

California Health Benefits Review Program

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

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



OVERVIEW

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

CHBRP's authorizing statute¹ requests that the University of California, through CHBRP, analyze introduced health insurance benefit bills, including benefit mandate and benefit mandate repeal bills. CHBRP's authorizing statute defines a benefit mandate as a law that requires a health care service plan or health insurer to: (1) permit enrollees to obtain health care treatment or services from a particular type of health care provider; (2) offer or provide coverage for the screening, diagnosis, or treatment of a particular disease or condition; (3) offer or provide coverage of a particular type of health care treatment or service, or of medical equipment, medical supplies, or drugs used in connection with a health care treatment or service; and/or (4) specify benefit design (limits, time frames, copayments, deductibles, coinsurance, etc.) for any of the other categories.

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

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

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

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



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

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

December 20, 2016

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Suggested Citation:

California Health Benefits Review Program (CHBRP). (2016). *Implementation of Senate Bill 125: Analysis of Legislation Mandating or Repealing Health Care Benefits and Related Topics: A Report to the California State Governor and Legislature*. Oakland, CA: CHBRP.

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EXECUTIVE SUMMARY

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

Currently set to sunset on December 31, 2017 (with funding through June 30, 2017), CHBRP was established by Assembly Bill (AB) 1996 (Thomson, 2002), which requested the University of California (UC) to assess bills proposing to mandate health benefits. In California, more than 40 health insurance benefit mandates had been enacted by the close of 2001. By the end of 2002, in response to concerns about benefit mandates serving their intended purposes without creating unintended consequences (including, but not limited to, large premium increases), California and 16 other states passed laws requiring benefit mandate evaluation. Since then, at least 12 additional states have formalized benefit mandate evaluation, bringing the current total to approximately 29.²

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

Table 1. Legislation Authorizing and Reauthorizing CHBRP

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

Source: California Health Benefits Review Program, 2016.

Note: *The initial version of CHBRP’s authorizing statute provided definitions for “health insurance benefit mandate” bills. The most recent version also consider bills relevant to benefit design, cost sharing, and other topics.

Key: AB = Assembly Bill; CHBRP = California Health Benefits Review Program; SB = Senate Bill.

The number of health benefit bills introduced in California’s Legislature and referred to CHBRP per year, an average of about 10, remained steady between 2002 and the passage of the Affordable Care Act (ACA) in 2010.³ Perhaps in response to the ACA, the number of bills

² For further details on other states’ benefit mandate review programs, see Appendix 22.

³ Although jointly referred to as the Affordable Care Act, the law is actually a product of the Patient Protection and Affordable Care Act (P.L.111-148) and the Health Care and Education Reconciliation Act (H.R. 4872), both passed in 2010.

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

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

CHBRP's most recent reauthorization, SB 125, requested a report be submitted to the Governor and the Legislature by January 1, 2017, describing implementation of the bill as enacted. This report is provided in response to that request, and describes how CHBRP has fulfilled the mission outlined in the current version of the authorizing statute⁴ during the years 2014 through 2016.⁵

Academic Rigor on Demand

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

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

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

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

⁴ The current version of CHBRP's authorizing statute is included in Appendix 1.

⁵ Because CHBRP's reauthorizations request implementation reports at the end of a calendar year—even though authorization runs through June (and so funds work during one more legislative cycle)—each of CHBRP's implementation reports includes all of the work accomplished after submission of its predecessor.

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

- Adapted the method of projecting baseline enrollment and premiums that support CBHRP’s bill-specific analyses to address ongoing implementation of the ACA.
- Adapted the approach to bill-specific analyses to consider possible interaction with either of the two benefit coverage floors required by the ACA.
- Provided an analysis of the interaction of the ACA’s federally specified preventive services mandate with California’s state mandates.⁶
- Worked with CHBRP’s contracted actuary to provide the Legislature with an analysis of options for the 2015 selection of the benchmark plan that would influence California EHBs as of 2017.⁷

California Cost and Coverage Model

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

Benefit Floors and Essential Health Benefits

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

⁶ See *The Federal Preventive Services Health Insurance Benefit Mandate and California’s Health Insurance Benefit Mandates*, available at www.chbrp.org/other_publications/index.php.

⁷ See *California’s Essential Health Benefit Base Benchmark Options Effective January 1, 2017*, available at www.chbrp.org/other_publications/index.php.

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

Figure 1. Bills and Benefit Floors Relevant to the Analysis

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

Source: California Health Benefits Review Program, 2016.

Notes: *Analyzed bills would generally be in effect the following calendar year, so a 2013 bill analysis takes into account benefit floors that would be applicable in 2014.

Key: BHCS = Basic Health Care Services; EHBs = Essential Health Benefits; FSPS = Federally Specified Preventive Services.

⁸ CHBRP maintains a list of mandates applicable in California, available at: www.chbrp.org/other_publications/index.php.

⁹ Through additional legislation, California requires some small group and individual market plans that are not associated with Covered California to also cover EHBs, see H&SC § 1357.500.

¹⁰ For more discussion of EHBs and relevant markets, see additional resources available at: www.chbrp.org/other_publications/index.php.

¹¹ Affordable Care Act Section 1001, modifying Section 2713 of the Public Health Service Act; California Health and Safety Code 1367.002; and California Insurance Code Section 10112.2.

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

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

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

CHBRP's Charge: Analyses and Approach

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

CHBRP Analyses During the Legislative Process

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

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

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

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

CHBRP Analyses Beyond the Legislative Cycle

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

Consideration of Multifaceted Requirements of Health Insurance Benefit Bills

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

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

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

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

¹³ See *Essential Health Benefits Bulletin*, available at:

www.cms.gov/CCIIO/Resources/Files/Downloads/essential_health_benefits_bulletin.pdf.

¹⁴ See *Essential Health Benefits: Balancing Coverage and Cost*, available at:

www.chbrp.org/other_publications/index.php.

¹⁵ See Appendices 20 and 21 for lists of references to CHBRP or its work that appeared during the period 2014 through 2016.

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

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

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

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

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

Source: California Health Benefits Review Program, 2016.

Broad Multidisciplinary Expertise

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

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

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

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

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

Unbiased and Neutral Analyses

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

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

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

Unique Information in a CHBRP Report

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

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

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

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

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

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

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

Summary of CHBRP Report Findings

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

Fulfilling CHBRP's Mission

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

INTRODUCTION

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

Currently set to sunset on December 31, 2017 (with funding through June 30, 2017), CHBRP was established by Assembly Bill (AB) 1996 (Thomson, 2002) which requested the University of California (UC), through CHBRP, assess bills proposing to mandate that health insurance benefits to be provided by health care service plans and health insurers. The provisions of AB 1996, originally set to sunset on January 1, 2007, were extended by Senate Bill (SB) 1704 (Kuehl, 2006) and further extended by AB 1540 (Assembly Health Committee, 2009), SB 1465 (Senate Health Committee, 2014) and SB 125 (Hernandez, 2015). The Legislature has twice broadened CHBRP's scope. SB 1704 added a provision that requested CHBRP analyze bills that would repeal existing benefit mandates and SB 125 added a provision that requested analysis of other¹⁷ bills related to health insurance benefits. As did previous reauthorizations, SB 125 also requested that CHBRP submit a report to the Governor and the Legislature describing the implementation of the program's authorizing statute by January 1, 2017.¹⁸ This implementation report is written in response to that request, and describes how the program has fulfilled the mission outlined in its authorizing statute during the years 20014 through 2016.¹⁹

History and Trends in Health Insurance Benefit Legislation

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

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

¹⁷ The initial version of CHBRP's authorizing statute provided definitions for "health insurance benefit mandate" bills. The most recent version also consider bills relevant to benefit design, cost sharing, and other topics.

¹⁸ CHBRP previously provided multiple similar reports to the Legislature and Governor, each regarding an earlier cycles of authorization. All are available at www.chbrp.org/other_publications/index.php.

¹⁹ The current version of CHBRP's authorizing statute is included in Appendix 1.

²⁰ Although jointly referred to as the Affordable Care Act, the law is actually a product of the Patient Protection and Affordable Care Act (P.L.111-148) and the Health Care and Education Reconciliation Act (H.R. 4872), both passed in 2010.

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

In California, more than 40 mandated benefits had been enacted into state law by the close of 2001, and during the 2001 to 2002 session, 10 benefit mandate bills were introduced. At that time, concerns arose regarding cost containment and whether well-intended laws actually served their intended purposes. In response, 16 states, including California, passed laws requiring the evaluation of health insurance benefit mandate bills during 2001 to 2002. Since then, at least 12 additional states have formalized benefit mandate evaluation, bringing the current total to approximately 29.²¹

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Source: California Health Benefits Review Program, 2016.

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

CHBRP'S CHARGE: ANALYSES AND APPROACH

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

CHBRP's Objectives and Charge

CHBRP's authorizing statute²³ outlines the program's objectives and charge. Due to the Legislature's continuing concern about health insurance benefit legislation bills, their potential impacts on health outcomes, and their potential impacts on cost and affordability, the Legislature has continued to commission the University of California (UC), through CHBRP, to conduct systematic analyses of proposed health insurance benefit bills.

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

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

²³ For a full description of CHBRP's Authorizing Statute, see Appendix 1.

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

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

CHBRP Analyses

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

Topics of Bills Analyzed

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

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

Table 4. CHBRP Analyzed Bills: Status, 2014–2016²⁴

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

Source: California Health Benefits Review Program, 2016.

Summary of CHBRP Bill Analyses

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

²⁴ For full details on each of the bills CHBRP analyzed during this period, please see Appendix 9.

²⁵ For full details on the analytic methods used for CHBRP’s medical effectiveness, cost, and public health impacts analyses, see Appendices 10, 11, and 12, respectively.

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

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

Medical effectiveness

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

Cost impact

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

Public health impacts

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

Use of CHBRP's Analyses

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

CHBRP analyses during the legislative process

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

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

CHBRP analyses beyond the legislative cycle

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

Outside of California, a federal report²⁶ cited a CHBRP analysis's estimate regarding the marginal cost of covering applied behavioral analysis as an EHB, and the Institute of Medicine (IOM) also recommended that CHBRP's approach serve as a guide for further defining EHBs in the future.²⁷

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

Other Publications

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

²⁶ Center for Medicare & Medicaid Services, Center for Consumer Information and Insurance Oversight, *Essential Health Benefits Bulletin*. December 16, 2011. Available at:

www.cms.gov/CCIIO/Resources/Files/Downloads/essential_health_benefits_bulletin.pdf.

²⁷ IOM, 2011. *Essential Health Benefits: Balancing Coverage and Cost*. Available at:

www.iom.edu/Reports/2011/Essential-Health-Benefits-Balancing-Coverage-and-Cost.aspx.

²⁸ See Appendices 20 and 21 for complete lists of references.

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

Resources

Estimates of the Sources of Health Insurance

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

Health Insurance Benefit Mandates in California State Law

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

Federal Preventive Services Benefit Mandate and California Benefit Mandates

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

Analysis: California’s EHB Base Benchmark Options

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

Background on Cost Sharing for Outpatient Prescription Drugs

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

Outpatient Prescription Drug Coverage 101

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

What Is Cost Sharing in Health Insurance?

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

Policy and Issue Briefs

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

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

Immunization Mandates, Benchmark Plan Choices, and Essential Health Benefits

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

Mammography Mandates, Benchmark Plan Choices, and Essential Health Benefits

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

Pediatric Dental and Pediatric Vision Essential Health Benefits

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

Policy Snapshot: Primer on Insurer Provider Networks

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

Legislative Outreach and Briefings

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

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

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

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

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

Continuous Quality Improvement

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

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

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

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

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

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

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

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

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

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

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

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

CHBRP's Analytic and Research Translation Process

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

Challenges Inherent to CHBRP's Analytic Process

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

Identifying Health Insurance Benefit Bills

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

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

Workflow and Timing

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

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

Estimating Public Health Projections With Data Limitations

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

Applicability and Limitations of the Medical Literature

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

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

ACADEMIC RIGOR ON DEMAND

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

Overall Structure

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

Broad Multidisciplinary Expertise

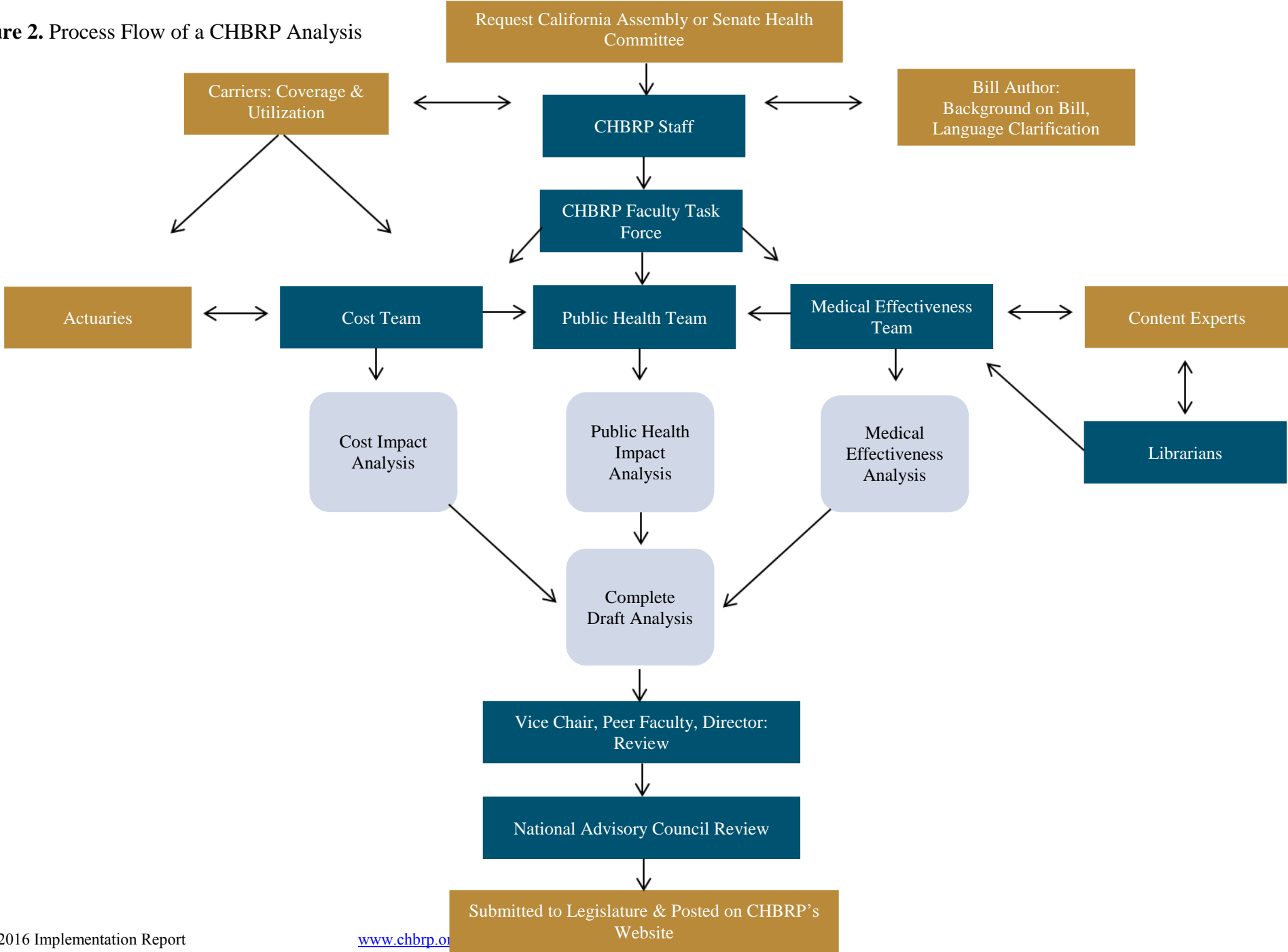
CHBRP reports provide academically rigorous analysis utilizing broad, multidisciplinary expertise. CHBRP's work achieves its standard academic rigor through the involvement of faculty, researchers and staff attached to the UC system. This includes individuals with expertise in medicine, health economics,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

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

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

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

Figure 2. Process Flow of a CHBRP Analysis



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

Research capacity and expertise: faculty task force

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

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

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

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

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

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

Professional analytic and administrative staff

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

Actuarial analysis

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

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

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

National Advisory Council: internal review

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

³² For a full list of CHBRP's current staff, see Appendix 2.

³³ Further information regarding CHBRP's contracting actuaries is included in Appendix 5.

³⁴ For a full list of the current National Advisory Council membership, see Appendix 4.

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

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

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

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

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

³⁵ See Appendix 16, NAC Review Criteria and Guidelines.

³⁶ For full details on the protocol for selecting CHBRP content experts, see Appendix 14.

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

Librarians: timely and relevant literature searches

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

Process and Workflow

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

Conflict-of-Interest Policy

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

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

³⁷ For a complete list of CHBRP's current librarians, see Appendix 6.

³⁸ See Appendix 15, CHBRP Conflict-of-Interest Policies, General Disclosure Form, and NAC Disclosure Form.

³⁹ The UC and CHBRP are grateful to the NAS for extending its permission to use the NAS form.

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

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

Clarifying Bill Language

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

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

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

⁴⁰ For the full questionnaire, see Appendix 17.

Obtaining Data From Health Plans and Insurers

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

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

Annual Enrollment and Premium Survey

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

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

Bill-specific surveys

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

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

Obtaining Information From Consumer Groups and Other Stakeholders

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

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

60-Day Timeline

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

⁴² Any interested party may request that he or she be added to the mailing list, or may add themselves via the CHBRP website at www.chbrp.org.

⁴³ For more detail on CHBRP’s 60-day timeline, see Appendix 13.

Figure 3. 60-Day Timeline of a CHBRP Analysis

	Day 0	Day 10	Day 20	Day 30	Day 40	Day 50	Day 60
Vice-Chairs & Team Leads	<ul style="list-style-type: none"> Identify analytic teams, faculty and staff leads, and reviewers Identify potential conflicts of interest Determine scope of services 	<ul style="list-style-type: none"> Review drafts (e.g., bibliography, baseline tables) 	<ul style="list-style-type: none"> Review drafts (e.g., medical effectiveness outcomes, impact tables) 	<ul style="list-style-type: none"> Complete 1st internal review of full report draft 			Final review by VCs and SVP of UC Office of the President Health Sciences & Services
CHBRP Staff	<ul style="list-style-type: none"> Post Legislature’s request on website Clarify intent of legislation Send coverage survey to carriers 	<ul style="list-style-type: none"> Compile carrier coverage and data Compile relevant information from interested parties Compile public program coverage information 	<ul style="list-style-type: none"> Review drafts, coordinate both internal and NAC reviews 	<ul style="list-style-type: none"> Integrate all sections for the 1st full report draft 	National Advisory Council Review		-----
Medical Effectiveness Team and Librarians	<ul style="list-style-type: none"> Screen and select content experts Identify search terms and scope of literature search Librarians conduct literature search 	<ul style="list-style-type: none"> Librarians prepare final abstract database Medical effectiveness team analyzes literature & prepares draft medical outcomes 	<ul style="list-style-type: none"> Complete 1st draft of medical effectiveness summary and appendices 	<ul style="list-style-type: none"> Address all comments on 1st full report draft 	Medical effectiveness lead, cost lead, public health lead, and CHBRP staff revise draft report to address all comments from NAC review		Medical effectiveness lead, cost lead, public health lead, and CHBRP staff revise draft report to address any final comments by VCs and EVP
Cost Team and Actuaries	<ul style="list-style-type: none"> Develop questions for coverage survey Conduct cost literature search Identify codes to assess utilization with claims data 	<ul style="list-style-type: none"> Develop baseline coverage & utilization tables Review evidence for projecting impacts (utilization assumptions, cost offsets, long term) 	<ul style="list-style-type: none"> Finalize approach to determine utilization & cost impacts Actuaries produce draft cost tables Complete 1st draft of cost section 	<ul style="list-style-type: none"> Finalize cost model/approach Actuaries produce draft cost tables Address all staff and VC comments on 1st full report draft 	Editor reviews completed draft of report		Final production
Public Health Team	<ul style="list-style-type: none"> Conduct public health literature search (on issues such as disease prevalence, racial disparities) 	<ul style="list-style-type: none"> Develop baseline public health tables and review evidence for projecting demographic impacts 	<ul style="list-style-type: none"> Finalize approach to determine public health impacts Draft postmandate impact section 	<ul style="list-style-type: none"> Address all staff and VC comments on 1st full report draft 			Report submitted to the Legislature and posted to CHBRP’s website

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

Disseminating CHBRP Reports

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

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

Analytic Methods

Medical Effectiveness Analysis

CHBRP's authorizing statute requires the program to analyze the following with regard to the analyses of medical effectiveness⁴⁵:

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

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

CHBRP's approach to medical effectiveness analysis

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

⁴⁴ For full lists of CHBRP staff and contributors, see Appendices 2, 3, and 4.

⁴⁵ For full details on CHBRP's medical effectiveness approach, see Appendix 10.

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

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

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

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

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

Source: California Health Benefits Review Program, 2016.

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

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

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

Content of the medical effectiveness sections of CHBRP reports

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

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

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

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

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

Enhancing the medical effectiveness analysis

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

Grey literature

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

Clinical practice guidelines

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

Presentation of the findings of the medical effectiveness analysis

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

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

Cost Impact Analysis

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

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

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

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

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

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

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

California Cost and Coverage Model

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

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

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

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

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

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

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

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

⁴⁷ CHBRP estimated Covered California enrollment using CalSIM.

Definitions/components of the Cost and Coverage Model

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

In evaluating aggregate expenditures, CHBRP includes:

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

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

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

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

1. “Knox-Keene” plans: These include health maintenance organizations (HMO), point-of-service (POS) health plans, and certain preferred provider organization (PPO) health plans subject to the requirements of the Knox-Keene Health Care Service Plan Act of 1975. These plans are regulated by the Department of Managed Health Care and are included in one category because they are similar in type and regulatory requirements.
2. “Insurance” policies: These include PPOs and fee-for-service (FFS) health insurance products subject to the California Insurance Code, which are regulated by the California Department of Insurance.

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

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

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

Coverage and demographic data sources.

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

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

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

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

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

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

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

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

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

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

Source: California Health Benefits Review Program, 2016.

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

Public Health Impact Analysis

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

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

Health outcomes and data sources

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

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

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

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

Impact on public health

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

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

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

Impact on gender and racial disparities

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

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

Impact on premature death and economic loss

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

Long-term impacts

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

Analyzing Repeal Bills

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

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

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

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

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

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

Overall approach

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

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

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

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

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

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

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

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

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

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

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

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

Fulfilling CHBRP’s Mission

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

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

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

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Acknowledgments

John Lewis, MPA, of CHBRP staff, and CHBRP's graduate student interns, Victoria Wertz, RN, and Ryan Natividad, prepared this report. Garen Corbett, MS, Erin Shigekawa, MPH, and Karla Wood, all of CHBRP staff, reviewed this report for its accuracy, completeness, and clarity. Additional review of this report was provided by Janet Coffman, PhD, and Lauren LeRoy, PhD.

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

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

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Garen Corbett, MS
Director



Appendix 1: Authorizing Legislation

Assembly Bill 1996 (2002)

On February 15, 2002, Assembly Bill (AB) 1996 was introduced by author Assembly Member Helen Thomson. On September 22, 2002, Governor Davis signed AB 1996 into law. (Chapter 795, Statutes of 2002.)

Senate Bill 1704 (2006)

On February 24, 2006, Senate Bill (SB) 1704 was introduced by author Senator Sheila Kuehl. On September 29, 2006, Governor Schwarzenegger signed SB 1704 into law. (Chapter 684, Statutes of 2006.)

Assembly Bill 1540 (2009)

On March 4, 2009, AB 1540 was introduced by the Assembly Committee on Health: Dave Jones (Chair), Anthony Adams, Tom Ammiano, Marty Block, Wilmer Carter, Hector De La Torre, Isadore Hall, Mary Hayashi, Edward Hernandez, Bonnie Lowenthal, Pedro Nava, V. Manuel Perez, and Mary Salas. On October 11, 2009, Governor Schwarzenegger signed AB 1540 into law. (Chapter 298, Statutes of 2009.)

Senate Bill 1465 (2014)

On March 20, 2014, SB 1456 was introduced by the Senate Committee on Health: Edward Hernandez (Chair), Jim Beall, Kevin de Leon, Mark DeSaulnier, Noreen Evans, Bill Monning, Mike Morrell, Jim Nielsen, and Lois Wolk. On September 18, 2014, Governor Brown signed SB 1456 into law. (Chapter 442, Statutes of 2014.)

Senate Bill 125 (2015)

On January 16, 2015, SB 125 was introduced by author Senator Edward Hernandez. On June 17, 2015, Governor Brown signed SB 125 into law. (Chapter 9, Statutes of 2015.)

The chaptered bills and the relevant language follow.

**CALIFORNIA CODES
HEALTH AND SAFETY CODE
SECTION 127660-127665**

127660. (a) The Legislature hereby requests the University of California to establish the California Health Benefit Review Program to assess legislation proposing to mandate a benefit or service, as defined in subdivision (d), and legislation proposing to repeal a mandated benefit or service, as defined in subdivision (e), and to prepare a written analysis with relevant data on the following:

(1) Public health impacts, including, but not limited to, all of the following:

(A) The impact on the health of the community, including the reduction of communicable disease and the benefits of prevention such as those provided by childhood immunizations and prenatal care.

