). A handful of other prominent researchers from these and other UC campuses, including the University of California, Berkeley (UC Berkeley), also serve as members of the FTF.

CHBRP makes a concerted effort to enhance our analytic model by periodically incorporating new faculty to provide fresh, unique perspectives and understanding of new and evolving research approaches. Over our history, CHBRP has also had prominent academics review our analytic approach, in order to gain insight into changes and refinements that might be made. CHBRP continually revisits aspects of our analytic approach to ensure that the highest quality and best approaches can be adopted in our work.

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

¹⁸ For a list of current staff, see Appendix B, or http://chbrp.org/about_chbrp/staff/index.php.

¹⁹ For a list of current Faculty Task Force members, see Appendix C, or http://chbrp.com/about_chbrp/task_force/index.php.

indirect funding opportunities as well as ongoing expertise in changes to state and federal law, which helps support their wider research efforts, and brings additional benefit to state policymakers.

Actuarial analysis

In compliance with its authorizing statute, CHBRP retains a contract with an actuarial firm to help assess cost impacts of proposed legislation. In 2003, after a competitive bidding process, CHBRP began contracting with Milliman, Inc. Milliman's senior actuaries have been heavily involved in developing and annually updating CHBRP's Cost and Coverage Model (CCM). We have periodically re-bid the actuarial contract since that time, and Milliman successfully re-bid for the contract through 2015.

After a competitive bidding process in 2015, CHBRP awarded the contract to PricewaterhouseCoopers (PwC). PwC became the contracted actuary beginning with the 2016 bill analysis season, but after another series of bids in 2018, Milliman was again awarded the contract, beginning with the 2019 analytic session.

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.²⁰

National Advisory Council: internal review

CHBRP's National Advisory Council (NAC) consists of experts from outside California who are selected to provide balanced representation among groups with an interest in health insurance benefit mandates. The NAC acts as an advisory body, rather than a governance board, and membership changes based on availability and program needs. We focus on maintaining a balanced group of stakeholders from key constituencies including providers, purchasers, consumers, and health plans, as well as health policy experts.²¹

For each analysis, CHBRP staff select a subcommittee — generally two to four members — of the NAC membership to serve as reviewers. NAC reviewers review the draft analyses for accuracy, balance, clarity, and responsiveness to the Legislature's request before we transmit reports to the Legislature.²² Reviewers note when underlying assumptions may be perceived as leading to biased results, and enhance the overall quality of our analyses 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

²⁰ Additional information regarding CHBRP's contracting actuaries is included in Appendix E.

²¹ For a list of current NAC members, see Appendix D, or http://chbrp.com/about_chbrp/national_advisory_council/index.php.

3. Noting text that may need to be reworded to be more accessible to a lay audience.

In addition to the NAC's biannual 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

At the outset of each analysis, CHBRP retains at least one content expert for each analytic team. 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:

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

Throughout a bill analysis, CHBRP carefully avoids any conflict of interest in its use of content experts as well as from all CHBRP contributors. More information on CHBRP's Conflict-of-Interest Policy is available in the section below.

Librarians: timely and relevant literature searches

CHBRP's work requires resource-intensive, systematic literature reviews to be conducted within the first few weeks of the analytic process. To accomplish this, several librarians from across the UC System with Master's Degrees in Library and Information Science conduct in-depth literature searches during CHBRP's analytic cycle.²³ Retaining 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. Librarians working with CHBRP do the following:

1. Develop search strategies specific to the mandated benefit or repeal;

²³ A list of CHBRP's current librarians is available in Appendix F.

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 "grey literature," and forward relevant abstracts to the other members of the analytic teams as needed.²⁴

Challenges

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 CHBRP's workflow, multiple bills need to be analyzed simultaneously, often during the same 60-day 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.

Process and Workflow

Since its inception, CHBRP has established policies and procedures to streamline activities, to allow the production of unbiased and thorough analyses within tight timelines while ensuring continuous quality improvement.

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 benefit mandate proposal.

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.²⁵ 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.²⁶

²⁴ Grey literature consists of material that is not published commercially or indexed systematically in bibliographic databases. For more information on CHBRP's use of grey literature, see http://chbrp.com/analysis_methodology/medical_effectiveness_analysis.php.

²⁵ See Appendix H, CHBRP Conflict-of-Interest Policies and General Disclosure Form.