(B) The impact on the health of the community, including diseases and conditions where disparities in outcomes associated with the social determinants of health as well as gender, race, sexual orientation, or gender identity are established in peer-reviewed scientific and medical literature.

(C) The extent to which the benefit or service reduces premature death and the economic loss associated with disease.

(2) Medical impacts, including, but not limited to, all of the following:

(A) 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, as demonstrated by a review of scientific and peer reviewed medical literature.

(B) The extent to which the benefit or service is generally available and utilized by treating physicians.

(C) The contribution of the benefit or service to the health status of the population, including the results of any research demonstrating the efficacy of the benefit or service compared to alternatives, including not providing the benefit or service.

(D) 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.

(3) Financial impacts, including, but not limited to, all of the following:

(A) The extent to which the coverage or repeal of coverage will increase or decrease the benefit or cost of the benefit or service.

(B) The extent to which the coverage or repeal of coverage will increase the utilization of the benefit or service, or will be a substitute for, or affect the cost of, alternative benefits or services.

(C) The extent to which the coverage or repeal of coverage will increase or decrease the administrative expenses of health care service plans and health insurers and the premium and expenses of subscribers, enrollees, and policyholders.

(D) The impact of this coverage or repeal of coverage on the total cost of health care.

(E) The potential cost or savings to the private sector, including the impact on small employers as defined in paragraph (1) of subdivision (l) of Section 1357, the Public Employees' Retirement

System, other retirement systems funded by the state or by a local government, individuals purchasing individual health insurance, and publicly funded state health insurance programs, including the Medi-Cal program and the Healthy Families Program.

(F) The extent to which costs resulting from lack of coverage or repeal of coverage are or would be shifted to other payers, including both public and private entities.

(G) The extent to which mandating or repealing the proposed benefit or service would not diminish or eliminate access to currently available health care benefits or services.

(H) The extent to which the benefit or service is generally utilized by a significant portion of the population.

(I) The extent to which health care coverage for the benefit or service is already generally available.

(J) The level of public demand for health care coverage for the benefit or service, including the level of interest of collective bargaining agents in negotiating privately for inclusion of this coverage in group contracts, and the extent to which the mandated benefit or service is covered by self-funded employer groups.

(K) In assessing and preparing a written analysis of the financial impact of legislation proposing to mandate a benefit or service and legislation proposing to repeal a mandated benefit or service pursuant to this paragraph, the Legislature requests the University of California to use a certified actuary or other person with relevant knowledge and expertise to determine the financial impact.

(4) The impact on essential health benefits, as defined in Section 1367.005 of this code and Section 10112.27 of Insurance Code, and the impact on the California Health Benefit Exchange.

(b) The Legislature further requests that the California Health Benefit Review Program assesses legislation that impacts health insurance benefit design, cost sharing, premiums, and other health insurance topics.

(c) The Legislature requests that the University of California provide every analysis to the appropriate policy and fiscal committees of the Legislature not later than 60 days, or in a manner and pursuant to a timeline agreed to by the Legislature and the California Benefit Review Program, after receiving a request made pursuant to Section 127661. In addition, the Legislature requests that the university post every analysis on the Internet and make every analysis available to the public upon request.

(d) As used in this section, "legislation proposing to mandate a benefit or service" means a proposed statute that requires a health care service plan or a health insurer, or both, to do any of the following:

(1) Permit a person insured or covered under the policy or contract to obtain health care treatment or services from a particular type of health care provider.

(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.

(e) As used in this section, "legislation proposing to repeal a mandated benefit or service" means a proposed statute that, if enacted, would become operative on or after January 1, 2008, and would repeal an existing requirement that a health care service plan or a health insurer, or both, do any of the following:

(1) Permit a person insured or covered under the policy or contract to obtain health care treatment or services from a particular type of health care provider.

(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.

127661. A request pursuant to this chapter may be made by an appropriate policy or fiscal committee chairperson, the Speaker of the Assembly, or the President pro Tempore of the Senate, who shall forward the introduced bill to the University of California for assessment.

127662. (a) In order to effectively support the University of California and its work in implementing this chapter, there is hereby established in the State Treasury, the Health Care Benefits Fund. The university's work in providing the bill analyses shall be supported from the fund.

(b) For the 2010-11 to 2016-17 fiscal years, inclusive, each health care service plan, except a specialized health care service plan, and each health insurer, as defined in Section 106 of the Insurance Code, shall be assessed an annual fee in an amount determined through regulation. The amount of the fee shall be determined by the Department of Managed Health Care and the Department of Insurance in consultation with the university and shall be limited to the amount necessary to fund the actual and necessary expenses of the university and its work in implementing this chapter. The total annual assessment on health care service plans and health insurers shall not exceed two million dollars (\$2,000,000).

(c) The Department of Managed Health Care and the Department of Insurance, in coordination with the university, shall assess the health care service plans and health insurers, respectively, for the costs required to fund the university's activities pursuant to subdivision (b).

(1) Health care service plans shall be notified of the assessment on or before June 15 of each year with the annual assessment notice issued pursuant to Section 1356. The assessment pursuant to this section is separate and independent of the assessments in Section 1356.

(2) Health insurers shall be noticed of the assessment in accordance with the notice for the annual assessment or quarterly premium tax revenues.

(3) The assessed fees required pursuant to subdivision (b) shall be paid on an annual basis no later than August 1 of each year. The Department of Managed Health Care and the Department of Insurance shall forward the assessed fees to the Controller for deposit in the Health Care Benefits Fund immediately following their receipt.

(4) "Health insurance," as used in this subdivision, does not include Medicare supplement, vision-only, dental-only, or CHAMPUS supplement insurance, or hospital indemnity, accident-only, or specified disease insurance that does not pay benefits on a fixed benefit, cash payment only basis.

127663. In order to avoid conflicts of interest, the Legislature requests the University of California to develop and implement conflict-of-interest provisions to prohibit a person from participating in any analysis in which the person knows or has reason to know he or she has a

material financial interest, including, but not limited to, a person who has a consulting or other agreement with a person or organization that would be affected by the legislation.

127664. The Legislature requests the University of California to submit a report to the Governor and the Legislature by January 1, 2017, regarding the implementation of this chapter. The report shall be submitted in compliance with Section 9795 of the Government Code.

127665. This chapter shall become inoperative on July 1, 2017, and, as of January 1, 2018, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2018, deletes or extends the dates on which it becomes inoperative and is repealed.



Appendix 2: CHBRP Staff List

Garen Corbett, MS
Director

John Lewis, MPA
Associate Director

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[Vacant]
Principal Analyst

Karla Wood
Program Specialist

In addition, CHBRP may contract for additional staff support, as it did in 2016 with **A.J. Scheitler, EdD**, and **Karen Shore, PhD**.



Appendix 3: Task Force Membership List

Task Force Members

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Appendix 4: National Advisory Council Membership List

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Alan Weil, JD, MPP

Editor-in-Chief
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Appendix 5: CHBRP Actuaries

The California Health Benefits Review Program’s (CHBRP’s) authorizing statute states, “In assessing and preparing a written analysis of the financial impact of legislation proposing to mandate a benefit or service and legislation proposing to repeal a mandated benefit or service pursuant to this paragraph, the Legislature requests the University of California to use a certified actuary or other person with relevant knowledge and expertise to determine the financial impact.”¹

Milliman, Inc, was CHBRP’s contracted actuarial firm for projects begun in 2014 and 2015. On February 1, 2016, after a competitive bidding process, PricewaterhouseCoopers became CHBRP’s actuary and provided consultation on all projects begun after that date.

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¹ California Health and Safety Code, Section 12766 (a)(3)(K).



Appendix 6: CHBRP Librarians

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Education Information Consultant
Library and Center for Knowledge Management
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Appendix 7: CHBRP Funding Process and Operating Costs

In order to effectively support the California Health Benefits Review Program (CHBRP), Section 127662 of the Health and Safety Code provides that:

- The Health Care Benefits Fund (HCBF) be established in the State Treasury;
- Each health plan and each health insurer be assessed an annual fee for which the total annual assessment not exceed \$2 million;
- The California Department of Managed Health Care (DMHC) assess health plans.
- Health plans be notified of the assessment on or before June 15 of each year;
- The California Department of Insurance (CDI) assess health insurers;
- Health insurers be notified of the assessment in accordance with the notice for the annual assessment or quarterly premium tax revenues;
- Assessed fees be paid on an annual basis no later than August 1 of each year; and
- DMHC and CDI forward the assessed fees to the Controller for deposit in the Health Care Benefits Fund following their receipt.

This appendix details the process by which DMHC and CDI determine the amount to assess health plans and insurers for a given fiscal year. The annual amounts transferred into the HCBF are equal to the total assessments less whatever amount was not collected by DMHC or CDI.

Regulator Assessments and Transfers into the Health Care Benefits Fund

1. During the spring, CHBRP provides the following information to DMHC:
 - a. Actual expenditures for the previous fiscal year
 - b. Projected expenditures for the remainder of that fiscal year
 - c. Projected budget for the next fiscal year
2. On the basis of the information provided in the spring, DMHC determines the total amount to be transferred to the HCBF for the next fiscal year.

3. Simultaneously, DMHC calculates the percentage share DMHC and CDI are required to collect and transfer to the HCBF.
 - a. CDI and DMHC percentage shares are based on the market shares of the privately insured population enrolled in DMHC-regulated health plans versus the privately insured population enrolled in preferred provider organizations or fee-for-service CDI-regulated insurance policies.
 - b. The market shares were initially determined in 2002 and are currently set at: 91.1% for DMHC and 8.9% for CDI. For example, in FY 16-17, the total amount CHBRP will receive is \$1,999,658, just under the cap (which by current law is set at \$2 million). The amount both departments are required to assess and transfer into the HCBF is calculated as follows:

Assessment Shares (FY 16-17)

DMHC portion	91.1%	\$1,821,688
CDI portion	8.9%	\$177,970
Total	100%	\$1,999,658

4. DMHC notifies health plans of the amount they will be assess, usually by mid-June.
5. CDI notifies health insurers of the amounts they will be assessed, usually by October.
6. DMHC transfers collected funds to the HCBF, usually by September. CDI transfers collected funds to the HCBF, usually in December and in March.

Summary of CHBRP Expenditures

The following tables provide a summary of the actual funding CHBRP received since the program’s last reauthorization, as well as for the 2014–2015 through 2016–2017 fiscal years (FY). Please note the 2016–2017 FY details are projected expenditures. Prior year expenditures may be found in prior implementation reports on CHBRP’s website.¹

Table 7-1. CHBRP Operating Costs and Assessment Share, Fiscal Years 2014–2017

Fiscal Year	Operating Costs (a)	DMHC Share (b)	CDI Share (b)
2014–2015	\$1,999,955.00	1,751,960.58	247,994.42
2015–2016	\$1,999,812.00	1,821,828.73	177,983.27
2016–2017	\$1,999,658.00 (est.)	\$1,821,688.00 (c)	\$177,970.00 (c)

Source: California Health Benefits Review Program, 2016.

Notes: (a) These amounts reflect the actual amounts transferred into the HCBF, not the actual amounts assessed on plans and insurers by DMHC and CDI. Slight differences in the amount assessed and the amount transferred are due to differences in the amounts assessed and actually collected by DMHC and CDI.

¹ Available at: http://www.chbrp.org/other_publications/index.php.

(b) CDI and DMHC percentage shares are based on the market shares of the privately insured population enrolled in DMHC-regulated health plans versus the privately insured population enrolled in preferred provider organizations or fee-for-service CDI-regulated insurance policies. The market shares have been periodically adjusted based on enrollment shifts between the two regulated insurance markets.

(c) Transfers for 2016–2017 FY have not yet been completed.

Table 7-2. Estimated CHBRP Average Expenditures by Category

Category	FY 2014–2017 Percentage (rounded)
Salary, wages, benefits (a)	35%
Actuarial services (b)	17%
Payments to campuses (c)	45%
Other (d)	4%
Total	100%

Source: California Health Benefits Review Program, 2016.

Notes: (a) Salaries, wages, and benefits for central offices operations.

(b) CHBRP’s authorizing statute requires use of actuarial services to conduct the cost impact analyses.

(c) Campus payments are for services provided by the faculty and researchers to conduct the medical effectiveness, cost impact, and public health impact analyses, and for reviews.

(d) This includes payments for travel, workshops, staff training, advisory council services, content expert services, librarian services, editorial services, website hosting, supplies and equipment, and other vendor payments.



Appendix 8: CHBRP List of Analyses and Other Products, 2014–2016

2016

California Health Benefits Review Program (CHBRP). *Analysis of Assembly Bill 533: Health Care Coverage: Out-of-Network Coverage*. Report to California State Legislature. Oakland, CA: CHBRP, 2016.

California Health Benefits Review Program (CHBRP). *Analysis of Assembly Bill 796: Health Care Coverage: Autism and Pervasive Developmental Disorders*. Letter to California State Legislature. Oakland, CA: CHBRP, 2016.

California Health Benefits Review Program (CHBRP). *Analysis of Assembly Bill 1763: Colorectal Cancer Screening Examinations*. Report to California State Legislature. Oakland, CA: CHBRP, 2016.

California Health Benefits Review Program (CHBRP). *Analysis of Assembly Bill 1763: Colorectal Cancer Screening Examinations*. Letter to California State Legislature. Oakland, CA: CHBRP, 2016.

California Health Benefits Review Program (CHBRP). *Analysis of Assembly Bill 1831: Topical Ophthalmic Refills*. Report to California State Legislature. Oakland, CA: CHBRP, 2016.

California Health Benefits Review Program (CHBRP). *Analysis of Assembly Bill 1954: Reproductive Health Care Services*. Report to California State Legislature. Oakland, CA: CHBRP, 2016.

California Health Benefits Review Program (CHBRP). *Analysis of Assembly Bill 2004: Hearing Aids: Minors*. Report to California State Legislature. Oakland, CA: CHBRP, 2016.

California Health Benefits Review Program (CHBRP). *Analysis of Assembly Bill 2050: Prescription Refill Synchronization*. Letter to California State Legislature. Oakland, CA: CHBRP, 2016.

California Health Benefits Review Program (CHBRP). *Analysis of Assembly Bill 2084: Medical Coverage for Comprehensive Medication Management (CMM) Services*. Report to California State Legislature. Oakland, CA: CHBRP, 2016.

California Health Benefits Review Program (CHBRP). *Analysis of Assembly Bill 2209: Clinical Pathways*. Letter to California State Legislature. Oakland, CA: CHBRP, 2016.

California Health Benefits Review Program (CHBRP). *Analysis of Assembly Bill 2372: HIV Specialists*. Report to California State Legislature. Oakland, CA: CHBRP, 2016.

California Health Benefits Review Program (CHBRP). *Analysis of Assembly Bill 2507: Telehealth*. Report to California State Legislature. Oakland, CA: CHBRP, 2016.

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California Health Benefits Review Program (CHBRP). *Analysis of Assembly Bill 2764: Mammography - Preliminary Analysis*. Letter to California State Legislature. Oakland, CA: CHBRP, 2016.

California Health Benefits Review Program (CHBRP). *Analysis of Senate Bill 999: Contraceptives: Annual Supply*. Report to California State Legislature. Oakland, CA: CHBRP, 2016.

California Health Benefits Review Program (CHBRP). *Analysis of Senate Bill 1034: Autism*. Report to California State Legislature. Oakland, CA: CHBRP, 2016.

California Health Benefits Review Program (CHBRP). *Background Brief: Clinical Care Pathways*. Report to California State Legislature. Oakland, CA: CHBRP, 2016.

California Health Benefits Review Program (CHBRP). *Estimates of Sources of Health Insurance in California for 2017*. Oakland, CA: CHBRP, 2016.

California Health Benefits Review Program (CHBRP). *Health Insurance Benefit Mandates in California State and Federal Law*. Oakland, CA: CHBRP, 2016.

California Health Benefits Review Program (CHBRP). *Briefing: CHBRP's Review of Health Insurance Bills*. Public Presentation. Sacramento, CA; February 2016.

2015

California Health Benefits Review Program (CHBRP). *Analysis of Assembly Bill 339: Outpatient Prescription Drugs*. Report to California State Legislature. Oakland, CA: CHBRP, 2015.

California Health Benefits Review Program (CHBRP). *Analysis of Assembly Bill 374: Step Therapy: Coverage*. Report to California State Legislature. Oakland, CA: CHBRP, 2015.

California Health Benefits Review Program (CHBRP). *Analysis of Assembly Bill 502: Dental Hygienists*. Report to California State Legislature. Oakland, CA: CHBRP, 2015.

California Health Benefits Review Program (CHBRP). *Analysis of Assembly Bill 623: Abuse-Deterrent Opioid Analgesics*. Report to California State Legislature. Oakland, CA: CHBRP, 2015.

California Health Benefits Review Program (CHBRP). *Analysis of Assembly Bill 796: Health Care Coverage: Autism and Pervasive Developmental Disorders*. Report to California State Legislature. Oakland, CA: CHBRP, 2015.

California Health Benefits Review Program (CHBRP). *Analysis of Assembly Bill 1102: Special Enrollment Periods*. Report to California State Legislature. Oakland, CA: CHBRP, 2015.

California Health Benefits Review Program (CHBRP). *Analysis of Assembly Bill 1305: Cost Sharing: Family Health Coverage*. Report to California State Legislature. Oakland, CA: CHBRP, 2015.

California Health Benefits Review Program (CHBRP). *Analysis of Assembly Bill 1305: Cost Sharing: Family Health Coverage*. Letter to California State Legislature. Oakland, CA: CHBRP, 2015.

California Health Benefits Review Program (CHBRP). *Analysis of Senate Bill 190: Acquired Brain Injury*. Report to California State Legislature. Oakland, CA: CHBRP, 2015.

California Health Benefits Review Program (CHBRP). *Analysis of Senate Bill 289: Telephonic and Electronic Patient Management Services*. Report to California State Legislature. Oakland, CA: CHBRP, 2015.

California Health Benefits Review Program (CHBRP). *Policy Snapshot: Primer on Insurer Provider Networks*. Report to California State Legislature. Oakland, CA: CHBRP, 2015.

California Health Benefits Review Program (CHBRP). *Background on Cost Sharing for Outpatient Prescription Drugs*. Report to California State Legislature. Oakland, CA: CHBRP, 2015.

California Health Benefits Review Program (CHBRP). *Survey and Analysis of Other States' Health Benefit Review Programs*. Oakland, CA: CHBRP, 2015.

California Health Benefits Review Program (CHBRP). *Analysis: California's EHB Base Benchmark Options*. Oakland, CA: CHBRP, 2015.

California Health Benefits Review Program (CHBRP). *Estimates of Sources of Health Insurance in California for 2016*. Oakland, CA: CHBRP, 2015.

California Health Benefits Review Program (CHBRP). *Health Insurance Benefit Mandates in California State and Federal Law*. Oakland, CA: CHBRP, 2015.

California Health Benefits Review Program (CHBRP). *Briefing: Health Insurance Benefit/Repeal Bills*. Public Presentation. Sacramento, CA; January 2015.

2014

California Health Benefits Review Program (CHBRP). *Analysis of Assembly Bill 1771: Telephonic Patient Management Services*. Report to California State Legislature. Oakland, CA: CHBRP, 2014.

California Health Benefits Review Program (CHBRP). *Analysis of Assembly Bill 1771: Telephonic Patient Management Services*. Letter to California State Legislature. Oakland, CA: CHBRP, 2014.

California Health Benefits Review Program (CHBRP). *Analysis of Assembly Bill 1917: Outpatient Prescription Drugs: Cost Sharing*. Report to California State Legislature. Oakland, CA: CHBRP, 2014.

California Health Benefits Review Program (CHBRP). *Analysis of Assembly Bill 1917: Outpatient Prescription Drugs: Cost Sharing*. Letter to California State Legislature. Oakland, CA: CHBRP, 2014.

California Health Benefits Review Program (CHBRP). *Analysis of Assembly Bill 2041: Developmental Services: Regional Centers: Behavioral Health Treatment*. Report to California State Legislature. Oakland, CA: CHBRP, 2014.

California Health Benefits Review Program (CHBRP). *Analysis of Assembly Bill 2418: Health Care Coverage: Prescription Drug Refills*. Report to California State Legislature. Oakland, CA: CHBRP, 2014.

California Health Benefits Review Program (CHBRP). *Analysis of Assembly Bill 2418: Health Care Coverage: Prescription Drug Refills*. Letter to California State Legislature. Oakland, CA: CHBRP, 2014.

California Health Benefits Review Program (CHBRP). *Analysis of Senate Bill 1053: Health Care Coverage: Contraceptives*. Report to California State Legislature. Oakland, CA: CHBRP, 2014.

California Health Benefits Review Program (CHBRP). *Analysis of Senate Bill 1239: Pupil Health Care: School Nurses*. Report to California State Legislature. Oakland, CA: CHBRP, 2014.

California Health Benefits Review Program (CHBRP). *Policy Brief: Pediatric Dental and Pediatric Vision Essential Health Benefits*. Report to California State Legislature. Oakland, CA: CHBRP, 2014.

California Health Benefits Review Program (CHBRP). *The Federal Preventive Services Health Insurance Benefit Mandate and California's Health Insurance Benefit Mandates*. Oakland, CA: CHBRP, 2014.

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California Health Benefits Review Program (CHBRP). *Estimates of Sources of Health Insurance in California for 2015*. Oakland, CA: CHBRP, 2014.

California Health Benefits Review Program (CHBRP). *Health Insurance Benefit Mandates in California State and Federal Law*. Oakland, CA: CHBRP, 2014.

California Health Benefits Review Program (CHBRP). *Briefing: Health Insurance Benefit/Repeal Bills*. Public Presentation. Sacramento, CA; January 2014.



Appendix 9: Summary of CHBRP Bill Analyses, 2014–2016

On the following page, Table 1 provides brief summaries of the bill analyses CHBRP completed during the period 2014 to 2016. In a trend of increasing requests during the period, CHBRP analyzed 6 bills in 2014, 9 bills in 2015, and 14 bills in 2016.

CHBRP analyses generally include the following elements (summarized in Table 1):

- Analyzed Bill Summary—a working interpretation of the bill’s potential effects;
- Medical Effectiveness of Service or Treatment—CHBRP’s analysis of the effectiveness of services or treatments relevant to the bill;
- Impacts—CHBRP’s estimates of impact, should the bill become law, including:
 - Benefit Coverage—change in enrollees with compliant health insurance;
 - Utilization—expected changes for relevant services or treatments;
 - Expenditures—expected change for total expenditures (which CHBRP defines as premiums plus relevant cost sharing and related out-of-pocket payments for noncovered benefits); and
 - Public Health—expected change in health outcomes.

Occasionally, one or more elements will not be present in a bill analysis. Some might not be appropriate because the potential effects of the bill are indeterminate or the bill effects could not be addressed in the limited time CHBRP had to complete the analysis.