²⁶ 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 who monitors potential conflicts and, as appropriate, requests 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 proposals can be vague and difficult to interpret. It is crucial that CHBRP interpret bills reasonably and correctly to develop the scope of an analysis and accuracy of impact estimates. Typical questions about language include:

- For which service(s) or treatment(s) would benefit coverage be mandated?
- Which providers would be authorized for reimbursement? Does the service or treatment fall within the scope of practice of multiple providers?
- Would the bill impose or prohibit limits on the mandated benefit or other specific activity/term of coverage? Can health plans and/or insurers apply their own utilization review criteria for determining eligibility, length of treatment, etc?
- Would the bill affect cost sharing for enrollees utilizing the benefit? For example, would the bill place limits on deductibles, copayments, coinsurance, or annual dollar limits?

CHBRP's general approach is to interpret the bill language by considering only the bill "as written." 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. CHBRP's analysis then proceeds based on the agreed-upon interpretation of the bill.

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 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.

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 state mandates.²⁷ 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 non-grandfathered plans as outlined in the ACA. This was necessary because CHBRP anticipated that benefit mandates would have differential impacts on non-grandfathered 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 may send 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:

²⁷ 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.

- Existing (baseline) coverage for the proposed mandate;
- Cost sharing;
- Other benefit limits or rules (e.g., prior authorization, limitations based on specific clinical guidelines);
- Changes that might impact administrative costs; and
- Differential impacts between self-insured and fully insured products.

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.²⁸ 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 1,000 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. 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.

²⁸ Any interested party may request to be added to the mailing list, or may add themselves via the CHBRP website at www.chbrp.org.

Table 5. Timeline for Report Production (60 days) — Overview

	Day 1-Day 9	Day 10-Day 19	Day 20-29	Day 30-Day 34	Day 35- Day 44	Day 45-Day 54	Day 55- Day 59	Day 60
CHBRP Staff Lead	<ul style="list-style-type: none"> Receive & post request to website Schedule weekly conference call for analytic team Check re recusals Identify bill language or interpretation ambiguity Draft Bill Specific Coverage Survey due 	<ul style="list-style-type: none"> Clarify intent with bill author Finalize interpretation of bill language With analytic team leads, finalize scope of analysis Finalize and transmit Bill-Specific Survey Screen content expert per protocol and schedule call with team Request information/confirmation from Public Programs 	<ul style="list-style-type: none"> Blind and post responses to Bill-Specific Surveys Post responses from Public Programs Compile public demand info 1st draft of Policy Context section & appendices due Review other sections 	<ul style="list-style-type: none"> Revised section & appendices due Assemble draft report for reviews 	<p>Vice Chairs Review</p> <hr/> <p>Team revisions due</p>	<p>NAC Subgroup Review + Peer Faculty Review* + Content Expert Review + Editor Review</p> <hr/> <p>Team revisions due</p>	<p>Editor Proof</p> <hr/> <p>Team revisions due</p>	<p>CHBRP staff finalize report, transmit to the Legislature, and post it on the website</p>
Medical Effectiveness Team Lead	<ul style="list-style-type: none"> Identify relevant diseases/services, health outcomes Identify potential content experts Initial literature search specifications due 	<ul style="list-style-type: none"> Finalize list of relevant diseases/conditions, treatments/services, and health outcomes Review abstract database and finalize analytic approach Draft tables summarizing effectiveness literature 	<ul style="list-style-type: none"> 1st draft Medical Effectiveness section & appendices Review other draft sections 	<ul style="list-style-type: none"> Revised section & appendices due 				
Cost Team Lead	<ul style="list-style-type: none"> Initial literature search specifications due Review draft Bill-Specific Coverage Survey 	<ul style="list-style-type: none"> Review abstract database and finalize analytic approach Identify relevant diseases/conditions, treatments/services/procedures for actuaries to pull baseline utilization and cost from claims database Review draft Table 1, draft cost model, medical effectiveness literature analysis, and evidence from the literature to identify: Per-unit cost; impact projection assumptions (utilization, cost offsets, long-term impacts, relevant CEA literature); bill specific assumptions 	<ul style="list-style-type: none"> 1st draft Cost section & appendices Review other draft sections 	<ul style="list-style-type: none"> Revised section & appendices due 				
Lead Actuary	<ul style="list-style-type: none"> Review draft Bill-Specific Coverage Survey 	<ul style="list-style-type: none"> Provide per-unit cost (if available from claims databases) Draft Table 1 due 1st draft cost model due (baselines and suggested formats for Tables 1, X, and Y) 	<ul style="list-style-type: none"> Compile responses to Bill-Specific Survey and responses from Public Programs 2nd draft cost model due (baselines and impacts) H team data runs due Review draft Cost section 					
Public Health Team Lead	<ul style="list-style-type: none"> Initial literature search specifications due 	<ul style="list-style-type: none"> Review abstract database and finalize analytic approach Compile baseline prevalence, incidence, and disparities information Review 1st draft cost model PH specific requests for actuaries due 	<ul style="list-style-type: none"> Provide evidence for impacts on subpopulations 1st draft Background, Public Health section & appendices Review other draft sections 	<ul style="list-style-type: none"> Revised section & appendices due 				
Librarian		<ul style="list-style-type: none"> Initial abstract database due 	<ul style="list-style-type: none"> Any revised/additional abstract databases shared 					

Disseminating CHBRP Reports

CHBRP submits reports via email 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.²⁹ Lastly, the website serves as the primary medium for making announcements. CHBRP redesigned its website for additional accessibility in 2012, and further improvements were made in 2016 and in 2018.

CHBRP also periodically submits pieces of its analyses or approach to journals for publication. A list of published articles is included in Appendix J.

Analytic Methods

A discussion of CHBRP's analytic methods for each section of its reports follows.

Medical Effectiveness Analysis

CHBRP's authorizing statute requires the program to analyze the following with regard to the analysis of medical effectiveness:

- 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.

²⁹ For full lists of CHBRP's staff, FTF members and contributors, and NAC members, see Appendices B, C, and D.

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 systematically reviewing the medical literature to assess the effectiveness of interventions (e.g., preventive services, diagnostic tests, or 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 ("content 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 6.

Table 6. 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, 2019.

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, or 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.

The medical effectiveness conclusions and figures

The Medical Effectiveness sections are centered on research questions and outcomes. Each subsection summarizes the available evidence and makes an overall conclusion regarding the strength of the evidence based on research design, consistency of findings, and generalizability of findings to the population whose coverage would be affected by the bill. The following terms are used to characterize the body of evidence regarding the medical effectiveness of the test, treatment, or service on the outcome:

- Clear and convincing evidence
- Preponderance of evidence
- Limited evidence
- Inconclusive evidence
- Insufficient evidence

Below are two examples of summary statements and figures included in a Medical Effectiveness section. Each figure includes a summary statement and a graphic that visually displays the conclusion.

Figure 3. Example 1 of a Medical Effectiveness Figure in a CHBRP Analysis

Summary of findings regarding IVF effectiveness: There is a preponderance of evidence from four systematic reviews that IVF is an effective treatment for infertility, resulting in increased pregnancy rates and birth rates.

Figure 1. Effectiveness of IVF as a Treatment for Infertility



Source: CHBRP 2019 Analysis of AB 767 Infertility

Figure 4. Example 2 of a Medical Effectiveness Figure in a CHBRP Analysis

Summary of findings: CHBRP did not identify any literature evaluating the effectiveness of psychiatric eConsults regarding the mental health treatment of pregnant or postpartum persons; therefore, there is insufficient evidence on the effectiveness of psychiatric eConsults for the mental health treatment of pregnant or postpartum persons.

Figure 4. Effectiveness of Psychiatric eConsults – Pregnant or Postpartum Persons

NOT EFFECTIVE		INSUFFICIENT EVIDENCE				EFFECTIVE	
Clear and Convincing	Preponderance	Limited	Inconclusive	Limited	Preponderance	Clear and Convincing	

Source: CHBRP 2019 Analysis of AB 1676 Mental Health.

Further information about the medical effectiveness analysis is presented in a standard appendix in the reports. Another appendix describes the methods used to conduct the literature review, including relevant search terms. CHBRP’s complete Medical Effectiveness Approach is available on CHBRP’s website.³⁰

Enhancing the medical effectiveness analysis

Since CHBRP’s most recent reauthorization, the medical effectiveness team has worked to enhance the medical effectiveness analysis in three key ways: (1) changing the evidence grading categories; (2) clearly defining the research questions; and (3) presenting the findings of the literature analysis.