Table 1. Summaries of Bill Analyses, 2014-2016

Analyzed Bill Summary	Medical Effectiveness of Service or Treatment	Benefit Coverage Impact	Utilization Impact	Expenditure Impact	Public Health Impact
<p>AB 533 (2016), Bonta Out-of-Network Coverage</p> <p>Would define and address “surprise medical bills” that occur when an enrollee receives care from an out-of-network (OON) health professional for covered services accompanying an in-network health facility encounter.</p>	<p>Given the breadth of diseases, conditions, and professional services that could be associated with an in-network encounter, medical effectiveness could not be considered within the available analytic time period.</p>	<p>Currently, 16.3 million enrollees (95%) of the 17.1 million enrollees with health insurance that would be subject to the bill have benefit coverage that is effectively compliant with bill’s requirements.</p>	<p>As the bill addresses “surprise” events, no change would be expected.</p>	<p>CHBRP projected total expenditure would decrease by \$251 million (-0.18%).</p>	<p>Given the breadth of diseases, conditions, and professional services that could be associated with an in-network encounter, public health impacts could not be considered within the available analytic time period.</p>

Analyzed Bill Summary	Medical Effectiveness of Service or Treatment	Benefit Coverage Impact	Utilization Impact	Expenditure Impact	Public Health Impact
<p>AB 796 (2016), Nazarian</p> <p>Health Care Coverage: Autism and Pervasive Developmental Disorders</p> <p>Would delay the sunset provision of an existing mandate for the coverage of behavioral treatments for persons with pervasive developmental disorders, or autism (PDD/A).</p>	<p>CHBRP found a preponderance of evidence that intensive behavioral intervention treatment (IBIT) is more effective than other treatments in improving behavioral outcomes, and a preponderance of evidence that IBIT delivered by persons who are trained or supervised by experienced IBIT providers are effective in improving outcomes.</p>	<p>CHBRP noted that other current mandates also require coverage for behavioral health treatment for PDD/A, so benefit coverage could be constant regardless of the sunset date AB 796 would alter.</p>	<p>CBHRP projected no measurable utilization impacts.</p>	<p>CBHRP projected no measurable expenditure impacts.</p>	<p>CBHRP projected no measurable public health impacts.</p>

Analyzed Bill Summary	Medical Effectiveness of Service or Treatment	Benefit Coverage Impact	Utilization Impact	Expenditure Impact	Public Health Impact
<p>AB 1763 (2016), Gipson</p> <p>Colorectal Cancer Screening</p> <p>Would require coverage for colorectal cancer screenings and tests with a grade of A or B by the U.S. Preventative Services Task Force (USPSTF), require coverage for additional screenings and tests for high-risk individuals, and prohibit cost sharing for enrollees aged 50 and over.</p>	<p>There is a preponderance of evidence that USPSTF-recommended colorectal cancer screening modalities are medically effective for the detection and prevention of CRC among average and high-risk patients.</p>	<p>If AB 1763 were enacted, CHBRP estimates the percent of enrollees with coverage for colorectal cancer screening exams and lab tests assigned a grade of A or B by the USPSTF and additional screening and tests recommended by a physician will remain to be 100%. However, AB 1763 will eliminate cost sharing on CRC screenings and lab tests for enrollees 50 years of age or older having colonoscopies with the removal of polyps and if the enrollee has a positive result on any fecal test.</p>	<p>CHBRP assumes that the overall utilization of CRC screening and lab tests is going to increase by 0.3% (1,764 users), mainly due to the increase in use among enrollees 50 years of age or older after the removal of cost sharing requirements for CRC screening and lab tests.</p>	<p>CHBRP projected total expenditure would increase by \$5.6 million (0.004%).</p>	<p>CHBRP projects no measurable public health impact on the diagnosis or prevention of colorectal cancer at the population level due to the small number (2,358) of additional enrollees who would avail themselves of CRC screening. At the individual level, AB 1763 would likely yield health and quality of life improvements, such as reduced screening-related financial burden and identification of CRC at earlier, and therefore more treatable, stages.</p>

Analyzed Bill Summary	Medical Effectiveness of Service or Treatment	Benefit Coverage Impact	Utilization Impact	Expenditure Impact	Public Health Impact
<p>AB 1831 (2016), Low</p> <p>Topical Ophthalmic Refills</p> <p>Would prohibit denial of refill coverage for covered topical ophthalmic products (often eye drops) at and after 70% of predicted use.</p>	<p>There is insufficient evidence to suggest that the limited number of additional days (often as few as 1–3 days) of adherence made possible by AB 1831 would measurably impact the effectiveness of treatment.</p>	<p>Currently, 3.9 million enrollees (15%) of the 25.2 million enrollees in DMHC-regulated plans and CDI-regulated policies have benefit coverage compliant with AB 1831.</p>	<p>Filled prescriptions per 1,000 enrollees would increase by 0.5%.</p>	<p>CHBRP projected total expenditure would increase by \$955,000 (0.0007%).</p>	<p>CHBRP does not project a measurable impact on the population’s health outcomes within the first year of the bill’s passage into law.</p>

Analyzed Bill Summary	Medical Effectiveness of Service or Treatment	Benefit Coverage Impact	Utilization Impact	Expenditure Impact	Public Health Impact
<p>AB 1954 (2016), Burke</p> <p>Reproductive and Sexual Health</p> <p>Would require enrollees with coverage for reproductive and sexual health services to be covered for care at an out-of-network (OON) provider if timely access to an in-network provider is unavailable.</p>	<p>There is evidence to support the effectiveness of timely access to emergency contraception pills and IUD implantation to prevent pregnancy. There is also evidence that increasing access for services involving the collection of forensic evidence or emergency contraception following sexual assault or rape would increase the effectiveness of those services.</p>	<p>If AB 1954 were enacted, CHBRP estimates the percent of enrollees with coverage for reproductive and sexual health care services through OON providers under specified circumstances without a referral will increase from 32% to 100%. The estimates were also based on the assumptions that HMOs, including HMO and POS plans need to be in compliance. AB 1954 only applies to grandfathered and nongrandfathered plans and policies including Covered California and CalPERS HMOs, but does not apply to Medi-Cal Managed Care.</p>	<p>CHBRP assumes that the overall utilization of reproductive and sexual health care services is not going to increase. However, CHBRP assumes that there will be a shift from using in-network services to OON services.</p> <p>CHBRP estimates that the in-network utilization will decline and the OON utilization would increase after the mandate due to the improved access to OON providers without a referral.</p> <p>CHBRP estimates that the utilization of OON sexual health care services among the enrollees will increase by 9 units per 1,000 enrollees; and use of OON reproductive health care services by 8 units per 1,000 enrollees.</p>	<p>CHBRP projected total expenditure would increase by \$23 million (0.0155%).</p>	<p>It stands to reason that public health impacts in the first year, postmandate, may include improved prevention of unintended pregnancies and STD/HIV morbidity, both in general and in the context of sexual assault/rape.</p>

Analyzed Bill Summary	Medical Effectiveness of Service or Treatment	Benefit Coverage Impact	Utilization Impact	Expenditure Impact	Public Health Impact
<p>AB 2004 (2016), Bloom</p> <p>Hearing Aids: Minors</p> <p>Would require coverage for initial hearing aid assessment, new hearing aids at least every 5 years, ear molds, fittings, adjustments, auditory training, and maintenance for enrollees under 18 years of age who require medically necessary hearing aids.</p>	<p>It is generally accepted that the use of hearing aids improves the hearing of children with hearing loss. A preponderance of evidence suggests that hearing aids are effective in improving speech and language outcomes among children with hearing loss. Early and consistent use of hearing aids is associated with better speech and language outcomes.</p>	<p>CHBRP estimates that in 2015, all state-regulated coverage (for 25.2 million Californians) would be subject to AB 2004.</p> <p>Currently, CHBRP estimates that in privately funded plans and policies, about 9% of enrollees aged 0 to 17 have coverage for hearing aids and services. In publicly funded plans, CHBRP estimates that 100% of enrollees aged 0 to 17 have coverage for hearing aids and services.</p>	<p>On the basis of literature and content expert input, CHBRP estimates that families of children who need hearing aids generally acquire them, even if they do not have coverage for this benefit.</p> <p>The count of hearing aids would increase from an estimated 5,862 hearing aids covered by insurance to an estimated 11,018 hearing aids covered by insurance postmandate. There would be a decrease of approximately 5,035 hearing aids paid for out-of-pocket by enrollees without hearing aid coverage.</p> <p>Other related covered services (maintenance and repair, replacement, ear molds, diagnostic tests, fittings and adjustments) are expected to roughly double from pre- to postmandate.</p>	<p>CHBRP projected total expenditure would increase by \$3.6 million (0.002%).</p>	<p>CHBRP expects that speech and language skills would improve for a subset of children with hearing loss who were unable to afford hearing aids premandate. CHBRP estimates that this bill would reduce the financial burden on families currently without coverage for hearing aids who would gain coverage postmandate.</p> <p>CHBRP estimates that AB 2004 would reduce the net financial burden of out-of-pocket expenses by approximately \$17 million for the families of 21,100 children who use hearing aids and services in the first year, postmandate. CHBRP estimates that the annual out-of-pocket costs for families of the 21,100 newly covered children would decrease from about \$1,850 to \$300.</p>

Analyzed Bill Summary	Medical Effectiveness of Service or Treatment	Benefit Coverage Impact	Utilization Impact	Expenditure Impact	Public Health Impact
<p>AB 2050 (2016), Steinorth</p> <p>Prescription Refill Synchronization</p> <p>Would require a synchronization policy that would allow enrollees to align prescription drug refill dates, should the enrollee have multiple prescriptions to refill.</p>	<p>CHBRP found the evidence to be insufficient to make a determination on effectiveness of synchronization on adherence.</p>	<p>Although a slight majority of enrollees would have altered benefit coverage, the changes would be limited, as those enrollees' benefit is very nearly already compliant—allowing for one or more prescriptions to be billed at a lower amount so as to synch with another for the next refill.</p>	<p>CBHRP projected no measurable utilization impacts.</p>	<p>CBHRP projected no measurable expenditure impacts.</p>	<p>CBHRP projected no measurable public health impacts.</p>

Analyzed Bill Summary	Medical Effectiveness of Service or Treatment	Benefit Coverage Impact	Utilization Impact	Expenditure Impact	Public Health Impact
<p>AB 2084 (2016), Wood</p> <p>Medi-Cal Coverage for Comprehensive Medication Management (CMM) Services</p> <p>Would require coverage for comprehensive medication management (CMM) services in Medi-Cal (both in Medi-Cal Managed Care plans and fee-for-service [FFS]) for beneficiaries taking three or more prescription drugs or biologics to treat or prevent one or more chronic conditions.</p>	<p>CHBRP found insufficient evidence about the impact of comprehensive medication management (CMM) services on health care utilization, clinical outcomes, mortality, medication adherence, and appropriateness of prescribing.</p> <p>CHBRP concludes that there is a preponderance of evidence that pharmacist services, including medication review, patient-directed education, care coordination, and follow-up, improve health care utilization, clinical and quality of life outcomes, medication adherence, and mortality relative to usual care. Many studies of direct pharmacist care concern more narrowly focused interventions than CMM, so the findings may not generalize to CMM.</p>	<p>Medicare-Medicaid Duals (1.4 million) appear to be Medi-Cal beneficiaries targeted for CMM on the basis of health needs and costs. This population has Medicare as the primary coverage, which includes prescription drug coverage. It would appear under AB 2084 that Medi-Cal would bear program costs, but any potential financial benefits would largely be realized by Medicare FFS or Medicare Advantage plans.</p>	<p>Due to the limited research, there is insufficient statistical power to detect statistically significant differences in hospital readmissions and emergency department visits. Therefore, CHBRP concludes there is insufficient evidence about the impact of CMM services compared to usual care on health care utilization.</p>	<p>Because of the variability in the design of programs, their target populations, sample size, and outcome measures, the current evidence is low to insufficient to conclude that medication therapy management (MTM) programs are consistently cost effective. Because the parameters of the proposed CMM are broad, it is not possible to estimate the likely return on investment for the proposed CMM program contained in AB 2084. At the same time, there is growing consensus that such interventions, particularly in the context of medical home- and team-based coordination of care, can be cost effective.</p>	<p>CBHRP projected no measurable public health impacts.</p>

Analyzed Bill Summary	Medical Effectiveness of Service or Treatment	Benefit Coverage Impact	Utilization Impact	Expenditure Impact	Public Health Impact
<p>AB 2209 (2016), Bonilla</p> <p>Clinical Pathways</p> <p>Would prohibit implementing clinical care pathways (CCPs) for use by providers in order to manage an enrollee's or insured's care.</p>	<p>There is insufficient evidence to assess the extent to which the use of CCPs by health plans/insurers impacts health outcomes.</p>	<p>Because no relevant definition was available, benefit coverage among enrollees in DMHC-regulated plans and CDI-regulated policies could not be estimated.</p>	<p>Because no relevant definition was available, benefit coverage among enrollees in DMHC-regulated plans and CDI-regulated policies could not be estimated.</p>	<p>There is limited evidence from three studies with weak research designs using data from two health plans that the use of oncology CCPs by plans/insurers reduces costs for oncology patients.</p>	<p>CHBRP concludes that there is insufficient evidence to assess the extent to which the use of CCPs by health plans/insurers impacts health outcomes.</p>

Analyzed Bill Summary	Medical Effectiveness of Service or Treatment	Benefit Coverage Impact	Utilization Impact	Expenditure Impact	Public Health Impact
<p>AB 2372 (2016), Burke</p> <p>HIV Specialists</p> <p>Would include HIV specialists meeting the plan/policy as potential primary care physicians (PCPs), provided the HIV specialist meets the plan/policy PCP eligibility criteria.</p>	<p>Physicians with more HIV experience/expertise provide better care on medication adherence and viral load control than physicians with less HIV experience/expertise.</p>	<p>AB 2372 would affect the health insurance of approximately 25.2 million enrollees (65.2% of all Californians) who would be eligible to designate an HIV specialist as their PCP.</p>	<p>CBHRP projected no measurable utilization impacts.</p>	<p>CBHRP projected no measurable expenditure impacts.</p>	<p>The use of primary care services provided by HIV specialists and the resulting health outcomes for people living with HIV (PLWH) is unknown.</p>

Analyzed Bill Summary	Medical Effectiveness of Service or Treatment	Benefit Coverage Impact	Utilization Impact	Expenditure Impact	Public Health Impact
<p>AB 2507 (2016), Gordon</p> <p>Telehealth: Access</p> <p>Would formally recognize telephone, e-mail, and synchronous text and chat conferencing as telehealth modalities. Later amended to omit e-mail and synchronous text and chat conferencing. Would require reimbursement parity to equivalent in-person visits and allows for cost sharing at least as favorable to the enrollee as equivalent in-person visits.</p>	<p>For live video, there is a preponderance of evidence that care provided by live video is at least as effective as care provided in person for both physical and mental health conditions. In particular, there is clear and convincing evidence that live video is equivalent to in person care for both mental health services and dermatology.</p> <p>For store-and-forward, there is a low preponderance of evidence that medical care provided by store-and-forward is at least as effective as medical care provided in person for both physical and mental health conditions. For telephone, the evidence is ambiguous related to medical care provided by telephone compared to in-person care.</p>	<p>CHBRP estimates that in 2017, all 25.2 million Californians with state-regulated coverage would be subject to AB 2507.</p> <p>Currently, 78% of enrollees in plans and policies subject to AB 2507 have coverage for phone telehealth services.</p> <p>Currently, 91% of enrollees in plans and policies subject to AB 2507 have coverage for live video and store-and-forward telehealth services.</p> <p>However, in spite of coverage, claims data did not reflect high rates of use of these services. This may be due to a lack of reimbursement or other issues related to the billing of telehealth services.</p>	<p>For phone telehealth services, the utilization rate in units per 1,000 covered enrollees would increase from 0.59 to 180.36 (>1,000% increase).</p> <p>For live video telehealth, the utilization rate in units per 1,000 covered enrollees would increase from 0.06 to 14.53 (>1,000% increase).</p> <p>For store-and-forward telehealth, the utilization rate in units per 1,000 covered enrollees would increase from 0.68 to 176.30 (>1,000% increase).</p>	<p>CHBRP used two scenarios to estimate the utilization and cost impact, a low telehealth adoption and a high telehealth adoption scenario.</p> <p>In the low-adoption scenario, total expenditures would increase by an estimated \$96.8 million (0.07%).</p> <p>In the high-adoption scenario, total expenditures would increase by an estimated \$402.6 million (0.28%).</p>	<p>CHBRP estimates that, postmandate, patient experience would improve as providers increase their telephone responses to patient inquiries. The improvement is partly attributable to increased access to (specialty or primary) care, as well as improved convenience for patients, such as reduced wait times and/or reduced travel time for some visits.</p> <p>CHBRP estimates that, postmandate, travel costs and travel time would likely decrease for some enrollees using newly covered, telehealth services. As a result, some enrollees with transportation challenges may have better outcomes because they would no longer delay or avoid in-person visits by favoring telephonic or electronic communications with their provider.</p>

Analyzed Bill Summary	Medical Effectiveness of Service or Treatment	Benefit Coverage Impact	Utilization Impact	Expenditure Impact	Public Health Impact
<p>AB 2764 (2016), Bonilla</p> <p>Mammography</p> <p>Would alter a current law to define required mammography coverage as inclusive of both digital mammography and digital breast tomosynthesis (DBT).</p>	<p>There is clear and convincing evidence that digital mammography alone leads to reduced breast cancer-related mortality, and may detect breast cancer at an earlier stage among some subgroups of women. There is insufficient evidence to determine the effectiveness of adding DBT to screening digital mammography on key clinical outcomes.</p>	<p>Currently, 15.4 million enrollees (64%) of the 25.2 million enrollees in DMHC-regulated plans and CDI-regulated policies subject to AB 912 have benefit coverage for DBT.</p>	<p>During the first postmandate year, use of DBT as a screening test would be expected to increase by 91%, from 862,000 to 1.6 million tests. Use of DBT as a diagnostic test would be expected to increase by 53%, from 303,000 to 464,000.</p>	<p>CHBRP projected total expenditure would increase by \$39 million (0.03%).</p>	<p>Because there is insufficient evidence to suggest that the use of DBT in addition to digital mammography would improve clinically meaningful health outcomes, the public health impact in the first year, postmandate, is unknown.</p>

Analyzed Bill Summary	Medical Effectiveness of Service or Treatment	Benefit Coverage Impact	Utilization Impact	Expenditure Impact	Public Health Impact
<p>SB 999 (2016), Pavley</p> <p>Contraceptives: Annual Supply</p> <p>Would require coverage for a 12-month supply of FDA-approved, self-administered hormonal contraceptives dispensed at one time to an enrollee (includes pill, patch, and ring). Prescribers may specify “no change to quantity” if they choose not to prescribe a 12-month supply.</p>	<p>Obtaining a 12-month supply of self-administered hormonal contraceptives at one time reduces the potential for delays in refills between cycles. Consistent, continuous contraceptive use helps to prevent any extension of the usual hormone-free interval; extension of this interval results in an increased possibility of unintended pregnancy.</p> <p>There is a preponderance of evidence to indicate that dispensing oral contraceptives in larger quantities leads to a reduction in unintended pregnancy and related outcomes.</p> <p>There is clear and convincing evidence that self-administered hormonal contraceptives are effective in preventing pregnancy. There is also clear and convincing evidence to suggest that unintended pregnancy leads to a decrease in prenatal care and breastfeeding.</p>	<p>CHBRP estimates that in 2016, 25.2 million Californians have state-regulated coverage that would be subject to SB 999.</p> <p>Premandate, 27% of enrollees in DMHC-regulated plans and CDI-regulated policies subject to SB 999 have benefit coverage for a 12-month supply of the oral contraceptive pill (all in Medi-Cal Managed Care).</p>	<p>The number of women using a 1-month supply of self-administered hormonal contraceptives was estimated to decrease from approximately 500,000 premandate to 185,000 postmandate (a 63% decrease).</p> <p>The number of women using a 3-month supply of self-administered hormonal contraceptives was estimated to increase from approximately 240,000 to 275,000 (a 15% increase).</p> <p>The number of women using a 12-month supply of self-administered hormonal contraceptives was estimated to increase from approximately 5,000 to 285,000 (a 5,603% increase).</p>	<p>CHBRP projected total expenditure would decrease by \$43 million (-0.03%).</p>	<p>As a result of SB 999, CHBRP estimates a first-year decrease in unintended pregnancies of 15,000 (which includes 6,000 fewer births, 2,000 fewer miscarriages, and 7,000 fewer abortions).</p> <p>The reduction in unintended pregnancies will also result in a reduction in negative health outcomes associated with unintended pregnancy, including delayed prenatal care, low birth weight, and preterm birth.</p> <p>There is no evidence to suggest that there would be any difference in health risks for women receiving a 1-month or 3-month supply versus a 12-month supply of self-administered hormonal contraceptives other than the increased risk of unintended pregnancy among the women in the 1-month and 3-month groups.</p>

Analyzed Bill Summary	Medical Effectiveness of Service or Treatment	Benefit Coverage Impact	Utilization Impact	Expenditure Impact	Public Health Impact
<p>SB 1034 (2016), Mitchell</p> <p>Autism</p> <p>Would alter a current law requiring coverage of behavioral health treatment (BHT) for autism spectrum disorder (ASD) to require coverage for maintenance of function, prohibit denials based on parent/caregiver nonparticipation or settings, and generally prohibit plan/insurer review of treatment plans at less than 6-month intervals.</p>	<p>In light of evidence that BHT improves functioning, it stands to reason that BHT could also be useful for maintaining functioning. A preponderance of evidence suggests: BHT is more effective than usual care regardless of the degree of parent/caregiver involvement; BHT can be delivered effectively in multiple settings, There is insufficient evidence to assess prohibiting health plans from reviewing treatment plans more frequently than every 6 months.</p>	<p>Currently, 1.8 million enrollees (6%) of the 18.3 million enrollees with health insurance that would be subject to the mandate have benefit coverage compliant with SB 1034 in regard to coverage for BHT for maintenance of functioning.</p>	<p>Use of BHT would be expected to increase by 3.03 hours per enrollee (7%).</p>	<p>CHBRP projected total expenditure would increase by \$8.3 million (0.006%).</p>	<p>CHBRP found wide variance in outcomes from BHT for ASD and insufficient longitudinal studies to indicate that ongoing maintenance therapy is effective or necessary to preserve gains, so the overall public health impact of SB 1034 is unknown. However, it would be reasonable to assume that, for some children and adolescents with a history of behavioral health treatment for ASD, maintenance therapy would reinforce and possibly enhance some gains.</p>

Analyzed Bill Summary	Medical Effectiveness of Service or Treatment	Benefit Coverage Impact	Utilization Impact	Expenditure Impact	Public Health Impact
<p>AB 339 (2015), Gordon</p> <p>Outpatient Prescription Drugs</p> <p>Would reduce cost-sharing amounts for a 30-day prescription to 1/24th of the annual out-of-pocket limit. Would also: require coverage for specified drugs under specified circumstances; standardize tiers; restrict cost sharing. Would exempt Medi-Cal Managed Care.</p>	<p>There is a preponderance of evidence from studies with strong research designs that persons who face higher cost sharing reduce use of both essential and nonessential health care services.</p>	<p>AB 339 mandates changes in prescription benefit formulary design and does not mandate coverage of specific treatments and services. All enrollees subject to AB 339 have coverage for outpatient prescription drugs, as defined by AB 339, and all have some form of cost sharing for these drugs. The number of enrollees with coverage for outpatient prescription drugs will remain the same postmandate.</p>	<p>Cost sharing for prescription drugs would be limited to 1/24 of the annual out-of-pocket maximum for up to a 30-day supply of prescription drugs. As discussed above, high-cost and/or specialty drugs are the ones most likely affected by AB 339 because they currently are often subject to high coinsurance levels. These drugs frequently include specialty and biologic drugs and, despite their high cost sharing, their use is relatively inelastic. For example, doubling in cost sharing of rheumatoid arthritis drugs would reduce utilization by 21% among privately insured patients. The reduction in utilization is even lower for cancer specialty drugs (1%).</p>	<p>CHBRP projected total expenditure would increase by \$322 million (0.237%).</p>	<p>Although the absolute number of enrollees facing a reduction in cost sharing due to AB 339 is not large (46,357 of 10.97 million enrollees, or 0.42%), the evidence indicated that reduced cost sharing is linked to improved medication initiation and adherence, which results in improved outcomes for some persons across a variety of conditions</p> <p>CHBRP estimates that 46,357 enrollees, including 947 new users, would fill an additional 13,184 high-cost prescription drugs were AB 339 enacted. Although across the state of California, this is a relatively small number, CHBRP recognizes that on a case-by-case basis, AB 339 may yield important health and quality-of-life improvements for some persons.</p>

Analyzed Bill Summary	Medical Effectiveness of Service or Treatment	Benefit Coverage Impact	Utilization Impact	Expenditure Impact	Public Health Impact
<p>AB 374 (2015), Nazarian,</p> <p>Step Therapy: Coverage</p> <p>Would require mandate-compliant override procedures for step therapy protocols (STPs) applicable to an outpatient prescription drug benefit.</p>	<p>CHBRP concludes that there is insufficient evidence to determine whether STPs directly affect health outcomes. Findings from studies of the impact of STPs on rates of initiation, continuation, and day supply of drugs are ambiguous. Finding from studies on the impact of STP on rates of hospital admission, emergency department visits, and outpatient visits are ambiguous across classes of drugs.</p> <p>CHBRP found no studies on the impact of step therapy overrides. Due to insufficient evidence, CHBRP concludes that impact of override procedures is unknown.</p>	<p>The terms and conditions of 27% of enrollees would change to become fully compliant with AB 374's override approval criteria.</p> <p>Following the enactment of AB 374, 100% of enrollees with coverage subject to AB 374 would have fully compliant coverage, with all five criteria for STP overrides included in their DMHC-regulated plans or CDI-regulated policies.</p>	<p>CHBRP estimates that the number of step therapy overrides per 1,000 enrollees in DMHC-regulated plans or CDI-regulated policies will increase to an average of 9.0 (see Table 1) for an increase of 0.31 step therapy overrides per 1,000 enrollees, in the year following implementation of AB 374. CHBRP estimates that the increase in approved postmandate override requests will be approximately 4% of the total number of override requests granted premandate, as enrollees with newly mandate-compliant coverage will increase their use of STP override procedures to match the same rate as enrollees who already had mandate-compliant coverage during the premandate period.</p>	<p>CHBRP projected total expenditure would increase by \$10.8 million (0.008%).</p>	<p>CHBRP finds insufficient evidence of the effect of STPs or override procedures on health outcomes. Therefore, the public health impact in the first year, postmandate, is unknown.</p>

Analyzed Bill Summary	Medical Effectiveness of Service or Treatment	Benefit Coverage Impact	Utilization Impact	Expenditure Impact	Public Health Impact
<p>AB 502 (2015), Chau</p> <p>Dental Hygienists</p> <p>Would require reimbursement of Registered Dental Hygienists in Alternative Practices (RDHAP) as out-of-network providers without registration process (germane to dental PPOs). Would prohibit requiring RDHAPs to obtain: (1) written verification of patient examination by a dentist, physician, or surgeon within the last 18 months; (2) a dental health prescription if last examination occurred >18 months prior to service.</p>	<p>CHBRP found a preponderance of evidence from moderate-quality research that the services potentially provided by RDHAPs are effective in alternative practice settings, such as schools, homes of homebound, institutions, and shortage areas.</p> <p>Although CHBRP is unable to estimate health benefits from AB 502 quantitatively, it stands to reason that access to effective oral health care would improve health outcomes among these populations.</p>	<p>Currently, all 8.34 million enrollees subject to AB 502 have access to dental hygiene services through their standalone or embedded dental benefit.</p> <p>There are not currently any RDHAPs that participate as contracted network providers in dental HMOs (DMO) or dental PPOs (DPPO) in California. Thus, CHBRP estimates that 5.25 million (62.9% are estimated to be in DPPO plans, in which RDAHPs can currently submit claims for services delivered as an out-of-network provider.</p> <p>AB 502 would require several changes that have utilization and cost implications for services delivered and billed to private, state-regulated dental PPOs in California.</p>	<p>It is expected that all RDHAPs providing care to any of the 5.25 million state-regulated, private DPPO enrollees would be reimbursed for services, if provided out of network.</p>	<p>CHBRP provides two estimates on expenditures, derived in part from two different data sources that generated its baseline expenditure estimates.</p> <p>Estimate A projects total net annual expenditures to increase by \$47,236 (0.001% in PMPM).</p> <p>In Estimate B, the projected increase in total net annual expenditures would be \$1.944 million (0.04% in PMPM).</p>	<p>Although CHBRP is unable to estimate the impact quantitatively, AB 502 is likely to lead in the long term to increased utilization and improved oral health in the affected populations.</p>

Analyzed Bill Summary	Medical Effectiveness of Service or Treatment	Benefit Coverage Impact	Utilization Impact	Expenditure Impact	Public Health Impact
<p>AB 623 (2015), Wood</p> <p>Abuse-Deterrent Opioid Analgesics</p> <p>Would require mandate-compliant utilization management protocols for coverage of opioid analgesics and Food and Drug Administration (FDA)-labeled abuse-deterrent opioid analgesics (ADOAs).</p>	<p>Although studies suggest that ADOAs can reduce abuse of the ADOA specific drug, studies also suggest that the presence of ADOAs shifts some abuse to other OAs and/or to illicit drugs (such as heroin). Therefore, the impact on abuse is ambiguous.</p>	<p>100% of enrollees in DMHC-regulated plans and CDI-regulated policies would have fully mandate-compliant benefit coverage.</p>	<p>CHBRP estimates that the annual use of FDA-ADOAs will increase to 13.41 per 1,000 enrollees, which is an increase of 38%. Under the assumption that the total number of opioid analgesic prescriptions will remain constant, there will be a corresponding 3.7 per 1,000 enrollee drop in the use of opioid analgesic prescriptions associated with changing protocols (not including FDA-ADOAs), a decrease of 1%.</p>	<p>CHBRP projected total expenditure would increase by \$7.9 million (0.0058%).</p>	<p>In the first year postmandate, CHBRP projects AB 623 would have an unknown public health impact due to both the ambiguous evidence of effectiveness of ADOAs deterring overall abuse and the unknown magnitude of changes in prescriber and patient behavior in response to changing utilization management protocols. However, CHBRP posits that it is unlikely AB 623 would have a measurable impact on abuse, overdose, and premature death.</p>

Analyzed Bill Summary	Medical Effectiveness of Service or Treatment	Benefit Coverage Impact	Utilization Impact	Expenditure Impact	Public Health Impact
<p>AB 796 (2015), Nazarian</p> <p>Health Care Coverage: Autism and Pervasive Developmental Disorders</p> <p>Would broaden definition of qualified autism services (QAS) professionals and paraprofessionals, specifying levels of education/experience and removing QAS professionals' requirements of applied behavioral analysis (ABA) training and regional center vendor status. Would exempt Medi-Cal Managed Care.</p>	<p>CHBRP found a preponderance of evidence that intensive behavioral intervention treatment (IBIT) is more effective than other treatments in improving behavioral outcomes, and a preponderance of evidence that IBIT delivered by persons who are trained or supervised by experienced IBIT providers are effective in improving outcomes. CHBRP found insufficient evidence to directly compare the provision of IBIT by different personnel.</p>	<p>CHBRP estimates that 100% of the 16.3 million enrollees in DMHC-regulated plans or CDI-regulated policies that would be subject to AB 796 have coverage for behavioral health treatment for pervasive developmental disorders, or autism (PDD/A) due to the current law (H&S Code 1374.73 and Ins Code 10144.51). If AB 796 were enacted, CHBRP estimates that the percentage of enrollees with benefit coverage for IBIT would remain the same due to the existence of the current law.</p>	<p>AB 796 would not alter benefit coverage for IBIT, which is already 100% due to the current mandate; CHBRP projects no change in utilization.</p>	<p>Because CHBRP estimates no change in utilization or unit cost, CBHRP projects no postmandate impact on expenditures.</p>	<p>Although evidence shows that trained and supervised QAS personnel are effective in delivering intensive behavioral intervention therapies in a manner that improves behavioral outcomes among children and adolescents with PDD/A, CHBRP concludes that passage of AB 796 would have no short-term public health impact due to no change in coverage, utilization, or unit cost. This is because coverage for IBIT services delivered by QAS personnel is already required under the current law, and AB 796 does not compel IBIT providers or markets to alter their current staffing and/or reimbursement arrangements.</p>

Analyzed Bill Summary	Medical Effectiveness of Service or Treatment	Benefit Coverage Impact	Utilization Impact	Expenditure Impact	Public Health Impact
<p>AB 1102 (2015), Santiago</p> <p>Special Enrollment Periods</p> <p>Would include pregnancy as a “qualifying event,” allowing a woman to enroll in or change her current health care plan or policy outside of the enrollment period.</p>	<p>There is clear and convincing evidence from meta-analyses and systematic reviews that certain prenatal care services produce better birth outcomes for mothers and infants. These services include screening tests, counseling regarding unhealthy behaviors, and treatments for diseases or conditions associated with poorer birth outcomes.</p>	<p>CHBRP estimates that in 2016, 4.33 million of 25.8 million Californians have individual market plans and policies (state-regulated coverage that would be subject to AB 1102). In addition, CHBRP estimates that 961,000 females between the ages of 15 and 44 remain uninsured (out of a total state population of 7.99 million in that demographic), of which 429,898 are documented residents.</p>	<p>If insured women switch from one plan to another, CHBRP uses the simplifying assumption that no change in utilization of prenatal care and labor and delivery occurs because coverage for prenatal services already exists among all plans and policies (per ACA or common practice in ERISA plans).</p> <p>If a pregnant woman is uninsured, utilization of prenatal care services would increase somewhat because women would not be able to activate new insurance until the beginning of the second trimester at the earliest, due to the insurance administrative process. Labor and delivery utilization and health outcomes would not change postmandate due to state law requiring hospitals to provide such services regardless of ability to pay or citizenship status.</p>	<p>CHBRP only estimated projected impacts on Covered California. AB 1102 would also impact enrollees in the remaining DMHC and CDI individual markets outside Covered California. These impacts were not estimated in the limited time given for this analysis.</p>	<p>Prenatal care reduces the risk of preterm birth, low birthweight, mother-to-child transmission of infectious disease, and other poor birth outcomes. There is also the potential to reduce morbidity and mortality and the associated societal costs.</p> <p>CHBRP does note the possibility for poorer health outcomes for those newly uninsured (women who decide to drop coverage), as well as increased enrollee expenses for health among this group of women.</p>

Analyzed Bill Summary	Medical Effectiveness of Service or Treatment	Benefit Coverage Impact	Utilization Impact	Expenditure Impact	Public Health Impact
<p>AB 1305 (2015), Bonta</p> <p>Cost Sharing: Family Health Coverage</p> <p>Would require standardizing, within the same contract, cost sharing for per-person deductibles and out-of-pocket limits across family and self-only benefit coverage. Delinks deductible levels for family and single high-deductible health plans (HDHPs).</p>	<p>CBHRP projected no measurable medical effectiveness impacts.</p>	<p>100% of DMHC-regulated plans or CDI-regulated policies would be mandate compliant, either because they have no family deductible or have an embedded per-person deductible in family plans or policies. To be IRS-compliant postmandate, 100% of the embedded per-person deductibles of family HDHPs would have to be no lower than \$2,600 (see Table 2 in the Policy Context section). Keeping with the insurance structure carriers reported for family-level HDHPs, 100% of total family deductibles are assumed to increase to \$5,200.</p>	<p>CHBRP analysis yielded an average estimated decrease in the covered benefits paid for by the DMHC-regulated plans and CDI-regulated policies of \$0.06 (-0.019%), for a postmandate total of \$347.11 PMPM in covered benefits paid for by the plans or policies. Direct costs to the enrollee will also decrease by \$0.04 (-0.04%), for a total postmandate of \$52.59 PMPM in covered benefits paid for by the enrollee.</p> <p>Taken together, the combined effect is a decrease of \$0.11 (-0.027%) in overall expenditures, for an average postmandate total of \$399.70 PMPM of covered benefits.</p>	<p>CHBRP projected total expenditure would decrease by \$38 million (-0.028%).</p>	<p>CBHRP projected no measurable public health impacts.</p>

Analyzed Bill Summary	Medical Effectiveness of Service or Treatment	Benefit Coverage Impact	Utilization Impact	Expenditure Impact	Public Health Impact
<p>SB 190 (2015), Beall</p> <p>Acquired Brain Injury</p> <p>Would require benefit coverage for post-acute residential transitional rehabilitation services (PARTRS), an intensive and specific treatment set, for persons affected by an acute brain injury (ABI). Would exempt Medi-Cal Managed Care.</p>	<p>CHBRP concludes that the preponderance of evidence, including the literature and content expert, suggests that PARTRS for persons with moderate-to-severe ABI statistically significantly improves functional status and outcomes compared to pre-treatment levels.</p> <p>However, there is insufficient evidence that PARTRS is more effective than any other form of multidisciplinary rehabilitation. The lack of evidence for PARTRS does not mean that it is not effective, only that the effectiveness has not been established by studies using the most rigorous research designs.</p>	<p>If SB 190 were enacted, CHBRP estimates that the percentage of enrollees with benefits coverage for PARTRS would increase to 100%.</p> <p>CHBRP found no evidence of PARTRS-specific benefit terms or coverage or any policy of making PARTRS subject to acute care treatment lifetime day limits. Therefore, it appears that enrollees in plans and policies subject to SB 190 already have health insurance compliant with these aspects of SB 190, and so CHBRP would expect no impact due to these aspects of the mandate.</p>	<p>CHBRP assumes that the mandate will increase access to PARTRS for those who, premandate, were without coverage for PARTRS. Though there are no existing data to verify the sufficiency of PARTRS providers in California, CHBRP does not anticipate any impacts on the service availability after the mandate because the number of persons with moderate-to-severe ABI annually qualifying for PARTRS is limited and because facilities that are PARTRS-ready or near-PARTRS-ready exist, CHBRP expects that persons with new benefit coverage would find a facility providing PARTRS.</p>	<p>CHBRP projected total expenditure would increase by \$216 million (0.16%).</p>	<p>CHBRP finds insufficient evidence of medical effectiveness to suggest that multidisciplinary PARTRS as described in SB 190 produces changes to health outcomes as compared with other rehabilitation services. Therefore, the public health impact in the first year, postmandate, is unknown. Please note that the absence of evidence is not “evidence of no effect.” It is possible that an impact—positive or negative—could result, but current evidence is insufficient to inform an estimate.</p>

Analyzed Bill Summary	Medical Effectiveness of Service or Treatment	Benefit Coverage Impact	Utilization Impact	Expenditure Impact	Public Health Impact
<p>SB 289 (2015), Mitchell</p> <p>Telephonic and Electronic Patient Management Services</p> <p>Would require reimbursement, based on complexity and time expenditure, to physicians and nonphysicians for telephonic and electronic evaluation and management when initiated by established patients.</p>	<p>The evidence for the medical effectiveness of either telephone or e-mail communication is either ambiguous or there is insufficient evidence to make a call. The exception to that is in health outcomes in diabetes, in which a preponderance of the evidence from studies with strong-to-moderate designs shows that use of secure e-mail as part of a multifaceted web portal is associated with better glycemic control. The preponderance of the evidence from moderate-to-strong studies across multiple diseases indicates that both live videoconference and store-and-forward are at least as effective in terms of health outcomes and diagnostic accuracy as in-person care and that these technologies can shorten wait times for specialty care, diagnosis, and treatment.</p>	<p>Postmandate, all 24.6 million enrollees with state-regulated health insurance would have coverage for telephone, e-mail, live videoconferencing, and store-and-forward evaluation and management services.</p> <p>California’s Medi-Cal Managed Care plans include coverage for live videoconferencing and store-and-forward technology within their capitated rates. The plans do not currently reimburse separately for telephone and e-mail encounters, but given the nature of capitation to the health plan, carriers or providers could decide to provide telehealth services although not separately reimbursable under current law.</p>	<p>CHBRP estimates that overall encounters—whether they occur in-person or via telehealth—would increase between 4.5% (low) and 20.0% (high). Telehealth, as a share of all visits, would range between 7.4% (low-Enhanced) to 29.2% (high), whereas in-person visits would decrease by 0.9% (low-enhanced) to 15.0% (high).</p>	<p>CHBRP provides three estimates on expenditures.</p> <p>A low estimate would increase total expenditure by \$47 million (0.03%).</p> <p>A low-enhanced estimate would increase total expenditure by \$78 million (0.06%).</p> <p>A high estimate would increase total expenditure by \$207 million (0.15%).</p>	<p>CHBRP found insufficient evidence to determine whether services provided via telephone or e-mail are as effective as in-person visits, with the exception of e-mail communication for glycemic control among diabetic patients.</p> <p>CHBRP estimates that positive mental health and dermatologic outcomes could occur for some newly covered enrollees with these conditions.</p>

Analyzed Bill Summary	Medical Effectiveness of Service or Treatment	Benefit Coverage Impact	Utilization Impact	Expenditure Impact	Public Health Impact
<p>AB 1771 (2014), Pérez</p> <p>Telephonic Patient Management Services</p> <p>Would require health insurance carriers to cover and reimburse physicians for telephone, e-mail, and other electronic patient management.</p>	<p>Advances in technology have been outpacing the publication of studies on these technologies, limiting the research literature on telephone, e-mail, live videoconference, and store-and-forward.</p> <p>There is insufficient evidence to determine whether electronic/medical (E/M) services provided via telephone or e-mail are as effective as medical care provided in-person.</p> <p>For the diseases and conditions studied, the evidence suggests that medical care provided by live videoconferencing and store-and-forward is at least as effective as medical care provided in person.</p>	<p>CHBRP projects AB 1771 would affect the health insurance of the approximately 23.4 million enrollees with state-regulated health plans and policies (61.6% of all Californians)</p> <p>All 23.4 million enrollees with state-regulated health insurance would have coverage for telephone and e-mail evaluation and management services.</p> <p>All 23.4 million enrollees with state-regulated health insurance would have coverage for the modalities.</p>	<p>On the low end, a 4.1% decline in in-person visits (from 21.2 million to 20.3 million), but a net increase of 2.3% in all visits—in-person and telehealth—to 21.7 million.</p> <p>On the high end, a 17.7% decline in in-person visits (from 21.2 million to 17.4 million), but a net increase of 9.9% in all visits—in-person and telehealth—to 23.3 million.</p> <p>CHBRP assumes telehealth services would not have an impact on hospital utilization because most hospitalization studies found telehealth had no statistically significant effect on volume regardless of the technology used.</p> <p>Similarly, CHBRP assumes telephone and e-mail services would not have an impact on volume of emergency room (ER) visits because the body of literature suggests there is no consistent impact.</p>	<p>CHBRP provides two estimates on expenditures.</p> <p>A low estimate would increase total expenditure by \$55 million (0.0431%).</p> <p>A high estimate would increase total expenditure by \$241 million (0.1875%).</p>	<p>CHBRP found insufficient evidence of the effectiveness of telephone and e-mail to produce equivalent or better morbidity or mortality outcomes than in-person visits. Therefore, although telephone and e-mail encounters would increase between 1.1 million and 4.6 million encounters (low and high-end scenarios), the public health impact of AB 1771 is unknown.</p> <p>CHBRP estimates that positive health outcomes could occur for some newly covered enrollees; however, the public health impact is unquantifiable due to the unknown health outcomes of additional encounters for patients with a wide array of conditions.</p>

Analyzed Bill Summary	Medical Effectiveness of Service or Treatment	Benefit Coverage Impact	Utilization Impact	Expenditure Impact	Public Health Impact
<p>AB 1917 (2014), Gordon</p> <p>Outpatient Prescription Drugs: Cost Sharing</p> <p>Would require nongrandfathered plans and policies to limit cost sharing for an outpatient prescription drug to no more than 1/24 of the annual out-of-pocket maximum mandated by the ACA (1/24 of \$6,350 in 2014), or \$265. For enrollees in high-deductible health plans, this limit would only apply once the enrollee met their annual deductible.</p>	<p>Overall, there is strong evidence that persons who face higher cost sharing reduce use of both essential and nonessential services. For prescription drugs, there is evidence that as cost sharing increases for prescription drugs, including specialty prescription drugs, usage decreases.</p>	<p>AB 1917 mandates changes in cost sharing and does not mandate coverage of specific treatments and services. CHBRP does not estimate changes to coverage of benefits due to AB 1917.</p>	<p>CHBRP estimates postmandate 46,357 enrollees will have a prescription drug claim in a year with cost sharing that would have exceeded 1/24 of the annual out-of-pocket maximum (\$265) for a 30-day supply premandate. This is an increase of 947 enrollees who previously did not use these prescription drugs. The estimated increase in number of new enrollees using these drugs of the total enrollees subject to the mandate is 0.01%.</p> <p>In addition, enrollees will refill 0.17 more qualifying prescription drugs (2.72%) but will reduce use of other medical services by 0.46 (0.31%) on average.</p>	<p>CHBRP projected total expenditure would increase by \$106 million (0.05%).</p>	<p>CHBRP estimates that 46,357 enrollees, including 947 new users, would fill an additional 13,184 high-cost prescription drugs were AB 1917 enacted. However, CHBRP projects no measurable public health outcomes impact due to the small number of enrollees (46,357 of 10.97 million, or 0.42%) with a reduction in cost sharing for prescriptions that would have exceeded the \$265/prescription limit premandate. CHBRP recognizes that on a case-by-case basis, AB 1917 may yield important health and quality-of-life improvements for some persons.</p>

Analyzed Bill Summary	Medical Effectiveness of Service or Treatment	Benefit Coverage Impact	Utilization Impact	Expenditure Impact	Public Health Impact
<p>AB 2041 (2014), Jones</p> <p>Developmental Services: Regional Centers: Behavioral Health Treatment</p> <p>Would modify and codify the definitions of behavior management assistants and behavior management consultants from existing state regulations. The modification aligns these providers' definitions with an existing state mandate to provide "behavioral health treatment" coverage for pervasive developmental disorder, or autism (PDD/A).</p>	<p>Research suggests that comprehensive behavioral health treatments have greater impact than usual treatment in improving adaptive behaviors, such as communication, daily living, motor, and social skills. Treatments that are delivered for more hours per week and for longer periods of time are also more effective. However, no studies directly compared the provision of behavioral health treatments by different personnel. Thus, the optimal combination of staff by level and type of training for delivering these interventions is unknown.</p>	<p>AB 2041's modification of the training descriptions for certain providers would not change the nature of the behavioral health treatment benefits for PDD/A mandated by law. Therefore, AB 2041 would have no impact on benefit coverage.</p>	<p>Previous CHBRP reports (SB TBD-1 [2011], and SB 126, [2013]) do not indicate that enrollees could not obtain treatments due to supplier bottlenecks. Therefore, CHBRP does not expect AB 2041 to change demand for these providers; thus, there would be no change in utilization.</p>	<p>Because AB 2041 would not change benefit coverage, utilization, or total expenditures for enrollees with state-regulated health insurance beyond the existing behavioral health treatment mandate for PDD/A, CHBRP does not anticipate a long-term cost associated with AB 2041.</p>	<p>CHBRP estimates AB 2041 would have no measurable impact on long-term health outcomes.</p>

Analyzed Bill Summary	Medical Effectiveness of Service or Treatment	Benefit Coverage Impact	Utilization Impact	Expenditure Impact	Public Health Impact
<p>AB 2418 (2014), Bonilla & Skinner</p> <p>Health Care Coverage: Prescription Drug Refills</p> <p>Would require state-regulated health plans and insurers that provide prescription drug benefits to comply with three provisions: (1) plans and insurers that impose a mandatory mail-order requirement for refills would have to implement and maintain an AB 2418-compliant opt-out process; (2) coverage denials for synchronizing refills would be prohibited; and (3) coverage denials for topical ophthalmic products at or after 70% of the prescription's expected days of use would be prohibited.</p>	<p>CHBRP evaluated the literature relating to the effect on adherence of AB 2418's three provisions (mandatory mail opt-out requirement, synchronization denial prohibition, and early topical ophthalmic product refill denial prohibition).</p> <p>CHBRP found insufficient evidence to determine the effect these provisions may have on adherence. Please note that the absence of evidence is not evidence of no effect.</p>	<p>Postmandate, there would be no coverage increase for outpatient prescription drugs due to AB 2418 changes. However, 1.1 million enrollees who have mandatory -mail-order requirements for some prescription drugs without a compliant opt-out process would have coverage with an AB 2418-compliant opt-out, a change in the terms of their benefit coverage.</p> <p>If they chose to do so, 10.28 million enrollees would have coverage for refills ordered for the purpose of placing drugs on a synchronized refill schedule, a change in the terms of their benefit coverage.</p> <p>Around 10.43 million enrollees would have changed terms of benefit coverage for topical ophthalmic products, allowing refills at or after 70% of the predicted days of use, which would be a lower threshold than current terms of benefit coverage (ranging from 75% to 85% of their topical ophthalmic products being used).</p>	<p>CHBRP estimates that there would be no utilization increase in prescription drugs due to the provision to opt out of mail orders. However, there would be some switches from existing mandatory mail orders to retail pharmacies.</p> <p>CHBRP estimates the switch rates would be at 23.2% postmandate based on the findings of the study conducted by Liberman and colleagues. The switch would lead to an increase of 14 prescriptions per 1,000 covered enrollees being refilled at retail pharmacies within one year, and a decrease of 5.1 prescriptions per 1,000 covered enrollees being refilled through mandatory mail orders within 1 year.</p> <p>CHBRP estimates minimal impact on utilization due to refill synchronization.</p> <p>CHBRP also estimates that within 1 year, 0.1 more prescriptions per 1,000 covered enrollees would be refilled for topical ophthalmic products</p>	<p>CHBRP projected total expenditure would increase by \$3.3 million (0.003%).</p>	<p>CHBRP finds insufficient evidence to suggest that any of the provisions in AB 2418—opt-outs from mandatory mail order, refill synchronization, or early refills for topical ophthalmic products—would improve medication adherence.</p> <p>Although CHBRP estimates a very limited increase in filled prescriptions for topical ophthalmic medications due to the 70% refill provision, CHBRP estimates that these enrollees (on average) could have filled their prescriptions at 75% to 80%; the extra time (generally a single day) of use is unlikely to have a measurable impact on adherence. Due to insufficient medical effectiveness evidence and unlikely impact on adherence despite very limited increases in filled prescriptions, the public health impact on health outcomes, gender or racial/ethnic disparities, and premature death in the first year, postmandate, is unknown.</p>

Analyzed Bill Summary	Medical Effectiveness of Service or Treatment	Benefit Coverage Impact	Utilization Impact	Expenditure Impact	Public Health Impact
<p>SB 1053 (2014), Mitchell</p> <p>Health Care Coverage: Contraceptives</p> <p>Would require all DMHC-regulated plans and CDI-regulated policies issued, amended, renewed, or delivered on January 1, 2015 to provide coverage for all Food and Drug Administration (FDA)-approved contraceptive drugs, devices, products, and sterilization procedures in each contraceptive category outlined by the FDA, as well as contraceptive education and counseling.</p>	<p>Most of the research related to contraceptive methods is not classified as high quality as defined by CHBRP methodology. This is due, in part, to the prevailing opinion that it is unethical to randomize women who do not want to get pregnant into groups using a placebo contraceptive. Therefore the comparison between a selected contraceptive and no contraceptive has to be estimated indirectly using published data on pregnancy rates among women using no contraception. On the basis of the results of these comparisons, it is reasonable to conclude that using any of the FDA-approved contraceptive methods is more effective than not using any contraception in preventing unintended pregnancies.</p>	<p>Of the 23.4 million enrollees in DMHC-regulated plans and CDI-regulated policies subject to state mandates, 16.2 million enrollees are subject to SB 1053.</p> <p>Currently, 97.5% of the 16.2 million enrollees have coverage for “any” female contraceptives without cost sharing, including coverage through a family member. Among these 16.2 million enrollees, 99.3% have coverage for vasectomies with a certain level of cost sharing. Zero percent of these enrollees have coverage for male condoms.</p>	<p>CHBRP estimates an 11% increase in contraceptive utilization overall, resulting in an additional 274,036 individuals using contraceptives. The largest increase in utilization will occur for male condom use, with a projected 17% increase due to a 100% increase in coverage. Of the estimated 274,036 additional enrollees using contraceptives as a result of SB 1053, the majority will be using either male condoms (66%) or oral contraceptives (12%).</p>	<p>CHBRP projected total expenditure would increase by \$47 million (0.036%).</p>	<p>Assuming typical use of each contraceptive method among the 274,036 additional contraceptive users, CHBRP estimates that SB 1053 will result in 186,308 averted unintended pregnancies and 72,660 averted abortions. The largest number of averted pregnancies will be due to an increase in male condom utilization (147,543 averted pregnancies).</p> <p>The mandate would expand coverage and reduce cost sharing, lowering financial burden among enrollees using contraceptives by \$46.5 million in the first year, postmandate.</p>

Analyzed Bill Summary	Medical Effectiveness of Service or Treatment	Benefit Coverage Impact	Utilization Impact	Expenditure Impact	Public Health Impact
<p>SB 1239 (2014), Wolk</p> <p>Pupil Health Care: School Nurses</p> <p>Would require state-regulated plans and insurers to reimburse school districts for covered services delivered to a pupil by a school nurse, registered nurse (RN), or licensed vocational nurse (LVN) employed by or under contract with the school district. Would also prohibit cost sharing for such services.</p>	<p>The findings from the four studies on direct services provided by a school nurse represent few of the services that SB 1239 would make reimbursable, and the studies have major methodological weaknesses or limited generalizability; therefore, CHBRP finds insufficient evidence of the effectiveness of direct school nurse services on pupil health.</p> <p>Studies present ambiguous findings on the effects of services delivered by a school nurse on pupil health and absenteeism. Most of these studies have serious methodological weaknesses or limited generalizability. Therefore, CHBRP finds insufficient evidence of the effectiveness of services delivered by school nurses on pupil health and absenteeism.</p>	<p>If SB 1239 were enacted, coverage for direct health services provided by a school nurse would increase to 100% for all enrollees in DMHC-regulated plans and CDI-regulated policies.</p>	<p>CHBRP projects that utilization of school nurse services will increase in the first year postmandate, due to the hiring of 10% additional school nurses statewide. Beyond the first year postmandate if SB 1239 were enacted, the school districts eligible for Local Control Funding Formula–Concentration Funding (LCFF-CF) would be required to employ at least one school nurse as a “health supervisor” on or after July 1, 2016.</p> <p>CHBRP estimates that the number of school nurses will increase from 2,918 to 3,210, which will translate to an increase in reimbursable school nurse visits from 3,554,070 to 3,909,477.</p>	<p>CHBRP projected total expenditure would increase by \$150 million (0.117%).</p>	<p>CHBRP is unable to estimate an impact on racial/ethnic or income disparities due to lack of data regarding the health status of pupils who could receive the additional school nurse services and an unknown distribution of pupils by race/ethnicity or income level who would access services and the types of services accessed. Due to SB 1239 language that excludes enrollee cost sharing, CHBRP projects that this mandate would pose no financial burden for enrollees who use school nurse services.</p>



Appendix 10: Medical Effectiveness Analysis and Research Approach

CHBRP's authorizing statute requests that CHBRP provide information on the medical effectiveness of screening, diagnostic, treatment, and other health services in proposed health benefit bills.¹

A summary of CHBRP's medical effectiveness analysis and research approach is described below.