Changes to the evidence grading categories

Through 2016, CHBRP categorized evidence using slightly different categories (see Figure 5 below). CHBRP narrowed the definition of *preponderance of evidence* and added *limited evidence* as potential grading categories. This was due to feedback that the *preponderance of evidence* category in the previous grading system was too broad and might lead some readers to believe that evidence of effectiveness is stronger than it actually is. Additionally, CHBRP changed *conflicting evidence* to *inconclusive evidence*. This category is used when no conclusion can be drawn from the available evidence, and is broader than only having evidence that is conflicting.

³⁰ For more detailed information about CHBRP’s methodological approach to the medical effectiveness section of our analyses, please visit http://chbrp.com/analysis_methodology/medical_effectiveness_analysis.php.

Table 7: Comparison of CHBRP's Previous and New Grading Systems

Previous Grading System (through 2016)	New Grading System (2017-present)
<ul style="list-style-type: none"> • Clear and Convincing Evidence • Preponderance of Evidence (low, medium, high) • Conflicting Evidence • Insufficient Evidence 	<ul style="list-style-type: none"> • Clear and Convincing Evidence • Preponderance of Evidence • Limited Evidence • Inconclusive Evidence • Insufficient Evidence

Research questions

Since 2018, Medical Effectiveness sections in CHBRP reports have clearly stated the research questions used to define the literature search parameters and to focus the Medical Effectiveness section. While medical effectiveness teams have always organized the search and the section using research questions, these questions were not always included in the reports. Adding these questions to the reports enables readers to more fully understand the objective of the literature search and understand the flow of the section.

Presentation of the findings of the medical effectiveness analysis

CHBRP continuously evaluates the best way to present the findings of the Medical Effectiveness section. The graphic figures included in the section are the third iteration, arrived upon after soliciting feedback from stakeholders and working with a designer. The placement of the graphic figures has changed from being included all at the end of the Medical Effectiveness section in a “summary” subsection to being located immediately after the discussed outcome.

A new feature included in CHBRP reports is a summary table that clearly presents findings for complex analyses that may include multiple diseases, conditions, tests, or treatments, and multiple outcomes. For example, the report on AB 744 Telehealth in 2019 analyzed multiple modalities of telehealth and sorted the evidence by multiple outcomes. The figures presented after each section provided an overall conclusion by each modality, but the table enables readers to more fully understand the effectiveness of the modalities.

Table 7: Summary of Evidence of Medical Effectiveness of Telehealth

Telehealth Modality	Access and Utilization	Processes of Care	Health Outcomes
Live video	Preponderance of evidence — effective	Clear and convincing evidence — effective	Clear and convincing evidence — effective
Store and forward	Preponderance of evidence — effective	Inconclusive evidence	Limited evidence — effective
E-mail, synchronous text, and chat conferencing	Inconclusive evidence	Limited evidence — effective	Limited evidence — effective
Telephone	Inconclusive evidence	Limited evidence — effective	Preponderance of evidence — effective
Telestroke	Insufficient evidence	Preponderance of evidence — effective	Preponderance of evidence — effective
Telerehabilitation	Inconclusive evidence	Insufficient evidence	Preponderance of evidence — effective
eConsult	Preponderance of evidence — effective	Insufficient evidence	Insufficient evidence
Remote patient monitoring	Clear and convincing evidence — effective	Insufficient evidence	Clear and convincing evidence — effective

Source: California Health Benefits Review Program, Analysis of AB 744 Telehealth, 2019.

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 insurance benefit bills, including benefit mandates: (1) current benefit coverage, utilization and cost (baseline); and (2) projected changes in coverage, utilization and costs after the implementation of a benefit mandate (postmandate).³¹

The baseline information requested by the California Legislature for each benefit mandate includes:

- Coverage of the service in the current insurance market;
- Utilization and cost of providing a benefit;
- Public demand for coverage among self-insured plans; and
- Costs borne by insurers.

³¹ For full detail on CHBRP’s cost approach, see http://chbrp.com/analysis_methodology/cost_impact_analysis.php.

The postmandate information 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.

For benefit mandate bills, CHBRP analyses present the baseline and postmandate figures. For the analysis of bills that would extend a benefit mandate beyond a current sunset date, CHBRP presents baseline and post-sunset figures (what would occur if the sunset is not extended).

This section presents the current methods used by CHBRP to conduct the cost impact analysis of proposed benefit mandates as required and highlights adjustments that CHBRP has had to make to account for changes resulting from implementation of the Affordable Care Act (ACA).