Summary of Medical Effectiveness Analysis Approach²

- Medical effectiveness provisions of CHBRP's authorizing statute
- General approaches to medical effectiveness analysis
- CHBRP's approach to analyzing medical effectiveness
- Differences between CHBRP's medical effectiveness reviews and other medical effectiveness reviews
- Content of the medical effectiveness sections of CHBRP reports

Medical Effectiveness Provisions

The following provisions of its authorizing statute describe CHBRP's responsibilities with regard to the preparation of medical effectiveness analyses.

(a)(2)(A) "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, as demonstrated by a review of scientific and peer reviewed medical literature."

CHBRP's approach to addressing this provision is discussed later in this summary under the heading CHBRP's Approach to Medical Effectiveness Analysis.³

(a)(2)(B) "The extent to which the benefit or service is generally available and utilized by treating physicians."

¹ Documents describing CHBRP's full medical effectiveness approach can be found on CHBRP's website: http://www.chbrp.org/analysis_methodology/medical_effectiveness_analysis.php.

² For a more detailed description of the procedures CHBRP follows when conducting medical effectiveness reviews, see CHBRP's document *Medical Effectiveness Analysis Research Approach*, available at: http://www.chbrp.org/analysis_methodology/medical_effectiveness_analysis.php.

³ For more details, see CHBRP's document *Medical Effectiveness Analysis Research Approach*, available at: http://www.chbrp.org/analysis_methodology/medical_effectiveness_analysis.php.

CHBRP addresses this provision in its medical effectiveness analyses by discussing physician practice patterns, standards of care, and technologies approved by the Food and Drug Administration that are pertinent to the screening, diagnostic, or treatment intervention in question.

General Approaches to Medical Effectiveness Analysis

CHBRP's approach to medical effectiveness analysis is grounded in the principles of evidence-based medicine (EBM), which has been defined as "a set of principles and methods intended to ensure that to the greatest extent possible, medical decisions, guidelines, and other types of policies are based on and consistent with good evidence of effectiveness and benefit" (DM Eddy, *Health Affairs*, 2005;24(1):16). The practice of EBM requires systematic review of the best available evidence from medical research. CHBRP applies the principles of EBM to health insurance mandates by performing systematic reviews to assess the medical effectiveness of proposed mandates.

Reviews of new medical services or procedures initially address issues of efficacy, or how well an intervention works under ideal conditions. EBM studies usually try to go beyond an examination of efficacy in ideal conditions to an examination of effectiveness, or how well an intervention works under usual conditions of clinical practice. Organizations that conduct EBM studies include the U.S. Preventive Services Task Force, the Centers for Medicare & Medicaid Services, and the Cochrane Collaboration, among others.

CHBRP's Approach to Medical Effectiveness Analysis

CHBRP's approach to medical effectiveness analysis is similar to that of other organizations that synthesize medical literature. Once CHBRP receives a request from the State Legislature, the medical effectiveness team defines the parameters for a search of the medical literature in consultation with a medical librarian and an expert on the disease or condition to which the proposed mandate would apply. The parameters for the literature review encompass the entire causal pathway of a potential intervention. For example, the pathway may include administration of a mandated screening test, additional tests that may be ordered as a result of a mandated screening test, treatments that may be provided if tests indicate the presence of a disease or condition, and health outcomes that might result from receipt of the test and treatment.

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.⁴

Team members systematically evaluate evidence across five domains, as illustrated in the table below:

⁴ For further information about the hierarchy of evidence, see CHBRP's document *Medical Effectiveness Analysis Research Approach*, available at: http://www.chbrp.org/analysis_methodology/medical_effectiveness_analysis.php.

Table 10-1. Evidence Domains

Domains	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.

Conclusions regarding an intervention's effects on outcomes are based on the strength of the evidence across all five domains.⁵

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);

⁵ For further information about CHBRP's approach to grading evidence of effectiveness, see CHBRP's document *Medical Effectiveness Analysis Research Approach*, available at: http://www.chbrp.org/analysis_methodology/medical_effectiveness_analysis.php.

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

Differences Between CHBRP Reviews and Other Medical Effectiveness Reviews

If a mandate bill specifies particular outcomes that are expected to result from the proposed mandate, CHBRP must assess the intervention's effect on these outcomes. This requirement distinguishes CHBRP reviews from typical medical effectiveness reviews in which the reviewers select outcomes based on availability of studies and the importance of outcomes to patients' health and well-being.

CHBRP medical effectiveness reviews differ from other medical effectiveness reviews in several other important respects. Most notably, the California Legislature is primarily concerned with determining the effect of an intervention on California's diverse population as part of usual community-based care rather than under ideal circumstances, such as in a randomized controlled trial (RCT) in an academic setting. CHBRP usually attempts to focus attention on those patients for whom the disease or condition in question is a major health problem. Such patients, however, may have other medical conditions (i.e., comorbidities) or other characteristics that limit their response to an intervention. For example, researchers often do not enroll pregnant women in RCTs of medications due to concern about potential adverse effects on their fetuses. However, if a mandate would apply to pregnant women, CHBRP must consider this population.

In addition, CHBRP's medical effectiveness analyses are usually not as simple as assessing whether drug A is better than drug B, or screening test A is better than screening test B. A proposed mandate may include a collection of services, some of which may entail behavioral modification and education programs. In many instances, the medical literature may evaluate a particular device or test, but a mandate may refer to a class of devices, tests, and procedures with varying degrees of effectiveness. The available evidence on a topic rarely assesses all possible combinations of services encompassed by a mandate that proposes coverage for a collection of services, or all items addressed by a mandate for coverage of a class of devices, tests, or procedures.

In some cases, very few studies address the outcomes most pertinent to assessing an intervention's effectiveness. For example, RCTs often focus on intermediate physiological endpoints, such as a cholesterol level or lung function, rather than on disability days or mortality. If no RCTs have been published on an important outcome, CHBRP reviews observational studies (i.e., studies in which subjects are not randomly assigned to intervention and control groups).

Although observational studies are less rigorous than are RCTs, CHBRP reviews their findings, if they are the only source of information about important outcomes.

Content of the Medical Effectiveness Sections of CHBRP Reports

Key findings from the review of the medical evidence are presented in the Executive Summary of each CHBRP report. The Executive Summary also includes caveats or limitations to the medical effectiveness analysis. These may include discussions about gaps in information, the methodological quality of studies, and implications of evidence for current practice guidelines.

More detailed findings are presented in the medical effectiveness section of the text of the report. The medical effectiveness section includes information regarding the:

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

All CHBRP reports contain a qualitative synthesis of the medical literature on the outcomes of interest. In some cases, the effectiveness team also produces quantitative estimates of effectiveness for select outcomes.⁶

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

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

⁶ Criteria and guidelines for quantitative estimates are discussed in CHBRP's document *Medical Effectiveness Analysis Research Approach*, available at: http://www.chbrp.org/analysis_methodology/medical_effectiveness_analysis.php.



Appendix 11: Cost Impact Analysis and Research Approach

CHBRP's authorizing statute requests that CHBRP provide two sets of financial information to assist the Legislature's considerations of proposed health benefit mandates: (1) current coverage, utilization, and cost and (2) projected changes in coverage, utilization, and costs after the implementation of proposed health benefit bills.

Documents describing CHBRP's full cost impact approach can be found on CHBRP's website.¹ These documents include:

- General Approach
 - The California Cost and Coverage Model: Analyses of the Financial Impacts of Benefit Mandates for the California Legislature
 - The Affordable Care Act: Initial Impacts of Implementation
 - The Affordable Care Act: Continued Implementation
 - 2016 Cost Impact Analyses: Data Sources, Caveats, and Assumptions
 - Estimates of Sources of Health Insurance in California for 2017
- Other Issues
 - Uninsured: Criteria and Methods for Estimating the Impact of Mandates on the Number of Individuals Who Become Uninsured in Response to Premium Increases
 - Actuarial Value: Criteria and Methods for Estimating the Impact of Benefit Mandates on Actuarial Value
 - Criteria and Guidelines for the Analysis of Long-Term Impacts on Healthcare Costs and Public Health

A summary of CHBRP's cost impact analysis and research approach is described below.

Summary of Cost Impact Analysis Approach

Table 11-1 below describes information requested by the Legislature in CHBRP's authorizing statute:

¹ Available at: http://www.chbrp.org/analysis_methodology/cost_impact_analysis.php.

Table 11-1. Cost Information Requested by the Legislature

Premandate	Postmandate
<ul style="list-style-type: none"> • Existing benefit coverage for the test/treatment/service in the current insurance market • Current utilization of the test/treatment/service • Cost of providing the test/treatment/service • Public demand for coverage of the test/treatment/service among self-insured plans • Current costs borne by insurers, relevant to the test/treatment/service 	<ul style="list-style-type: none"> • Changes in benefit coverage for the test/treatment/service if the proposed mandate is enacted • Changes in utilization of the test/treatment/service • Changes in the per unit cost of the test/treatment/service • Changes in administrative costs • Impact on total health care costs • Costs or savings for different types of insurers • Impact on access and availability of tests/treatments/services

California Cost and Coverage Model

CHBRP developed the California Cost and Coverage Model (aka Cost Model) to produce baseline and postmandate financial impacts requested by the Legislature. CHBRP’s Cost Model is primarily an actuarial forecasting model. Each year, a team of economists and researchers from a number of UC campuses, along with CHBRP staff and actuaries from Milliman and PricewaterhouseCoopers, update and refine the CHBRP Cost Model.

This summary first describes the methods and assumptions developed by CHBRP to respond to these requests. Then it will describe adjustments that CHBRP has had to make to this model to account for changes resulting from the Affordable Care Act (ACA).

Baseline

Before CHBRP can measure an incremental change resulting from a proposed mandate, it must first establish a starting point, or baseline. This is a two-step process: (1) estimating current overall health insurance coverage for California and (2) 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/policies in relevant market segments (individual, small group, large group), California Public Employees’ Retirement System (CalPERS) HMO plans, and Medi-Cal Managed Care.
- **Premiums:** current premiums by market segment (split according to individual, small group and large group segments in DMHC-regulated plans or CDI-regulated policies).

A comprehensive list of CHBRP’s sources for coverage and demographic data can be found in Coverage and Demographic Data Sources section of this Appendix, but in short, CHBRP relies

on both public administrative data, as well as an annual survey of the state's largest insurance carriers (representing 97% of the state-regulated market).

Baseline adjustments to account for the ACA

Since the 2013 Legislative cycle, CHBRP made adjustments to its cost model to account for continuing implementation of the ACA. Key changes were made to:

- **Enrollment:** CHBRP began relying on the California Simulation of Health Insurance Markets (CaSIM), a microsimulation model, in addition to its usual sources of enrollment data, to estimate how enrollment would change post-ACA implementation of the individual mandate and subsidies.
- **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. To determine enrollment and premium costs associated with grandfathered versus nongrandfathered health insurance, CHBRP's Annual Enrollment and Premium Survey now asks the state's largest health plans to include that detail as part of its annual survey instrument. Beyond grandfathered and nongrandfathered plans, the addition of Covered California (the state's health marketplace where subsidized health insurance may be purchased) is also now included as a market segment.
- **Premiums:** CHBRP's Annual Enrollment and Premium Survey asks the largest insurance carriers in California to provide their average premium rates separately for grandfathered and nongrandfathered plans. The ratios from the carrier survey data are then applied to a national survey of aggregate premium rates to estimate premium rates for grandfathered and non-grandfathered plans that were consistent with the national premium results. Mandate-specific baseline

Coverage: For each proposed mandate, CHBRP surveys each of the state's largest insurance carriers on specific tests, treatments, and services relevant to the mandate. These surveys provide CHBRP with baseline coverage for a proposed mandate (as opposed to baseline coverage for health insurance generally), which would change based on the details of proposed legislation.

Utilization and unit cost: CHBRP must also determine how frequently a treatment or service is currently used (whether or not an individual has benefit coverage) and how much each unit of the test, treatment, or service costs. This is determined using a variety of sources, including CHBRP's contracted actuaries' data sources, academic literature related to health costs, and other sources.

Incremental Change

Once CHBRP has estimated a baseline for the cost, coverage, and utilization of services associated with a proposed mandate, CHBRP estimates how the volume of utilization would change if a mandate were to be enacted.

Changes in utilization of health care services are driven by several factors: changes in benefit levels; levels of cost-sharing; enrollees demand and awareness of benefit coverage; providers' practice patterns; and level of health care management. CHBRP takes these factors into account when producing estimates. Similarly, CHBRP also determines the unit cost for each unit of the proposed mandate, and whether that would change postmandate if demand for the treatment or service is expected to change. Together, CHBRP's projections of changes in cost and utilization provide an estimate of the incremental change a proposed mandate would have on the state-regulated health insurance market.

Other important considerations:

- **Long-term impacts.** CHBRP has limited its impact analysis to a one-year horizon for several reasons: 1) CHBRP cost impact models for premium and total expenditure estimates mimic most insurers' internal processes for determining premium changes in a given year. 2) CHBRP has limited capacity for modeling the long-term cost and health consequences of benefit mandates. Conducting such analyses requires sophisticated, disease-specific simulation models that permit analysis of the progression of a disease (and the disease treatment's technological advancement) over the course of individual lifetimes and allows for individual variability in disease progression, health outcomes, and subsequent costs. 3) Given the specific nature of most mandates analyzed by CHBRP, the long-term cost or public health impact as a result of the mandate are not necessarily addressed in the literature. Given these constraints, CHBRP will make a long-term cost estimate, when the literature and data permit.²
- **Impact on the number of uninsured individuals.** CHBRP also considers a proposed mandate's potential impact on the number of uninsured individuals. CHBRP models this impact if a proposed mandate's estimated increase in premiums exceeds 1 percent.³

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 each of 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, co-insurance)

² For more information, see CHBRP's document *Criteria and Guidelines for the Analysis of Long-Term Impacts on Healthcare Costs and Public Health*, available at:

http://www.chbrp.org/analysis_methodology/cost_impact_analysis.php.

³ For more information, see CHBRP's document *Criteria and Methods for Estimating the Impact of Mandates on the Number of Individuals Who Become Uninsured in Response to Premium Increases*, available at:

http://www.chbrp.org/analysis_methodology/cost_impact_analysis.php.

- Total cost of covered benefits (paid by insurer)
- Non-covered health expenses (paid by enrollees who have health insurance but whose insurance does not cover specified services)
- Total expenditures for health insurance premiums, enrollee cost sharing, and noncovered health expenses

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

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

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

1. **“Knox-Keene” plans:** These include health maintenance organizations (HMO), point-of-service (POS) health plans, and certain preferred provider organization (PPO) health plans subject to the requirements of the Knox-Keene Health Care Service Plan Act of 1975. These plans are subject to the California Health and Safety Code and are regulated by the California Department of Managed Health Care (DMHC). They are included in one category because they are similar in type and regulatory requirements.
2. **“Insurance” policies:** These include PPOs and fee-for-service (FFS) health insurance products subject to the California Insurance Code, which are regulated by the California Department of Insurance (CDI).

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

- Individual market (direct purchase)
- Small group (1 to 100 employees)
- Large group (101 or more employees)

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

Coverage and Demographic Data Sources

The following bullets and Table 11-2 provide an enumeration of all data sources in California’s Cost and Coverage Model.

CHBRP utilizes both internal and external data to undertake cost impact analyses. Internal data are collected by CHBRP, while external data are produced by other entities and stakeholders.

Internal data

- CHBRP's Annual Enrollment and Premium Survey collects data from the six largest providers of health insurance in California (Aetna, Anthem Blue Cross of California, Blue Shield of California, Cigna, Health Net, and Kaiser Foundation Health Plan) to obtain estimates of enrollment not associated with the CalPERS or Medi-Cal by purchaser (large group, small group, individual market, etc.), state regulator (DMHC or CDI), grandfathered or nongrandfathered status, and average premiums. Respondent data represent a super-majority of enrollees with health insurance potentially subject to state mandates (enrollees in non-specialty DMHC-regulated plans or CDI-regulated policies). CHBRP separately collects information regarding CalPERS and Medi-Cal.
- California Simulation of Insurance Markets (CalSIM) and market trends were applied to project 2017 health insurance enrollment in DMHC-regulated plans and CDI-regulated policies.
- CHBRP's other surveys of the largest health plans/insurers collect information on benefit coverage relevant to health insurance legislation that CHBRP analyzes. In each bill analysis, CHBRP indicates the proportion of Californians enrolled in privately funded DMHC-regulated plans or CDI-regulated policies. These data are gathered from responses to CHBRP's bill-specific coverage surveys. The proportions are derived from data provided by DMHC and CDI.

External sources

- California Department of Health Care Services (DHCS) data are used to estimate enrollment in Medi-Cal Managed Care (beneficiaries enrolled in the Two-Plan Model, Geographic Managed Care, or County Operated Health System plans), as well as enrollment in Medi-Cal Fee-For-Service (FFS). More information on DHCS data is available at:
http://www.dhcs.ca.gov/dataandstats/statistics/Pages/Monthly_Trend_Report.aspx.
- California Employer Health Benefits Survey data are used to make specific estimates: premiums for employment-based enrollment in DMHC-regulated plans (primarily HMOs and POS plans) and premiums for employment-based enrollment in CDI-regulated policies (primarily PPOs). Premiums for fee-for-service (FFS) policies are no longer available due to scarcity of these policies in California. Survey data are also used to determine the percentage of Californians enrolled in self-insured products. This annual survey is released by the California Health Care Foundation/National Opinion Research Center (CHCF/NORC) and is similar to the national employer survey released annually by the Kaiser Family Foundation and the Health Research and Educational Trust. More information on CHCF/NORC data is available at:
<http://www.chcf.org/publications/2016/06/employer-health-benefits>.

- California Health Interview Survey (CHIS) data are 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. CHIS data are also used to determine the number of Californians with incomes below 400% of the federal poverty level. CHIS is a continuous survey that provides detailed information on demographics, health insurance coverage, health status, and access to care. More information on CHIS is available at: <http://healthpolicy.ucla.edu/chis/Pages/default.aspx>.
- CalPERS data are used to estimate premiums and enrollment in DMHC-regulated plans (which may be subject to state benefit mandates), as well as enrollment in CalPERS' self-insured plans (which are not subject to state benefit mandates). CalPERS does not currently offer enrollment in CDI-regulated policies. Data are provided for DMHC-regulated plans enrolling non-Medicare beneficiaries. In addition, CHBRP obtains information on the current scope of benefits from evidence of coverage (EOC) documents publicly available. More information on CalPERS data is available at: <http://www.calpers.ca.gov>.
- California Simulation of Insurance Markets (CalSIM) estimates are used to project health insurance status of Californians aged 64 and under. CalSIM is a microsimulation model that projects the effects of the Affordable Care Act (ACA) on firms and individuals. More information on CalSIM is available at: <http://healthpolicy.ucla.edu/programs/health-economics/projects/CalSIM/Pages/default.aspx>.
- OptumInsight MDR Payment System provides data about professional fees paid for health care services. This information is based on claims from commercial insurance companies, HMOs, and self-insured health plans. More information is available at: <https://www.optum.com>.
- MarketScan Research Databases, which reflect health care claims experience of employees and dependents covered by health benefit programs of large employers, are used to estimate utilization and unit cost. These claims data are collected from insurance companies, Blue Cross Blue Shield plans, and third-party administrators. These data represent the medical experience of insured employees, dependents of active employees, early retirees, individuals with COBRA continuation coverage, and Medicare-eligible retirees with employer-provided Medicare Supplemental plans. No data on Medicaid enrollees or workers' compensation are included. More information is available at: <http://truvenhealth.com/your-healthcare-focus/analytic-research/marketscan-research-databases>.
- Milliman Health Cost Guidelines (HCGs) are health care pricing tools used by many of the major health plans in the United States. Most of the data sources underlying the HCGs are claims databases from commercial health insurance plans. The data are supplied by health insurance companies, HMOs, self-funded employers, and private data vendors. The data are mostly from loosely managed health care plans, generally characterized as PPO plans. CHBRP uses the HCGs to establish baseline premiums.

More information on the Milliman HCGs is available at:
<http://us.milliman.com/Solutions/Products/Health-Cost-Guidelines-Suite>.

- PricewaterhouseCoopers (PwC) pricing model is a proprietary, comprehensive pricing model that enables CHBRP to estimate the premium impact of certain mandates. The pricing model provides benchmark data and pricing capabilities for commercial health plans. The pricing model factors in health plan features such as deductibles, copays, out-of-pocket maximums, covered services, and the degree of health care management. The pricing model uses normative data and benefit details to produce estimates of allowed and net benefit costs. The normative benchmarking utilization metrics within the pricing model are developed from a database of commercial (under 65) health plan experience representing approximately 20 million individuals.

Utilization and expenditure data sources

The utilization and expenditure data for the California Cost and Coverage Model are drawn primarily from multiple sources of data used to produce the Milliman Health Cost Guidelines (HCGs). The HCGs are a health care pricing tool used by actuaries in many of the major health plans in the United States. The guidelines provide a flexible but consistent basis for estimating health care costs for a wide variety of commercial health insurance plans. The HCGs are used nationwide and by several California HMOs and insurance companies, including at least five of the largest plans. It is likely that these organizations would use the HCGs, among other tools, to determine the initial premium impact of any new mandate. In addition to producing accurate estimates of a mandate costs, the HCG-based values should also be reasonable estimates of the premium impact as estimated by the HMOs and insurance companies.

The baseline analyses performed by Milliman start with PPOs in the large-group national market, which are adjusted to account for differences by type of insurance, size of market, and geographic location. The process of applying adjustments to arrive at estimates of baseline utilization and expenditures in each of the market segments and the process of estimating changes in utilization due to mandates are both described in a detailed model description.⁴

⁴ See research article *The California Cost and Coverage Model: Analyses of the Financial Impacts of Benefit Mandates for the California Legislature*, available at:
http://www.chbrp.org/analysis_methodology/cost_impact_analysis.php.

Table 11-2. Population and Cost Model Data Sources and Data Items

Data Source	Items
California Department of Health Care Services (DHCS) administrative data for the Medi-Cal program; data as of December 31, 2015	Distribution of enrollees by managed care or FFS distribution by age: 0–17; 18–64; 65+ Medi-Cal Managed Care premiums
California Department of Managed Health Care (DMHC) data from the interactive website “Health Plan Financial Summary Report”; August–October, 2015	Distribution of DMHC-regulated plans by market segment*
California Department of Insurance (CDI) Statistical Analysis Division data; data as of December 31, 2015	Distribution of CDI-regulated policies by market segment
California Health Benefits Review Program (CHBRP) Annual Enrollment and Premium Survey of California’s largest (by enrollment) health care service plans and health insurers; data as of September 30, 2015	Enrollment by: <ul style="list-style-type: none"> • Size of firm (1–100 as small group and 101+ as large group) • DMHC-regulated vs. CDI-regulated • Grandfathered vs. nongrandfathered Premiums for individual plans/policies by: <ul style="list-style-type: none"> • DMHC-regulated vs. CDI-regulated • Grandfathered vs. nongrandfathered
California Employer Health Benefits Survey, 2015 (conducted by the NORC and funded by CHCF)	Enrollment by HMO/POS, PPO/indemnity self-insured, fully insured Premiums (not self-insured) by: <ul style="list-style-type: none"> • Size of firm (3–25 as small group and 26+ as large group) • Family vs. single HMO/POS vs. PPO/indemnity vs. HDHP employer vs. employer premium share
California Health Interview Survey (CHIS); data as of December 31, 2015	Uninsured, age: 65+ Medi-Cal (non-Medicare), age: 65+ Other public, age: 65+ Employer-sponsored insurance, age: 65+
California Public Employees’ Retirement System (CalPERS) data; data as of October 1, 2016	CalPERS HMO and PPO enrollment <ul style="list-style-type: none"> • Age: 0–17; 18–64; 65+ • HMO premiums
California Simulation of Insurance Markets (CalSIM) projections for 2017	Uninsured, age: 0–17; 18–64 Medi-Cal (non-Medicare), age: 0–17; 18–64 Other public, age: 0–64 Individual market, age: 0–17; 18–64 Small group, age: 0–17; 18–64 Large group, age: 0–17; 18–64
Milliman Health Cost Guidelines (HCGs)	Medical trends influencing annual premium increases



Appendix 12: Public Health Impact Analysis and Research Approach

CHBRP's authorizing statute requests that CHBRP provide information on the public health impacts of proposed health benefit bills.

Documents describing CHBRP's full public health impact approach can be found on CHBRP's website.¹ These documents include:

- Research Approach;
- *Estimating Potential Impacts of Health Insurance Benefit Mandates on Racial/Ethnic Disparities Attributable to Disproportionate Benefit Coverage*; and
- *Incorporating Relevant Social Determinants of Health into CHBRP Benefit Mandate Analyses*.

A summary of CHBRP's public health impact analysis and research approach is included below.

Summary of Public Health Impact Analysis Approach

The public health impact analyses capture the potential value of a proposed health benefit mandate—what health outcomes are improved at what cost. 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 summary describes the methods and assumptions that the California Health Benefits Review Program (CHBRP) developed to conduct public health impact analyses of proposed health benefit mandates, as required by the program's authorizing statute. CHBRP's authorizing statute requires a public health impact analysis that includes but is not limited to the following:

- The impact on the health of the community, including the reduction of communicable disease and the benefits of prevention such as those provided by childhood immunizations and prenatal care.
- The impact on the health of the community, including diseases and conditions where gender and racial disparities in outcomes are established in peer-reviewed scientific and medical literature.
- The extent to which the proposed service reduces premature death and the economic loss associated with disease.

¹ Available at: http://www.chbrp.org/analysis_methodology/public_health_analysis.php.

Health Outcomes and Data Sources

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

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

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

Impact on Public Health

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

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

First, using registry- or survey-based data sets and/or literature, the public health team estimates baseline health status relevant to the health benefit mandate. This includes, but is not limited to, rates of morbidity (disease), mortality, premature death, disability, health behaviors, and other

risk factors stratified by age, gender, race, and ethnicity. Second, the public health impacts section uses findings from the literature review in the medical effectiveness analysis. The literature review commonly includes meta-analyses and randomized controlled trials, which provide information on the effectiveness of the proposed benefit or service on specific health outcomes. Third, the public health impacts section uses estimated changes in benefit coverage and/or utilization of treatments or services relevant to the proposed legislation from the cost impact analysis section. Estimated changes in benefit coverage include the number of insured Californians who are presently covered for the proposed benefit and the number who would be newly covered if the mandate were enacted. The cost section also estimates changes in utilization rates for insured Californians who are presently covered for the proposed benefit and for those who will be newly covered for the benefit, postmandate. Using these data elements, estimates are made regarding the impact of new utilization of the mandated benefit on specific health outcomes in the affected population (e.g., the effect of asthma self-management training on the reduction of hospitalizations for asthma). The results are compiled by the public health team to produce an overall mean estimate that can be used to calculate the predicted short-term (1 year) health effects of the benefit mandate.

Impact on Gender and Racial Disparities

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

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

Impact on Premature Death and Economic Loss

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

Long-Term Impacts

When the expected benefits may not be realized within the 1-year time frame used in the cost and utilization analyses, the public health team also projects the long-term public health impacts (beyond 12 months) associated with a benefit mandate. In this case, the public health team generally relies on qualitative assessments based on longitudinal studies and other research about the long-term impacts of health care. This type of analysis is especially relevant for preventive care and disease management programs where the benefits accrue over many years. For more detailed information about CHBRP's public health impact approach, see Public Health Impact Analysis: Research Approach.



Appendix 13: CHBRP 60-Day Timeline of the Analytical Process

CHBRP’s authorizing statute requests that CHBRP provide the Legislature with its analysis within 60 days of having received a request from the referring committee. To meet this deadline, a timeline was developed to coordinate the various analytical processes. Below is an abbreviated version of the CHBRP 60-day timeline that describes in broad terms the steps taken to produce a report.

	Days 0–3
CHBRP Staff	CHBRP staff work with faculty to: <ol style="list-style-type: none"> 1. Identify and screen content expert per protocol 2. Convene conference call so that all potential faculty/staff recusals can be identified 3. Post analysis request on website (including solicitation for information from interested parties by day 19) 4. Work with faculty and with bill author’s office to clarify intent of the bill
Vice Chairs, Task Force Members, Leads	Task Force conference call to: <ol style="list-style-type: none"> 1. Establish leads 2. Select peer faculty reviewer 3. Discuss bill and issues particular to the analysis including content expert 4. Identify areas of draft bill warranting clarification from bill author’s office 5. Discuss conflicts and potential recusals
Cost Team/Actuaries	<ol style="list-style-type: none"> 1. Discuss with internal faculty/staff any potential conflicts so recusals can be identified 2. Confer with content expert and others on call about scope, strategy, and search terms for cost literature review 3. Provide to ME team any mandate-specific questions to add as part of literature review/effectiveness analysis
Medical Effectiveness (ME) Team	<ol style="list-style-type: none"> 1. Work with faculty/staff leads to contact content expert and conduct initial (verbal) conflict-of-interest (COI) screening and complete COI form 2. Discuss with internal faculty/staff any potential conflicts so recusals can be identified 3. Begin to identify search terms 4. In consultation with clinical/content expert, provide librarians with essential bibliography and determine scope of search, search terms, and strategies for librarians 5. Develop a diagram of likely effects of the mandate (e.g., increase in use of treatment vs. increased screening, true and false positives, possible treatment, etc.)

Public Health (PH) Team	<ol style="list-style-type: none"> 1. Discuss with internal faculty/staff any potential conflicts so recusals can be identified 2. Confer with content expert and others on call about scope, strategy, and search terms for public health literature review 3. Provide questions to the ME team regarding literature needed for PH analysis (e.g., prevalence, incidence, racial disparities)
Librarians	Conduct literature search iteratively under direction of ME team with input from content expert (days 0–4)

Days 4–6	
CHBRP Staff	<ol style="list-style-type: none"> 1. Send information regarding subject background, bill intent, and clarifying language to all teams 2. Consult with faculty lead, ME team, content expert, cost team, PH team, and actuaries on health plan/insurer bill-specific coverage survey
Vice Chairs, Task Force Members, Leads	<ol style="list-style-type: none"> 1. Review and comment on health plan/insurer bill-specific coverage survey 2. Suggest any additional (beyond National Advisory Council [NAC]) external reviewers if bill requires specific types of reviewers
Cost Team/Actuaries	<p>► Launch cost literature search:</p> <ol style="list-style-type: none"> 1. Conduct cost literature review (days 4–7) 2. Review and comment on health plan/insurer bill-specific coverage survey
ME Team	<p>► Essential bibliography due:</p> <ol style="list-style-type: none"> 1. Provide UCSF librarians with essential bibliography (key, seminal research) 2. Identify types of services and outcomes to be examined; review search results with content expert and provide feedback to librarian on any additions/modifications needed
PH Team	<p>► Launch public health literature search:</p> <ol style="list-style-type: none"> 1. Conduct public health impact literature review (days 4–7)

Days 7–10	
CHBRP Staff	<ol style="list-style-type: none"> 1. Send bill-specific coverage survey to health plans/insurers 2. Contact NAC reviewers 3. Collect coverage information from available sources and send to cost team/actuaries 4. Compile benefit coverage information for public programs subject to the mandate (such as managed care options offered by CalPERS, Healthy Families, and Medi-Cal) 5. Compile information regarding labor groups' negotiations and CalPERS PPO benefit coverage to assess public demand
Vice Chairs, Leads	Faculty to review benefit coverage information sent by CHBRP staff
Cost Team/Actuaries	<ol style="list-style-type: none"> 1. Decide on strategy for projecting post-mandate utilization 2. Review coverage information sent by CHBRP team

ME Team	<ol style="list-style-type: none"> 1. Identify articles that clinical content expert wants to read in full text 2. Report on search and key literature 3. Continue to collect, review, and synthesize literature for medical impacts (days 10–13)
PH Team	Collect baseline data (e.g., prevalence, incidence, racial disparities, etc.) (days 10–14); provide actuaries information on how data should be cut to meet PH team’s needs for analysis
Librarians	<p>► Refined bibliography due:</p> <ol style="list-style-type: none"> 1. Provide ME team and content expert with refined bibliography 2. Provide PH teams and cost team literature search findings per request

	Days 11–14
CHBRP Staff	Health plan/insurer benefit coverage data due; ensure all proprietary information is masked, aggregated, and sent to analysis teams
Vice Chairs, Leads	Review health plan/insurer responses to bill-specific coverage survey
Cost Team/Actuaries	<ol style="list-style-type: none"> 1. Provides utilization data 2. Review health plan/insurer responses to bill-specific coverage survey and identify any gaps 3. Provide PH team with coverage and utilization impacts
ME Team	Prepare draft medical effectiveness analysis tables of key findings including info needed by cost and public health teams.
PH Team	Prepare draft public health tables with baseline information.

	Days 15–20
CHBRP Staff	<ol style="list-style-type: none"> 1. Review information submitted by interested parties and highlight any that would need to be considered by any team(s) in particular 2. Review public health and cost tables from actuaries; provide comments/questions
Vice Chairs, Leads	<ol style="list-style-type: none"> 1. Review information submitted by interested parties and highlight any that would need to be considered by any team(s) 2. Review and comment on draft introduction/background 3. Review public health and cost tables from actuaries; provide comments/questions
Cost Team/Actuaries	<ol style="list-style-type: none"> 1. Review information submitted by interested parties 2. Draft cost tables due from actuaries to cost team/CHBRP staff/faculty 3. Draft tables/data pulls due to PH team/CHBRP staff/faculty 4. Compile information from cost literature (e.g., offsets, substitution effects, shifts to other programs) 5. Draft cost section with placeholders for final cost tables and final cost estimates
ME Team	Review information submitted by interested parties

PH Team	<ol style="list-style-type: none"> 1. Review information submitted by interested parties 2. Decide parameters for public health impact estimate (e.g., outcome measures) 3. Review the public health data pulls and tables; consult with actuaries on proposed revisions
Days 21–25	
CHBRP Staff	<ol style="list-style-type: none"> 1. Review and comment on draft effectiveness section 2. Check for consistency with cost tables; provide comments to ME team
Vice Chairs, Leads	<ol style="list-style-type: none"> 1. Review and comment on draft effectiveness section 2. Check for consistency with cost tables; provide comment to staff lead to compile
Cost Team/Actuaries	FINAL cost tables due from actuaries to cost team/CHBRP staff/faculty FINAL tables/data pulls due to PH team/CHBRP staff/faculty ► 1st draft cost section due
ME Team	► 1st draft medical effectiveness section due
PH Team	► 1st draft public health impact section due
Days 26–31	
CHBRP Staff	<ol style="list-style-type: none"> 1. Check for consistency and content between cost tables and text, and underlying assumptions, as well as consistency among effectiveness, public health, and cost sections 2. Prepare full integrated draft with executive summary and introduction
Vice Chairs, Leads	Check for consistency and content between cost tables and text, and underlying assumptions, as well as consistency among effectiveness, public health, and cost sections
Cost Team/Actuaries	► Revised cost impact section due
ME Team	► Revised medical effectiveness section due
PH Team	► Revised public health impact section due
Days 32–40	
CHBRP Staff	► Full draft due <ol style="list-style-type: none"> 1. Send to content expert, full task force, peer faculty reviewer 2. Revise based on comments from task force, content expert, cost team/actuaries
Vice Chairs, Leads	Review and send comments to CHBRP staff to compile integrated draft report
Cost Team/Actuaries	Review and send comments to CHBRP staff to compile integrated draft report

	Days 41-45
CHBRP Staff	► Revised full draft sent to NAC, editor, and any other external expert reviewer. Send NAC review version to faculty lead and analytic team. Editor’s review will happen concurrently with NAC review, with a final proofread by the editor on day 50
	Days 46–49
CHBRP Staff	<ol style="list-style-type: none"> 1. Comments received by NAC, editor, designated task force members, other external reviewers 2. Forward comments to faculty lead, Vice Chairs, teams, and actuaries
Vice Chairs, Leads	<ol style="list-style-type: none"> 1. Faculty lead to review NAC and editor comments and work with teams to ensure all comments are addressed
Cost Team/Actuaries	<p>► Final revised cost section due:</p> <ol style="list-style-type: none"> 1. Work with CHBRP staff and faculty to revise in response to reflect NAC and editor comments 2. Send final revised section to CHBRP staff by day 49
ME Team	<p>► Final revised cost section due:</p> <ol style="list-style-type: none"> 1. Work with CHBRP staff and faculty to revise in response to reflect NAC and editor comments 2. Send final revised section to CHBRP staff by day 49
PH Team	<p>► Final revised cost section due:</p> <ol style="list-style-type: none"> 1. Work with CHBRP staff and faculty to revise in response to reflect NAC and editor comments 2. Send final revised section to CHBRP staff by day 49
	Days 50-54
CHBRP Staff	<p>Report editing, layout, and production</p> <ol style="list-style-type: none"> 1. Send draft to editor for final proofread 2. CHBRP staff sends draft to faculty lead and vice chairs with editor’s final proofread comments
Vice Chairs, Leads	Review and sign-off on revised, edited report or specify remaining changes
	Days 55-59
CHBRP Staff	<ol style="list-style-type: none"> 1. Revisions to incorporate final Vice Chair changes 2. Provide final version to Provost, SVP of Health Sciences and Services; final formatting and proofing and any changes in response to SVP’s review
	Day 60
CHBRP Staff	<p>► Final report sent to State Legislature:</p> <ol style="list-style-type: none"> 1. Electronic version of report (.PDF format) transmitted to bill authors, to requesting committees by e-mail, and posted on website 2. CHBRP mailing list notified

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Appendix 14: Content Expert Identification, Screening, and Selection Protocol

This document clarifies the process and serves as a guideline by which the California Health Benefits Review Program (CHBRP) identifies, screens, selects, and compensates content experts for each bill analysis.

This process should be undertaken as early as possible—preferably 1 week before the Legislature’s request for the CHBRP bill analysis. If that is not possible, then this process should occur during days 0 to 4 of the 60-day time period.

Not all bill analyses require the use of a content expert. For example, for a bill that may have a small number of providers (e.g., transplant centers that conduct surgeries for HIV+ patients), the need for a content expert might be filled by conducting a survey of those providers, making use of in-house expertise or a combination of the above. This determination will be made on a case-by-case basis.

I. Criteria for Selecting the Content Expert

1. In general, content experts need clinical and/or health services research experience in order to:
 - Advise the medical effectiveness team and other members of the analytic team on:
 - Key literature (to facilitate literature review) and analysis to determine whether mandated benefit/service/treatment is clinically effective (e.g., state of the art research, research specific to California, summary of evidence on effectiveness);
 - Search criteria/terms for literature review (e.g., medical conditions and outcomes) to guide the team in using the appropriate search terms that will identify key articles;
 - Research in progress that could affect the final conclusions of the effectiveness analysis; and
 - Clinical care management, controversies in practice, and knowledge of specialty society positions and guidelines.
 - Advise cost team on:
 - Bundle of services utilized along with the associated CPT codes, ICD-10 codes, pharmaceuticals, and devices.

- Will those newly covered by the mandate be likely to change utilization?
 - How would the mandate change provider practice patterns?
 - Will utilization of mandated benefit/service produce offsets in current or future utilization? Does the mandated benefit/service replace old interventions or become add-ons, complements, or substitutes? Is there an associated time horizon for those cost offsets (i.e., how long would it take for the health care system to realize the cost of those savings—1 year, 5 years, etc.).
- Advise public health team on:
 - Incidence and prevalence rates of medical condition(s) addressed by the mandate; and
 - Likely impact of the mandate on public health outcomes.
2. Content experts need to be interested in supporting an analysis that informs policymakers through an impartial and balanced analysis that does not make a specific recommendation. Further, content experts need to be willing to work in what can be a controversial area. CHBRP reports are sometimes used in an adversarial context. We need to treat both sides of an issue in a balanced and fair manner in CHBRP reports.
 - Are they clearly identified with one side or another? It does not necessarily disqualify them, but we may want to get a second reviewer identified with the other side.
 - How comfortable would they be if they were criticized by advocates on one side or another?
 3. Content experts need to be available for consultation during the full 60-day analytic timeframe.
 4. Ideally, content experts need to be available for a total of at least one working day during the 60-day analytic timeframe.
 5. Content experts must not have a financial, business, or professional conflict of interest. (See section below for Conflict of Interest Screening Questions.)

II. Process for Identifying Potential Content Experts

A CHBRP lead (generally the report's Medical Effectiveness lead or the CHBRP staff lead) will initiate the search for content experts by taking the following steps as needed:

1. Query full Faculty Task Force for recommendations.
2. Query other research centers (e.g., Public Health Institute, RAND).
3. Query contracted actuary for suggestions.
4. Identify NIH grant recipients in subject area.

5. Identify those who may be affiliated with an AHRQ Evidence-based Practice Center conducting related research.
6. Work with a Librarian to search for the most frequent and/or most recent authors of articles on the subject, especially those who have been involved in Cochrane Collaboration reviews or have participated in the development of clinical guidelines.
7. Solicit help from state and national specialty societies.
8. Search Academy Health's expertise directory.

III. Process for Screening Potential Content Experts' Qualifications, Interests, Availability

1. The CHBRP lead (generally the report's Medical Effectiveness lead or the CHBRP staff lead) will conduct initial screening of content experts based on:

- Clinical and/or health services research experience;
- Strengths and weaknesses of the potential expert and how/whether best to use him/her. For example, if he/she would not be a good clinical expert but may be knowledgeable about insurance, access, and the health services research as it relates to the mandate, we may consider him/her as a potential reviewer;
- Interest and willingness to work in a potentially controversial area;
- Availability in general but particularly during the first 2 weeks after the CHBRP request and for review of the draft report; and
- Potential conflicts of interest (see following section).

2. The CHBRP lead will follow up via e-mail.

3. The CHBRP lead may interview several potential content experts.

4. The CHBRP lead will forward CVs and pertinent information about potential content experts to medical effectiveness, public health, and cost teams for consideration.

5. Once a potential content expert is identified and the analytic teams agree that the content expert meets criteria, the CHBRP lead will begin the conflict of interest screening process (see below), although CHBRP staff (including the director) will be required to complete it.

Standard Content Expert Questions to Support Literature Review, Cost & Utilization Baseline Analysis, and Public Health Baseline Analysis

- a. What medical condition(s) related to this mandated benefit, service, or treatment have the highest prevalence?
- b. What is your view of the clinical effectiveness of this mandated benefit, service, or treatment for this condition(s)?
- c. What is your view of the cost effectiveness of this mandated benefit, service, or treatment for this condition(s)?
- d. Are there alternatives that are already generally covered services?
- e. What key literature will help facilitate literature review and analysis document evidence of the effectiveness of the mandated benefit/service/treatment (e.g., state-of-the-art research, research in progress, research specific to California)?
- f. What are search criteria for literature review (e.g., conditions and outcomes) and search terms?
- g. What research in progress could affect the final conclusions of the effectiveness analysis?
- h. What are the clinical care management standards or practices associated with the mandate?
- i. What are the controversies in practice associated with this mandate?
- j. What are the specialty societies related to this mandated benefit and do they have positions or guidelines regarding the mandated benefit?
- k. Can you provide us with the names of any professional or trade journals that are specific to the medical condition or profession involved in delivering the treatment/service that may not be included in databases such as PubMed?
- l. What are the incidence and prevalence rates of the medical condition addressed by the mandate? What is the population used in the denominator to calculate these rates (entire population, women aged 50+, etc.)?
- m. Are there productivity or economic losses associated with the medical condition?
- n. Based on your knowledge of the evidence, are you aware of disparities in the health status or outcomes for subpopulations (e.g., uninsured versus the insured, by gender, race, language, or socioeconomic status)?
- o. Are you aware of access issues to care for this benefit or service and if so, what do you see as the major barriers to access?
- p. Who are the current users of care for the medical condition addressed by the mandate (e.g., women ages 50+)? What bundle of services do they utilize, and what are the associated CPT codes, ICD-9 codes, pharmaceuticals, devices, etc.?
- q. Who will be newly covered by the mandate? Specifically, how will utilization change as a result of the mandate? Will there be more users (change in utilization rates per 1,000), a different mix of services among current users (change in intensity of care per user), or both?

- r. Will utilization of the mandated benefit produce offsets in current or future utilization?
- s. Are you aware of any studies that look at the long-term benefits (i.e., greater than one year time frame) for those who have received this benefit?

IV. Process for Screening Potential Content Experts' Potential Conflicts of Interest

The questions below are designed to raise awareness in the potential content expert of potential conflicts of interest (COI) before they undergo the formal written COI review process. The CHBRP lead will bring to the CHBRP Director's (or the designee's) immediate attention any issue that could prohibit an individual from participating as an expert.

1. Do you have any financial interest in the proposed mandated benefit?
 - Examples of financial conflicts: investments in pharmaceutical companies or medical device manufacturers; relations with drug company with products or research funding related to this mandate; or own investments related to this mandate?
2. Do you have an interest from an insurance perspective in the proposed mandated benefit?
 - Examples: Have they acted as expert witness; if so, for one or both sides? Member of a task force that has voted on benefit being mandated? Testified or taken a public position on mandate?
3. Could your existing research create a perception of bias as it pertains to the proposed mandate?
 - This might arise if a content expert authored research that included recommendations that are substantially similar to or that directly oppose the proposed mandate. This is to limit the possibility that outside observers could perceive our experts as possibly having a documentable, pre-existing bias that the outcome of the CHBRP review be consistent with their own research finding and prior recommendations. Because they are a content expert, it is likely that their name will appear in literature searches. However, their work would need to be evaluated to determine whether there is potential for bias.

V. Selecting the Content Expert

1. The final selection decision will be made in consensus with the analytic teams, with greatest emphasis on the preferences of the medical effectiveness team.
2. If the candidate indicates his/her ability, interest, willingness, and availability to answer questions, CHBRP staff will provide a COI form to be completed and signed.
3. The candidate completes the COI form and forwards it to CHBRP staff.
4. The COI application is reviewed by CHBRP's Director and, if necessary, legal staff at UCOP.

5. CHBRP staff notifies the candidate and the CHBRP analytic teams of COI status.
6. A candidate, whose COI disclosures are cleared, is eligible to provide his/her services.



Appendix 15: CHBRP's Conflict of Interest Policies and General Disclosure Form

In order to avoid conflicts of interest, the Legislature requested the University of California to develop and implement conflict of interest provisions. These will prohibit a person from participating in any analysis if he or she has material financial interest and/or has a consulting or other agreement with a person or organization that would be affected by the legislation.

CHBRP's authorizing statute includes the following provision:

Section 127663. In order to avoid conflicts of interest, the Legislature requests the University of California to develop and implement conflict of interest provisions to prohibit a person from participating in any analysis in which the person knows or has reason to know he or she has a material financial interest, including, but not limited to, a person who has a consulting or other agreement with a person or organization that would be affected by the legislation.

The following clarifies the process by which the California Health Benefits Review Program (CHBRP) implements this provision.

General request for conflict of interest (COI) form completion process:

- When a new CHBRP staff or faculty member is hired or designated to work on CHBRP analyses, the CHBRP Director or Program Specialist sends them the standard form letter requesting them to complete a COI form. This letter contains instructions and the due date.
- The same applies for content experts or special reviewers requested to conduct analyses-specific work. However, the lead analyst may also send a request letter. In addition, the lead analyst and/or the lead from the CHBRP medical effectiveness team should initially screen the potential content expert by querying him/her about any potential conflicts of interest. (See Appendix 14: Content Expert Identification, Screening, and Selection Protocol.)
- The CHBRP Program Specialist, and the CHBRP Director and the lead CHBRP analyst (if specific to a bill) should be carbon copied on the COI request e-mail.

General submission process:

- When a new or revised COI form is submitted, the original goes to the CHBRP Program Specialist, who will provide it to the CHBRP Director.

- The CHBRP Director will update the tracking database with the new information, and contact the person submitting the COI form to clarify any questions, if necessary.
- The CHBRP Director will consult the Academic Affairs, Director of Research Policy Development if there are any potential conflicts that require further vetting.