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.

CHBRP developed the California Cost and Coverage Model (referred to as "the Cost Model") to produce baseline and postmandate financial impact estimates 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 Cost Model.

Before CHBRP can estimate the incremental change likely to result 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:

- **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 on our website³², 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 ongoing 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, 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), 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.

³² More information on CHBRP's cost analysis methodology is available online at http://chbrp.com/analysis_methodology/cost_impact_analysis.php.

- **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.

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 bill-relevant services.

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

The CHBRP Cost Model includes two types of state-regulated health insurance:

- 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 subject to the California Health and Safety Code and are regulated by the California Department of Managed Health Care (DMHC).
- 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 (CDI).

These plans and policies are divided into three market segments representing private purchaser categories:

- Large-group market — 101 or more employees;

- Small-group market — 2 to 100 employees; 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 Cost Model also makes a distinction between “grandfathered” and “nongrandfathered” plans.

Coverage and demographic data sources

The following data points provide an enumeration of all data sources in CHBRP’s Cost 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.³³ 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.³⁴ CHIS provides detailed information on demographics, health insurance coverage, health status, and access to care. 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 dependants 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).

³³ 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.

³⁴ 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, the surveyed health plans and insurers include: Aetna, Anthem Blue Cross, Blue Shield of California, CIGNA, Health Net, Kaiser Permanente, Molina, and UnitedHealthcare. 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 CHBRP's Cost Model are drawn 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 8.

Table 8. Sources of Health Insurance In California, 2020

Publicly Funded Health Insurance						
	Age	DMHC-regulated		Not regulated by DMHC or CDI		Total
Medi-Cal	0-17	2,647,000		441,000		3,088,000
	18-64	3,436,000		573,000		4,009,000
	65+	52,000		13,000		65,000
Medi-Cal COHS	All	-		1,603,000		1,603,000
Other public	All	-		-		619,000
Dually eligible Medicare & Medi-Cal	All	1,456,000		324,000		1,780,000
Medicare (non Medi-Cal)	All	-		-		4,561,000
CalPERS	All	523,000		165,000		688,000
Privately Funded Health Insurance						
	Age	DMHC-regulated		CDI-regulated		Total
		Grand-fathered	Non-Grand-fathered	Grand-fathered	Non-Grand-fathered	
Self-insured	All	-	-	-	-	2,877,000
Individually purchased, Subsidized CovCA	0-17	-	116,000	-	4,000	120,000
	18-64	-	1,112,000	-	36,000	1,148,000
	65+	-	-	-	-	-
Individually purchased, Non-Subsidized CovCA and Outside CovCA	0-17	7,000	197,000	6,000	7,000	217,000
	18-64	26,000	696,000	21,000	26,000	769,000
	65+	1,000	29,000	1,000	1,000	32,000
Small group	0-17	80,000	664,000	0*	26,000	770,000
	18-64	248,000	2,070,000	1000	80,000	2,399,000
	65+	4,000	33,000	0*	1,000	38,000
Large group	0-17	553,000	2,406,000	4,000	85,000	3,048,000
	18-64	1,399,000	6,083,000	10,000	215,000	7,707,000
	65+	23,000	101,000	170	4,000	128,000
Uninsured						
	Age					Total
	0-17					557,000
	18-64					3,386,000
	65+					39,000
California's Total Population						39,648,000

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.

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.

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 2). Baseline data on prevalence/incidence for the disease/condition and relevant outcomes are presented in the Background section of each report. This provides context for analyses in the medical effectiveness, cost and utilization, and public health sections.

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 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. 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. 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.

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.

FULFILLING CHBRP'S MISSION

For 17 years, CHBRP's Faculty Task Force and staff have provided rigorous and impartial analysis of health insurance benefit bills, with efforts to continuously evolve and meet the changing needs of the Legislature and primary readers. The program has adapted to changing circumstances, 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. During the period of 2017 through 2019, 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, and have found our efforts to enhance the readability and accessibility of key information in our reports to be helpful and effective. During the most recent reauthorization by Assembly Bill 114 (Chapter 38, Statutes of 2017) and maintained by Assembly Bill 2893 (Chapter 326, Statutes of 2018), as before, CHBRP has provided timely, objective, thorough, and high-quality work — thus effectively fulfilling the mandate outlined in CHBRP's authorizing statute.