Ongoing review of potential conflicts—reviewing and tracking:

- *Bill-specific conflicts of interest:* When the Legislature requests a new bill analysis, as part of the initial Faculty Task Force conference calls, CHBRP staff will ask potential team members for the bill analysis to assess potential conflicts of interest, and update their file, if necessary, before the analysis starts. Files can be updated with an e-mail providing information about the conflict. Both potential conflicts and recusals from a specific bill analysis should be documented in the file. The CHBRP Director will notify CHBRP staff (and sometimes the Faculty Task Force) when a conflict has been identified and when a recusal is confirmed. If a recusal applies for a specific bill analysis, the lead analyst is responsible to ensure that the appropriate recusal notations are made in the preface or back matter of the final report.
- *Ongoing tracking:* The CHBRP Program Specialist and the CHBRP Director are to check the database regularly to identify any missing forms or individuals for follow up. They are to identify who must submit a form and keep track of who has/has not submitted their form. Appropriate follow up will be done to ensure completed and updated COI forms are maintained.
- *Annual updates of COI forms:* Updates of all COI forms occur on an annual basis.
 - The CHBRP Director will review the current form and determine whether updates need to be made.
 - The CHBRP Program Specialist and CHBRP Director will work together to complete an update request to all CHBRP affiliated faculty and staff during the last quarter of the calendar year. If the information that was submitted the previous year is the same, individuals may check a box that stated “same as last year” and return it with their signature page.
 - CHBRP Program Specialist will e-mail to faculty, CHBRP staff, National Advisory Council members, and other affiliated researchers and contractors a request to update and return all COI forms by the end of the calendar year.
 - CHBRP Director will complete a review of all updates by the beginning of the Legislative session, or no later than January 30 of each year.

Forms:

- All CHBRP staff, faculty, affiliated researchers, analyst, actuaries, librarians, and content experts will complete the Standard COI Disclosure form electronically (Attachment 1).

Attachment 1: STANDARD COI DISCLOSURE FORM

**University of California (UC)
Form for Obtaining Background Information and Conflict-of-Interest Disclosure for
Activities Related to the California Health Benefits Review Program (CHBRP)¹**

NAME: _____

TELEPHONE: _____

ADDRESS: _____

E-MAIL ADDRESS: _____

CURRENT
EMPLOYER: _____

THE DECLARATIONS IN THE ATTACHED FORM APPLY TO DECLARANT’S CONFLICTS OF INTERESTS IN REGARD TO HEALTH INSURANCE BENEFIT MANDATE REVIEWS CONDUCTED UNDER THE AUSPICES OF THE CALIFORNIA HEALTH BENEFITS REVIEW PROGRAM (CHBRP) BEGINNING JANUARY 1, 2016 AND ENDING DECEMBER 31, 2016.

There are two parts to this form, Part I—Background Information, and Part II—Conflict of Interest Disclosure. Please complete both parts, **sign** and **date** this form on the last page, and return the form to the CHBRP administrator who requested your participation in the activity to which this form applies. **Please retain a copy for your records.**

You may opt to submit a copy of your curriculum vitae as your response, to Questions I–V, which follow on the next page.

PART I—BACKGROUND INFORMATION

Please provide the information requested below regarding relevant organizational affiliations, government service, public statements and positions, research support, and additional information (if any). Information is “relevant” if it is related to—and might reasonably be of interest to others concerning—your knowledge, experience, and personal perspectives regarding

¹ This form was 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. The University of California and CHBRP are grateful to the NAS for extending its permission to use the NAS form. This CHBRP form may be subject to change. A substantially similar version of this form, “*For Activities Related to Government Regulation*”, is to be used for members of scientific advisory panels that UC convenes at the request of the State and for UC-recommended experts whose reports and/or advice are to be provided to the state for official use in a government regulatory process. CHBRP is grateful also to the UC Office of Research for its assistance in developing this form.

This form and the information provided by you therein may be disclosable to the public under applicable state laws and regulations.

the subject matter and issues to be addressed by the activity (e.g., service as a health insurance benefits mandate evaluator) for which this form is being prepared.

I. ORGANIZATIONAL AFFILIATIONS. Report your *relevant* business relationships (as an employee, owner, officer, director, consultant, etc.) and your relevant remunerated or volunteer non-business relationships (e.g., professional organizations, trade associations, public interest or civic groups, etc.).

II. GOVERNMENT SERVICE. Report your *relevant* service (full-time or part-time) with federal, state, or local government in the United States (including elected or appointed positions, employment, advisory board memberships, military service, etc.).

III. RESEARCH SUPPORT. Report *relevant* information regarding both public and private sources of research support (other than your present employer), including sources of funding, equipment, facilities, etc.

IV. PUBLIC STATEMENTS AND POSITIONS. List your *relevant* articles, testimony, speeches, etc., by date, title, and publication (if any) in which they appeared, or provide relevant representative examples if numerous. Provide a brief description of relevant positions of any organizations or groups with which you are closely identified or associated.

V. ADDITIONAL INFORMATION. If there are *relevant* aspects of your background or present circumstances not addressed above that might reasonably be construed by others as affecting your judgment in matters within the assigned task of the committee or other activity in which you have been invited to participate, and therefore might constitute an actual or potential source of bias, please describe them briefly.

PART II — CONFLICT- OF-INTEREST DISCLOSURE

Instructions: When the State of California requests assistance from the University of California (UC) in convening scientific advisory committees, such as the California Health Benefits Review Program (CHBRP), or asks UC for recommendations of scientific experts to produce reports, such as CHBRP’s evaluations of health insurance mandates, for the purpose of providing expert advice intended to be used by the State in formulating state laws or regulations, it is essential that the work of the participants in such activities not be compromised by any significant conflict of interest.

For this purpose, **the term “conflict of interest” means any financial or other interest which conflicts with the service of the individual because it (1) could significantly impair the individual’s objectivity or (2) could create an unfair competitive advantage for any person or organization.**

Except for those situations in which UC and/or the government agency requesting UC’s and CHBRP’s assistance determines that a conflict of interest is unavoidable and publicly discloses the conflict of interest, no individual can be appointed to serve (or continue to serve) on a UC-convened scientific advisory committee, such as CHBRP, or serve as a UC- or CHBRP-recommended expert evaluator when the report(s) developed by such service are intended to be used by the State as part of the official process for developing government laws or regulations, if the individual has a conflict of interest that is relevant to the functions to be performed.

The term “conflict of interest” means something more than individual bias. There must be an *interest*, ordinarily financial, that could be directly affected by the work of CHBRP or the UC- or CHBRP-recommended expert evaluator.

Conflict of interest requirements are *objective* and *prophylactic*. They are not an assessment of one’s actual behavior or character, one’s ability to act objectively despite the conflicting interest, or one’s relative insensitivity to particular dollar amounts of specific assets because of one’s personal wealth. Conflict-of-interest requirements are objective standards designed to eliminate certain specific, potentially compromising situations from arising, and thereby to protect the individual, the other members of the committee, the institution, and the public interest. The individual, the committee, and the institution should not be placed in a situation where others could reasonably question, and perhaps discount or dismiss, the work of the committee simply because of the existence of conflicting interests.

The term “conflict of interest” applies only to *current interests*. It does not apply to past interests that have expired, no longer exist, and cannot reasonably affect current behavior. Nor does it apply to possible interests that may arise in the future but do not currently exist, because such future interests are inherently speculative and uncertain. For example, a pending formal or informal application for a particular job is a current interest, but the mere possibility that one might apply for such a job in the future is **not** a current interest.

The term “conflict of interest” applies not only to the personal interests of the individual but also to the *interests of others* with whom the individual has substantial common financial interests if these interests are relevant to the functions to be performed. Thus, in assessing an individual’s potential conflicts of interest, consideration must be given not only to the interests of the

individual but also to the interests of the individual's spouse and dependent children, the individual's employer, the individual's business partners, and others with whom the individual has substantial common financial interests.

Consideration must also be given to the interests of those for whom one is acting in a fiduciary or similar capacity (e.g., being an officer or director of a corporation, whether profit or nonprofit, or serving as a trustee).

This disclosure form is used for members of CHBRP, an entity that UC has convened at the request of the state, and for CHBRP-recommended experts whose reports and/or advice are to be provided to a state agency or to the Legislature for official use to evaluate proposed health insurance benefit mandates legislation. For such activities, *the focus of the conflict-of-interest inquiry is on the identification and assessment of any interests that may be directly affected by the use of such reports in the regulatory process.*

For example, if CHBRP or the CHBRP-recommended expert evaluator were conducting a study of a proposed health insurance benefit mandate requiring coverage for a particular medical technology, the focus of the conflict-of-interest-inquiry would be on the identification and assessment of any interests that would be directly affected by that regulatory process if the report were to provide the basis for regulatory action or inaction. The concern is that if an individual (or others with whom the individual has substantial common financial interests) has specific interests that could be directly affected by the regulatory process, the individual's objectivity could be impaired.

Such interests could include an individual's significant stock holdings in a potentially affected medical technology company or being an officer, director, or employee of the company. Serving as a consultant to the company could constitute such an interest if the consulting relationship with the company could be directly affected or is directly related to the subject matter of the regulatory process.

An individual's other possible interests might include, for example, relevant patents and other forms of intellectual property, serving as an expert witness in litigation directly related to the subject matter of the regulatory process, or receiving research funding from a party that would be directly affected by the regulatory process if the research funding could be directly affected or is directly related to the subject matter of the regulatory process and the right to independently conduct and publish the results of this research is limited by the sponsor. Consideration would also need to be given to the interests of others with whom the individual has substantial common financial interests—particularly spouses, employers, clients, and business or research partners.

Questions: The following questions are designed to elicit information from you concerning possible conflicts of interest that may be relevant to the function(s) you have been asked to serve in regard to CHBRP's evaluation of proposed health insurance mandates.

1. EMPLOYMENT. (a) If the reports resulting from CHBRP's health insurance benefit mandate evaluations were to provide the basis for government regulatory action or inaction with respect to the matters addressed in the reports:

(i) If you are employed or self-employed, could your current employment or self-employment (or the current employment or self-employment of your spouse, registered domestic partner, or dependent children) be directly affected?

YES NO NOT APPLICABLE

If "Yes," briefly describe the circumstances here (continuing on the last page of the form if necessary).

(ii) To the best of your knowledge, could any financial interests of your (or your spouse's or dependent children's) employer or, if self-employed, your (or your spouse's or dependent children's) clients and/or business partners be directly affected?

YES NO NOT APPLICABLE

If "Yes," briefly describe the circumstances here (continuing on the last page of the form if necessary).

(iii) If you are an officer, director, or trustee of any corporation or other legal entity, could the financial interests of that corporation or legal entity be directly affected?

YES NO NOT APPLICABLE

If "Yes," briefly describe the circumstances here (continuing on the last page of the form if necessary).

(iv) If you are a consultant (whether full-time or part-time), could there be a direct effect on any of your current consulting or advisory relationships?

YES NO NOT APPLICABLE

If "Yes," briefly describe the circumstances here (continuing on the last page of the form if necessary).

(v) Regardless of the potential effect on the consulting relationship, do you have any current or continuing consulting relationships (including, for example, commercial and professional consulting and service arrangements, scientific and technical advisory board memberships, serving as an expert witness in litigation, or providing services in exchange for honorariums and

travel expense reimbursements, but excluding consulting relationships for which you received less than \$5,000 in fees, honorariums, reimbursements, or other compensation) that are directly related to the subject matter of the possible government regulatory action or inaction?

YES NO NOT APPLICABLE

If “Yes,” briefly describe the circumstances here (continuing on the last page of the form if necessary).

(b) If you are or have ever been a government employee (either civilian or military), to the best of your knowledge are there any federal or state conflict of interest restrictions that may be applicable to your service in connection with your activities on behalf of CHBRP?

YES NO NOT APPLICABLE

If “Yes,” briefly describe the circumstances here (continuing on the last page of the form if necessary).

(c) If you are a government employee, are you currently employed by a state or federal agency that is sponsoring proposed health insurance benefit mandates? If you are not a government employee, are you an employee of any other sponsor (e.g., advocacy group, private foundation, etc.) of proposed health insurance benefit mandates?

YES NO NOT APPLICABLE

If “Yes,” briefly describe the circumstances here (continuing on the last page of the form if necessary).

2. INVESTMENT INTERESTS. Taking into account stocks, bonds, and other financial instruments and investments including partnerships—excluding broadly diversified mutual funds and any investment or financial interest valued at less than \$5,000, but including any equity interest in non-publicly traded entity—if the reports resulting from CHBRP’s health insurance benefit mandate evaluations were to provide the basis for government regulatory action or inaction with respect to the matters addressed in the reports—

(a) Do you or your spouse or dependent children own directly or indirectly (e.g., through a trust or an individual account in a pension or profit-sharing plan) any stocks, bonds or other financial instruments or investments that could be affected, either directly or by a direct effect on the business enterprise or activities underlying the investments?

YES NO NOT APPLICABLE

If “Yes,” briefly describe the circumstances here (continuing on the last page of the form if necessary).

(b) Do you have any other significant financial investments or interests such as commercial business interests (e.g., sole proprietorships), investment interests (e.g., stock options), or personal investment relationships (e.g., involving parents or grandchildren) that could be affected, either directly or by a direct effect on the business enterprise or activities underlying the investments?

YES **NO** **NOT APPLICABLE**

If “Yes,” briefly describe the circumstances here (continuing on the last page of the form if necessary).

3. PROPERTY INTERESTS. Taking into account real estate and other tangible property interests, as well as intellectual property (patents, copyrights, etc.) interests, if the reports resulting from CHBRP’s health insurance benefit mandate evaluations were to provide the basis for government regulatory action or inaction with respect to the matters addressed in the reports:

(a) Do you or your spouse or dependent children own directly or indirectly any such property interests that could be directly affected?

YES **NO** **NOT APPLICABLE**

If “Yes,” briefly describe the circumstances here (continuing on the last page of the form if necessary).

(b) To the best of your knowledge, do any others with whom you have substantial common financial interests (e.g., employer, business partners, etc.) own directly or indirectly any such property interests that could be directly affected?

YES **NO** **NOT APPLICABLE**

If “Yes,” briefly describe the circumstances here (continuing on the last page of the form if necessary).

4. RESEARCH FUNDING AND OTHER INTERESTS. (a) Taking into account your research funding (including gifts, if used for research, grants and contracts) and other research support (e.g., equipment, facilities, industry partnerships, research assistants and other research personnel, etc.), if the reports resulting from CHBRP’s health insurance benefit mandate evaluations were to provide the basis for government regulatory action or inaction with respect to the matters addressed in the reports:

(i) Could the research funding and support for you or your close research colleagues and collaborators be directly affected, **or**

(ii) If you have any research agreements for current or continuing research funding (including gifts, grants and contracts) or support from any party whose financial interests could be directly affected, and such funding or support is directly related to the subject matter of the regulatory process, do such agreements significantly limit your ability to independently conduct and publish the results of your research (other than for reasonable delays in publication, as defined by UC policy or, if you are not UC faculty, 30 days, in order to file patent applications)?

YES **NO** **NOT APPLICABLE**

If “Yes,” briefly describe the circumstances here (continuing on the last page of the form if necessary).

(b) Is the central purpose of CHBRP’s health insurance benefit mandate evaluations for which this disclosure form is being prepared a critical review and evaluation of your own work or that of your employer?

YES **NO** **NOT APPLICABLE**

If “Yes,” briefly describe the circumstances here (continuing on the last page of the form if necessary).

(c) Do you have any existing professional obligations (e.g., as an officer of a scientific or engineering society) that effectively require you to publicly defend a previously established position on an issue that is relevant to the functions to be performed in CHBRP’s health insurance benefit mandate evaluations?

YES **NO** **NOT APPLICABLE**

If “Yes,” briefly describe the circumstances here (continuing on the last page of the form if necessary).

(d) To the best of your knowledge, will your participation in CHBRP’s health insurance benefit mandate evaluations enable you to obtain access to a competitor's or potential competitor's confidential proprietary information?

YES **NO** **NOT APPLICABLE**

If “Yes,” briefly describe the circumstances here (continuing on the last page of the form if necessary).

(e) Could your participation in CHBRP’s health insurance benefit mandate evaluations create a specific financial or commercial competitive advantage for you or others with whom you have substantial common financial interests?

YES **NO** **NOT APPLICABLE**

If “Yes,” briefly describe the circumstances here (continuing on the last page of the form if necessary).

(f) If the CHBRP health insurance benefit mandate evaluations for which this form is being prepared involve reviews of specific applications and proposals for contract, grant, fellowship, etc. awards to be made by sponsors, do you or others with whom you have substantial common financial interests, or a familial or substantial professional relationship, have an interest in receiving or being considered for awards that are currently the subject of the reviews that are being conducted?

YES **NO** **NOT APPLICABLE**

If “Yes,” briefly describe the circumstances here (continuing on the last page of the form if necessary).

(g) If CHBRP’s health insurance benefit mandate evaluations for which this form is being prepared involve developing requests for proposals, work statements, and/or specifications, etc., are you interested in seeking an award under the program for which the committee on which you have been invited to serve is developing the request for proposals, work statement, and/or specifications, or, are you employed in any capacity by, or do you have a financial interest in or other economic relationship with, any person or organization that to the best of your knowledge is interested in seeking an award under this program?

YES **NO** **NOT APPLICABLE**

If “Yes,” briefly describe the circumstances here (continuing on the last page of the form if necessary).

FURTHER EXPLANATION OF “YES” RESPONSES:

*During your period of service, **January 1, 2016, through December 31, 2016**, for which the preceding disclosures apply, any changes in the information reported, or any new information that needs to be reported, must be reported promptly by written or electronic communication to the responsible CHBRP administrator.*

SIGNATURE

DATE

PRINT NAME

Reviewed by Name/Title:

Responsible California Health
Benefits Review Program Administrator

DATE



Appendix 16: NAC Review Criteria and Guidelines

A National Advisory Council (NAC) reviews the California Health Benefits Review Program's (CHBRP's) analyses for quality and objectivity before they are submitted to the Legislature. This document provides the criteria and guidelines used for these reviews.

Guidelines for NAC Review of Draft Bill Analyses

Purpose of the review: To help assure the accuracy, responsiveness, completeness, and clarity of CHBRP reports on bills that propose health benefit mandates (or repeals).

Structure of bill analyses: The bill analyses are structured around specific issues mentioned in CHBRP's authorizing statute, which asks the University of California to consider relevant issues of medical effectiveness and to estimate each bill's likely impacts on benefit coverage, cost, utilization, and public health. When a particular piece of legislation would mandate something other than the coverage of services (e.g., access to certain types of providers), CHBRP may modify the structure of the written report to provide the Legislature with other information CHBRP deems more relevant to the bill's potential impacts.

State health benefit mandates (or repeals), such as those in bills analyzed by CHBRP, apply only to health insurance subject to state regulation. Uniquely, California has a bifurcated system of health insurance regulation. The California Department of Managed Care (DMHC) regulates health care service plans and the California Department of Insurance (CDI) regulates health insurers. Approximately half of California's population has health insurance through a DMHC-regulated plan or CDI-regulated policy.¹ Most of these persons are enrolled in plans or policies that have been privately purchased. However, some public programs purchase DMHC-regulated plans for some (but not all) of their beneficiaries.

Audience: CHBRP's primary audience is the California State Legislature; CHBRP submits each report to the committee that requested it (usually the Assembly or Senate Committee on Health) as well as to the author(s) of the legislation analyzed. Other legislators and committees of the Legislature, as well as California state government agencies such as the Office of the Governor, DMHC, CDI, and the California Public Employees Retirement System (CalPERS), may also be interested in our analyses, as may other proponents and opponents of a particular bill. In accordance with its authorizing statute, CHBRP makes its reports available to the public on its website, www.chbrp.org. There may be additional interest in CHBRP reports both in California and nationally.

Review Criteria: CHBRP asks reviewers to comment on the extent to which the report meets the criteria of 1) accuracy and objectivity 2) responsiveness to the legislative request 3) completeness, and 4) clarity of presentation. On the following pages are the Review Form and a Check List. Please note: reviews are expected to be based on the reviewer's current information. Reviewers are not expected to do further literature reviews or background research.

¹ CHBRP's estimates on sources of health insurance are available at: http://www.chbrp.org/other_publications/index.php.

REVIEW FORM

Date:

Reviewer Name:

Bill Number (or Name) of Draft Report:

Please comment on the extent to which the draft report meets each of the following criteria (using the listed questions as a guide). The last question asks for general comments or mention of specific parts of the text about which you have comments.

Please indicate whether your comments are:

- 1) **Suggestions;**
 - 2) **Issues or items the authors should consider; or**
 - 3) **Serious concerns about the report that must be addressed.**
-

Accuracy and Objectivity:

- Are conclusions adequately supported with objective evidence?
 - Does the report adequately discuss situations for which evidence does not exist? In such circumstances does it discuss the implications of such a lack?
 - Does the report avoid perceptions of bias? For instance, does it note when cited studies are conducted by interested parties? Does it properly frame findings that may have resulted from biased research or reporting?
 - Does the report use neutral language when discussing politically-sensitive issues?
-

Responsiveness:

- Are the analytic approach, findings and conclusions relevant to the bill in question?
-

Completeness:

- Does the report adequately address relevant issues of medical effectiveness and possible impacts of the bill on cost, utilization, and public health impacts specified in CHBRP's authorizing statute? If not, does the text or appendices offer an explanation? (*See following Check List*)
 - To the best of your knowledge, does the report miss any high-quality evidence that would alter its findings or conclusions?
-

Clarity:

- Does the executive summary concisely and clearly summarize the report's findings and conclusions?
 - Are findings and conclusions clearly and concisely stated in understandable language?
 - Is supporting evidence described in sufficient detail?
 - Upon first mention, are technical terms defined appropriately for an interested lay audience?
 - Is the organization of the report easy to follow and appropriate for the topic?
-

Other Comments:

CHECK LIST: Issues to be addressed in CHBRP Reports²

<p>(1) Medical Effectiveness</p>	<p>a) The extent to which services or items relevant to the bill are generally recognized (as demonstrated by a review of scientific and peer reviewed medical literature) by the medical community as being effective in the screening, diagnosis, or treatment of a condition or disease.</p> <p>b) The extent to which the services or items relevant to the bill are generally available and utilized by treating providers.</p>
<p>(2) Cost, Utilization, and Benefit Coverage Impacts</p>	<p>a) The bill’s potential impact on the cost of relevant services and/or items.</p> <p>b) The bill’s potential impact on the utilization of the relevant services or items and how the bill may impact cost or utilization of alternative services or items.</p> <p>c) The bill’s potential impact on premiums and expenses of subscribers, enrollees, and policyholders and the bill’s potential impact on the administrative expenses of health care service plans and health insurers.</p> <p>d) The bill’s potential impact on total cost of health care.</p> <p>e) The bill’s potential impact on private sector costs (including the impact on small employers), the California Public Employees’ Retirement System (CalPERS), other retirement systems funded by the state or by a local government, persons purchasing individual health insurance, and publicly funded programs, such as the Medi-Cal program (Medicaid).</p> <p>f) The extent to which costs resulting from lack of benefit coverage are shifted to other payers, including both public and private entities.</p> <p>g) The bill’s potential impacts on access to currently available health care services and/or items.</p> <p>h) The extent to which relevant services and/or items are utilized by a significant portion of the population.</p> <p>i) The extent to which benefit coverage for relevant services and/or items is already available.</p> <p>j) The level of public demand for relevant benefit coverage, including the level of interest of collective bargaining agents in negotiating for inclusion of this type of benefit coverage in group contracts and the extent to which the benefit is covered by self-funded employer groups.</p>
<p>(3) Public Health Impacts</p>	<p>a) The bill’s potential impact on the health of the community, including the reduction of communicable disease and the desirable health outcomes related to prevention (such as those provided by childhood immunizations and prenatal care).</p> <p>b) The bill’s potential impact on the health of the community, with attention to impacts on diseases and conditions for which gender and racial disparities in outcomes are established in peer-reviewed scientific and medical literature.</p> <p>c) The bill’s potential impact on premature death and the economic loss associated with disease.</p>

² The Check List is adapted from CHBRP’s authorizing statute which can be reviewed at: http://www.chbrp.org/docs/authorizing_statute.pdf.



Appendix 17: Clarification of Bill Language and Legislative Intent (Bill Author Questionnaire)

For each analysis, the California Health Benefits Review Program (CHBRP) conducts an interview with the bill author’s staff and any others (e.g., bill sponsors) the author’s office suggests as a part of the process. Shortly after each bill request is received, CHBRP staff use this standardized questionnaire to confirm with the bill author’s staff a mutual understanding of both the intent of the bill and the likely interpretations of the bill as written.

Questionnaire Regarding Health Insurance-Related Legislation Referred to California Health Benefits Review Program (CHBRP) for Independent Analysis

[Bill Number (Author) Title, and Introduction Date]

Date: [Questionnaire Date]

Prepared by: [CHBRP staff, bill author’s office staff, and sponsor/others]

Established by statute¹ in 2002, CHBRP responds to requests from the California Legislature to provide independent, evidence-based analysis of proposed health insurance benefit mandates/ repeals and other related health insurance topics. CHBRP does not issue recommendations and remains neutral on all topics it analyzes.

- I. Describe the issue the bill addresses, including:
 - The scope of the issue and what groups may be affected;
 - How the information was obtained (example: A particular constituent, stakeholder, opinion poll, focus group, etc.);
 - The discrepancy/issue that the bill seeks to address. For example:

¹ Available at http://www.chbrp.org/docs/CHBRP_authorizing_statute_071915.pdf

- Is there a lack of benefit coverage for specific populations and/or for persons who have specific types of insurance?
- Is a new or available technology not widely used?
- Is there is a discrepancy between current medical practice and evidenced-based standards of care?
- Are costs for persons with insurance prohibitive even if the service is covered?
- Are there other barriers to access?
- Are any legal requirements related to benefit coverage already in place? Please provide references to citations in the Insurance Code, Health and Safety Code, Business and Professions Code, Welfare and Institutions Code, California Code of Regulations, and/or applicable federal statute.

II. What would the bill do?

- 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?

III. Does the bill have sponsors? If so, who are they? Can we contact them for additional information, if necessary? Please provide contact information.

IV. Are you aware of any published medical standards of care, clinical benchmarks, or clinical guidelines for diseases or conditions relevant to the benefit?

V. Have similar bills been proposed previously in California? If so, please provide Bill Number and Legislative Session. Are similar pieces of legislation in effect, or being considered, in other states? If so, please list those states.

VI. Health insurance-related laws may affect multiple segments of the state-regulated insurance market.

Please use the tables below to indicate which segments would be affected by this bill.

A. DMHC-Regulated Health Plans—purchased from the commercial market with **PRIVATE** funds

Private, Full-Service, Knox-Keene Health Care Service Plans						Private, Specialized Knox-Keene Health Care Service Plans ¹	
Large-Group Purchaser		Small-Group Purchaser		Individual Purchaser		Grand-fathered	Non-grand-fathered
Grand-fathered	Non-grand-fathered	Grand-fathered	Non-grand-fathered	Grand-fathered	Non-grand-fathered		

udes plans such as vision-only, dental-only, or behavioral health-only insurance.

B. CDI-Regulated Health Insurance—purchased from the commercial market with **PRIVATE** funds

Private, Full-Service Health Insurance						Private, Specialized Health Insurance ¹		Private, “Non-Health” Disability Insurance ²	
Large-Group Purchaser		Small-Group Purchaser		Individual Purchaser		Grand-fathered	Non-grand-fathered	Grand-fathered	Non-grand-fathered
Grand-fathered	Non-grand-fathered	Grand-fathered	Non-grand-fathered	Grand-fathered	Non-grand-fathered				

¹ Includes policies such as vision-only, dental-only, or behavioral health-only insurance.

² “Non-health disability insurance” includes policies such as Medicare supplement, hospital indemnity, CHAMPUS supplement, specified disease insurance that does not pay benefits on a fixed-benefit or a fixed-cash-only basis, etc. “Health insurance” is defined per California Insurance Code Section 106(a)-(c), for statues that become effective after 2002, and refers to forms of disability insurance that provide coverage for hospital, medical, or surgical benefits.

C. Plans/insurance regulated by DMHC/CDI—purchased from the commercial market with **PUBLIC** funds

Public, Full-Service, Knox-Keene Health Plans		
CalPERS HMOs ¹	Medi-Cal Managed Care Plans ²	Covered California Plans ³

¹ Many, but not all, persons with health insurance through CalPERS are enrolled in DMHC-regulated (Knox-Keene licensed) health care service plans and so have health insurance subject to state-level benefit mandates.

² Many, but not all, Medi-Cal beneficiaries are enrolled in DMHC-regulated (Knox-Keene licensed) health care service plans and so have health insurance subject to state-level benefit mandates.

³ Many, but not all, persons with health insurance through Covered California (the state’s health insurance marketplace) have public subsidies.

VII. Who are anticipated supporters and/or opponents?

VIII. Are there any plans to amend the bill? If so, can you provide information on what the amendments will be?

IX. Bill specific questions: [Add here]



Appendix 18: Health Care Service Plans' and Health Insurers' Proprietary Data Retention and Destruction Policy

The California Health Benefits Review Program (CHBRP) acknowledges its responsibility to preserve information relating to litigation, audits, and investigations. It is a crime to alter, cover up, falsify, or destroy any document to prevent its use in an official proceeding. Failure on the part of employees to follow this policy can result in possible civil and criminal sanctions against CHBRP, the University of California and its employees, and possible disciplinary action against responsible individuals (up to and including termination of employment). Each employee has an obligation to contact the CHBRP Director of a potential or actual litigation, external audit, investigation, or similar proceeding involving CHBRP that may have an impact on the approved records retention and document destruction schedule.

Documents covered under this policy. This policy covers “proprietary data,” that is, all records and documents that may associate data with a specific health care service plan or health insurer, as referenced in Health and Safety Code Section 127662, that have been received by CHBRP from health plans in connection with CHBRP’s analytical activities under Health and Safety Code Sections 127660–127664.

Document destruction. CHBRP is responsible for the ongoing process of identifying its records of proprietary data that have met a maximum retention period and overseeing the destruction of these data. Destruction of the proprietary information may be accomplished by shredding, burning, or sending them to the landfill. Retention policies for proprietary information submitted to CHBRP are as follows:

- Information related to specific legislation will have a maximum retention period of 30 days after the relevant report is submitted to the Legislature.
- Information submitted as part of CHBRP’s annual survey will have a maximum retention period of 30 days after CHBRP’s final report (of the analytic season) is submitted to the Legislature.

Electronic documents. Electronic documents that reveal proprietary data shall be retained as if they were paper documents. Therefore, any electronic files that contain proprietary data shall be scheduled to be destroyed by the end of the maximum retention period. Destruction of electronic documents may be accomplished by deleting proprietary data from CHBRP’s electronic files. Data that have been de-identified by removing the health plan’s or health insurer’s name may be retained beyond the maximum retention period noted above.

Suspending document destruction. Upon any indication of an official investigation of CHBRP related

to any legal proceeding or by any governmental entity, document destruction shall be suspended immediately. Destruction shall be reinstated upon conclusion of such proceeding.

Use of documents. CHBRP staff shall remove health plan or insurer identifiers prior to circulating it outside of its offices, including CHBRP-affiliated faculty and contracted actuaries.

Effective date of policy: 12/1/12



Appendix 19: Benefit Mandates in California and Federal Law in effect in 2016

This list is annually prepared by the California Health Benefits Review Program (CHBRP) so that CHBRP will be better enabled to respond to requests from the California Legislature to provide independent analyses of the medical, financial, and public health impacts of proposed health insurance benefit bills. Updates to this list of health insurance benefit mandates current in California, as well as additional information about CHBRP, can be found at www.chbrp.org.¹

Purpose of this list: This list is intended to alert interested parties of existing state legislation that may relate to the subject or purpose of a health insurance benefit mandate or repeal bill. CHBRP maintains a list of existing health insurance benefit mandates in California and federal law including an explanation of terms and categories, a discussion of basic health care services, and a listing of California's mandates organized by Health and Safety Code section and by Insurance Code section.²

Benefit mandates listed: CHBRP defines health insurance benefit mandates per its authorizing statute.³ Therefore, the listed mandates fall into one or more of the following categories: (a) offer or provide coverage for the screening, diagnosis, or treatment of specific diseases or conditions; (b) offer or provide coverage for types of health care treatments or services, including coverage of medical equipment, supplies, or drugs used in a treatment or service; and/or (c) offer or provide coverage permitting treatment or services from a specific type of health care provider. Listed mandates also include those that (d) specify terms (limits, timeframes, copayments, deductibles, coinsurance, etc.) for any of the other categories. Table 19-1 includes California's state-level health insurance benefit mandate laws, and Table 19-2 includes federal health insurance benefit mandate laws.

Information included for listed mandates: Table 19-1 identifies relevant California statutes. The table specifies when the law mandates *an offer* of coverage for the benefit. The table also identifies which health insurance markets (group and/or individual) are subject to the mandate. Table 19-2 identifies relevant federal statutes, both those in existence prior to passage of the Patient Protection and Affordable Care Act (ACA), as well as

¹ Available at: http://www.chbrp.org/other_publications/index.php.

² Available at: http://www.chbrp.org/other_publications/index.php

³ Available at: www.chbrp.org/documents/authorizing_statute.pdf.

federal mandates in the ACA. Like Table 19-1, Table 19-2 identifies the health insurance markets subject to the mandate. Because none of the federal mandates are mandates to *offer* coverage, this information is not included in Table 19-2.

Other important information:

- Not all health insurance is subject to state-level health insurance benefit mandate laws. CHBRP annually posts estimates of Californians' sources of health insurance, including figures for the numbers of Californians with health insurance subject to state-level benefit mandates.⁴
- California has a bifurcated legal and regulatory system for health insurance products. The Department of Managed Health Care (DMHC) regulates health care service plans, which are subject to the Health and Safety Code. The California Department of Insurance (CDI) regulates health insurance policies, which are subject to the California Insurance Code. DMHC-regulated plans and CDI-regulated policies may be subject to state-level benefit mandate laws, depending upon the exact wording of the law.
- DMHC-regulated plans and CDI-regulated policies may also be subject to federal benefit mandate laws. Federal benefit mandates may interact or overlap with state-level benefit mandates. Some known interactions are noted in the footnotes for Table 19-1.
- Federal benefit mandates can apply more broadly than state-level benefit mandates. For example, federal benefit mandates may apply to Medicare or to self-insured plans. Table 19-2 only lists federal benefit mandate laws that would be relevant to DMHC-regulated plans and CDI-regulated policies.
- DMHC-regulated health plans are subject to “minimum benefit” laws and regulations (also known as “Basic Health Care Services”) that may interact or overlap with state-level benefit mandate laws. The Basic Health Care Services requirement for DMHC-regulated health plans is noted in Table 19-1.
- Although CHBRP assesses the impacts of bills, not existing laws, CHBRP’s analysis of Assembly Bill 1214 (2007) required a review of mandate laws current at that time. That report and all other CHBRP analyses may be found at http://www.chbrp.org/completed_analyses/index.php.⁵

⁴ Available at: www.chbrp.org/other_publications/index.php.

⁵ Available at: www.chbrp.org/completed_analyses/index.php.

Table 19-1. California Health Insurance Benefit Mandates⁶ (by Topic)

#	Topic	California Health and Safety Code (DMHC)	California Insurance Code (CDI)	Mandate to Offer? ⁷	Markets (regulated by DMHC or CDI) Subject to the Mandate	Mandate Category
DMHC-Regulated Health Care Service Plan “Minimum Benefits”						
0	Health Plans regulated by the Department of Managed Health Care (DMHC) are required to cover medically necessary basic health care services, including: (1) physician services; (2) hospital inpatient services and ambulatory care services; (3) diagnostic laboratory and diagnostic and therapeutic radiologic services; (4) home health services; (5) preventive health services; (6) emergency health care services, including ambulance and ambulance transport services, out-of-area coverage, and ambulance transport services provided through the 911 emergency response system; (7) hospice care. See Appendix B for further details.	Multiple Sections—See Appendix B	N/A ⁸		Group and individual	Not a distinct mandate
Essential Health Benefits						
1	A federal mandate that requires some plans and policies to cover essential health benefits (EHBs) and places limits on cost sharing. The state statutes listed in this row define EHBs and cost sharing for California. ^{9,10}	1367.005 1367.006 1367.0065	10112.27 10112.28 10112.285		Small group and individual ¹¹ In 2017, large group sold via Covered California ¹²	a, b, d
Cancer Benefit Mandates						
2	Breast cancer screening, diagnosis, and treatment	1367.6	10123.8		Not specified	a
3	Cancer screening tests	1367.665	10123.20		Group and individual	b
4	Cervical cancer screening	1367.66	10123.18		Group and individual	a
5	Mammography	1367.65	10123.81		Not specified	a, c

⁶ CHBRP defines health insurance benefit mandates as per its authorizing statute, available at: www.chbrp.org/other_publications/index.php. This list includes laws that meet that definition and are known to CHBRP.

⁷ “Mandate to offer” indicates that all health care service plans and health insurers selling health insurance subject to the benefit mandate are required to *offer* coverage for the benefit. The health plan or insurer may comply (1) by including coverage for the benefit as standard in its health insurance products or (2) by offering coverage for the benefit separately and at an additional cost (e.g., a rider).

⁸ N/A indicates that the benefit mandate does not apply to products governed under the specified code.

⁹ Affordable Care Act (ACA), Section 1301, 1302, and Section 1201 modifying Section 2707 of the Public Health Service Act (PHSA). See Table 19-2 below.

¹⁰ Review report: *California’s State Benefits Mandates and the Affordable Care Act’s “Essential Health Benefits,”* available at: www.chbrp.org/other_publications/index.php.

¹¹ The EHB coverage requirement will apply to nongrandfathered plans and policies sold outside of the exchange as well as to qualified health plans (QHPs, see ACA Section 1301) certified by and sold via a health insurance exchange.

¹² Effective 2017, states may allow large-group market qualified health plans (QHPs, see ACA Section 1301) to be certified by and sold via an exchange [ACA Section 1312(f)(2)(B)]. Large-group QHPs would be subject the EHB coverage requirement.

#	Topic	California Health and Safety Code (DMHC)	California Insurance Code (CDI)	Mandate to Offer? ⁷	Markets (regulated by DMHC or CDI) Subject to the Mandate	Mandate Category
6	Mastectomy and lymph node dissection (length of stay, complications, prostheses, reconstructive surgery)	1367.635	10123.86		Not specified	b, d
7	Oral anticancer medication cost-sharing limits	1367.656	10123.206		Group and individual	d
8	Patient care related to clinical trials for cancer	1370.6	10145.4		Not specified	d
9	Prostate cancer screening	1367.64	10123.835		Group and individual	a
Chronic Conditions Benefit Mandates						
10	Diabetes education	N/A	10176.6	Offer	Not specified (CDI)	a
11	Diabetes education, management, and treatment	1367.51	10176.61		Not specified	a, b, d
12	HIV/AIDS, AIDS vaccine	1367.45	10145.2		Group and individual (DMHC), not specified (CDI)	a
13	HIV/AIDS, HIV testing	1367.46	10123.91		Group and individual	a
14	HIV/AIDS, transplantation services for persons with HIV	1374.17	10123.21(a)		Not specified	d
15	Osteoporosis	1367.67	10123.185		Not specified	a
16	Phenylketonuria	1374.56	10123.89		Not specified	a
Hospice & Home Health Care Benefit Mandates						
17	Dementing illness exclusion prohibition	1373.14	10123.16		Group and individual	a, d
18	Home health care	1374.10 (non-HMOs only)	10123.10	Offer	Group	b, d
19	Hospice care	1368.2	N/A		Group (DMHC)	b
Mental Health Benefit Mandates						
20	Alcohol and drug exclusion prohibition	N/A	10369.12		Group (CDI)	d
21	Alcoholism treatment	1367.2(a)	10123.6	Offer	Group	a
22	Behavioral health treatment for autism and related disorders	1374.73	10144.51 10144.52		Not specified	b
23	Care provided by a psychiatric health facility	1373(h)(1)	N/A		Not specified (DMHC)	b, d
24	Coverage and premiums for persons with physical or mental impairment	1367.8	10144		Group and individual	a, d
25	Coverage for mental and nervous disorders, including care provided by a psychiatric health facility	N/A	10125	Offer	Group (CDI)	a
26	Coverage for persons with physical handicap	N/A	10122.1	Offer	Group (CDI)	a, d
27	Coverage for severe mental illnesses (in parity with coverage for other medical conditions) ¹³	1374.72	10144.5 10123.15		Not specified	a, b, d
28	Nicotine or chemical dependency treatment in licensed alcoholism or chemical dependency facilities	1367.2(b)	10123.6	Offer	Group	b, d

¹³ In addition to these state benefit mandates, the federal Mental Health Parity and Addition Equity Act of 2008 requires that *if* a group plan or policy covers mental health, it must do so at parity with coverage for medical and surgical benefits. See Table 19-2 below.

#	Topic	California Health and Safety Code (DMHC)	California Insurance Code (CDI)	Mandate to Offer? ⁷	Markets (regulated by DMHC or CDI) Subject to the Mandate	Mandate Category
29	Prohibition of lifetime waiver for mental health services	1374.5	10176(f)		Individual	a, d
30	Prohibition on determining reimbursement eligibility from inpatient admission status	1374.51	10144.6		Not specified	d
Orthotics & Prosthetics Benefit Mandates						
31	Orthotic and prosthetic devices and services	1367.18	10123.7	Offer	Group	b
32	Prosthetic devices for laryngectomy	1367.61	10123.82		Not specified	b
33	Special footwear for persons suffering from foot disfigurement	1367.19	10123.141	Offer	Group	b
Outpatient Drug Benefit Mandates						
34	Authorization for nonformulary prescription drugs	1367.24	N/A		Not specified (DMHC)	d
35	Oral anticancer medication cost-sharing limits	1367.656	10123.206		Group and individual	d
36	Prescription cost sharing	1342.71 1367.205 1367.41 1367.42	10123.192 10123.193 10123.201		Varied: not specified or small group and individual	b, d
37	Prescription drugs: coverage for previously prescribed drugs	1367.22	N/A		Not specified (DMHC)	d
38	Prescription drugs: coverage of "off-label" use	1367.21	10123.195		Not specified (DMHC), group and individual (CDI)	d
39	Step therapy	1367.244	10123.197		Not specified	d
Pain Management Benefit Mandates						
40	Acupuncture	1373.10 (non-HMOs only)	10127.3	Offer	Group	c, d
41	General anesthesia for dental procedures	1367.71	10119.9		Not specified	b
42	Pain management medication for terminally ill	1367.215	N/A		Not specified (DMHC)	b
Pediatric Care Benefit Mandates						
43	Asthma management	1367.06	N/A		Not specified (DMHC)	a
44	Comprehensive preventive care for children aged 16 years or younger	1367.35	10123.5		Group	b
45	Comprehensive preventive care for children aged 17 or 18 years	1367.3	10123.55	Offer	Group	b
46	Coverage for the effects of diethylstilbestrol	1367.9	10119.7		Not specified	a
47	Screening children for blood lead levels	1367.3(b)(2)(d)	10119.8	Offer	Group (DMHC), group and individual (CDI)	b
Provider Reimbursement Mandates						
48	Emergency 911 transportation ¹⁴	1371.5	10126.6		Not specified	d

¹⁴ The ACA (Section 1001 modifying Section 2719A of the PHSA) imposes a related requirement regarding coverage and cost-sharing for emergency services. Grandfathered health plans (ACA Section 1251) are not subject to this requirement. See Table 19-2 below.

#	Topic	California Health and Safety Code (DMHC)	California Insurance Code (CDI)	Mandate to Offer? ⁷	Markets (regulated by DMHC or CDI) Subject to the Mandate	Mandate Category
49	Licensed or certified providers	1367(b)	N/A		Not specified	c, d
50	Medical transportation services—direct reimbursement	1367.11	10126.6		Not specified	d
51	OB-GYNs as primary care providers ¹⁵	1367.69 1367.695	10123.83 10123.84		Not specified	c, d
52	Pharmacists – compensation for services within their scope of practice	1368.5	10125.1	Offer	Not specified	c, d
Reproduction Benefit Mandates						
53	Contraceptive devices and sterilization, and contraceptive education and counseling	1367.25	10123.196		Group and individual	b
54	Contraceptive devices requiring a prescription	1367.25	10123.196		Group and individual	b
55	Infertility treatments	1374.55	10119.6	Offer	Group	a, b, d
56	Maternity services	N/A	10123.865 10123.866		Group and individual (CDI)	b
57	Maternity— amount of copayment or deductible for inpatient services	1373.4	10119.5		Not specified	d
58	Maternity— minimum length of stay ¹⁶	1367.62	10123.87		Not specified (DMHC), group and individual (CDI)	d
59	Participation in the statewide prenatal testing Expanded Alpha Feto Protein (AFP) program	1367.54	10123.184		Group and individual	b
60	Prenatal diagnosis of genetic disorders	1367.7	10123.9	Offer	Group	b
Sterilization						
61	Sterilization rationale exclusion prohibition	1373	10120		Not specified	d
Surgery Benefit Mandates						
62	Jawbone or associated bone joints	1367.68	10123.21	i	Not specified (DMHC), group and individual (CDI)	a
63	Reconstructive surgery ¹⁷	1367.63	10123.88		Not specified	b
Other Benefit Mandates						
64	Blindness or partial blindness exclusion prohibition	1367.4	10145		Group and individual	a, d
65	Family cost-sharing limits	1367.006 1367.007	10112.28 10112.29		Varied: large group, small group, individual	d

¹⁵ The ACA (Section 1001 modifying Section 2719A of the PHSA) imposes a similar requirement prohibiting prior authorization for access to OB-GYNs. Grandfathered health plans (ACA Section 1251) are not subject to this requirement. See Table 19-2 below.

¹⁶ The federal Newborns' and Mothers' Health Protection Act of 1996 requires coverage for a minimum length of stay in a hospital after delivery *if* the plan covers maternity services. See Table 19-2 below.

¹⁷ The federal Women's Health and Cancer Rights Act of 1998 requires coverage for postmastectomy reconstructive surgery. See Table 2 below.

#	Topic	California Health and Safety Code (DMHC)	California Insurance Code (CDI)	Mandate to Offer? ⁷	Markets (regulated by DMHC or CDI) Subject to the Mandate	Mandate Category
66	Preventive services without cost sharing (in compliance with federal laws and regulations) ¹⁸	1367.002	10112.2		Group and individual	b, d
67	Second opinions	N/A	10123.68		Not specified (CDI)	c

Table 19-2. Federal Health Insurance Benefit Mandates¹⁹

#	Federal Law	Topic Addressed by Benefit Coverage Mandate ²⁰	Markets Subject to the Mandate ²¹	Mandate Category
Federal Mandates in Existence Prior to the Passage of the Affordable Care Act of 2010 (ACA)				
1	Pregnancy Discrimination Act of 1978 amending Title VII of the federal Civil Rights Act	Requires coverage for pregnancy and requires the coverage be in parity with other benefit coverage.	Group (15 or more)	d
2	Newborns' and Mothers' Health Protection Act of 1996	If maternity is covered, requires that coverage include at least a 48-hour hospital stay following childbirth (96-hour stay in the case of a cesarean section).	Group	d
3	Women's Health and Cancer Rights Act of 1998	If mastectomy is covered, requires coverage for certain reconstructive surgery and other postmastectomy treatments and services.	Group	b
4	Mental Health Parity and Addiction Equity Act of 2008, modified by the Affordable Care Act of 2010 [ACA Section 1311(j) and Section 1563(c)(4) modifying Section 2726 of the Public Health Services Act (PHSA)]	If mental health or substance use disorder (MH/SUD) services are covered, requires that cost-sharing terms and treatment limits be no more restrictive than the predominant terms or limits applied to medical/surgical benefits.	Group and individual	d
Federal Mandates in the Affordable Care Act of 2010 (ACA)				
5	Section 1001 modifying Section 2711 of the PHSA	Prohibits lifetime and annual limits on the dollar value of benefits. ²²	Group and individual	d

¹⁸ ACA, Section 1001 modifying Section 2713 of the PHSA. See Table 19-2 below.

¹⁹ CHBRP defines health insurance benefit mandates as per its authorizing statute, available at: www.chbrp.org/other_publications/index.php. This list includes laws that meet that definition and are known to CHBRP.

²⁰ All listed federal health insurance benefit mandates are benefit coverage mandates. CHBRP is aware of no federal "mandates to offer."

²¹ Unless otherwise noted, the federal mandates in the ACA do not apply to grandfathered health plans (Section 1251).

²² Annual limits and lifetime limits apply to grandfathered plans, with the exception that grandfathered individual market plans are not subject to the prohibitions on annual limits [ACA Section 1251(a)(4)].

#	Federal Law	Topic Addressed by Benefit Coverage Mandate ²⁰	Markets Subject to the Mandate ²¹	Mandate Category
6	Section 1001 modifying Section 2713 of the PHSA	Preventive services without cost sharing. ^{23,24} As soon as 12 months after a recommendation appears in any of three sources, benefit coverage is required. The four sources are: <ul style="list-style-type: none"> • ‘A’ and ‘B’ rated recommendations of the United States Preventive Services Task Force (USPSTF)²⁵; • Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC)²⁶; • For infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA)²⁷; and • For women, preventive care and screenings provided for in comprehensive guidelines supported by HRSA.²⁸ 	Group and individual	a, d
7	Section 1001 modifying Section 2719A(b) of the PHSA	If emergency services are covered, requires coverage for these services regardless of whether the participating provider is in or out of network, with the same cost-sharing levels out of network as would be required in network, and without the need for prior authorization.	Group and individual	d
8	Section 1001 modifying Section 2719A(d) of the PHSA	Prohibits requiring prior authorization or referral before covering services from a participating health care professional who specializes in obstetrics or gynecology.	Group and individual	d
9	Section 1201 modifying Section 2704 of the PHSA	Prohibits “pre-existing condition” benefit coverage denials.	Group and individual ²⁹	d

²³ California law requires compliance with this mandate. See Table 1 above (categorized with “Other Benefit Mandates”).

²⁴ For more information on the preventive services coverage requirement, see CHBRP’s resource, *Federal Preventive Services Benefit Mandate and the California Benefit Mandates*, available at: www.chbrp.org/other_publications/index.php.

²⁵ Available at: <http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/>.

²⁶ Available at: www.cdc.gov/vaccines/hcp/acip-recs/index.html.

²⁷ Regulations published in the Federal Register (Vol. 75, No 137, July 19, 2010) clarified which HRSA guidelines were applicable. The guidelines appear in two charts: Periodicity Schedule of the Bright Futures Recommendations for Pediatric Preventive Health Care, available at: http://brightfutures.aap.org/clinical_practice.html; and Uniform Panel of the Secretary’s Advisory Committee on Heritable Disorders in Newborns and Children, available at: <http://www.hrsa.gov/advisorycommittees/mchbadvisory/heritabledisorders/recommendedpanel/index.html>.

²⁸ Available at: www.hrsa.gov/womensguidelines.

²⁹ Applies to grandfathered group market health plans and grandfathered individual market plans [ACA Section 1251(a)(4)].

#	Federal Law	Topic Addressed by Benefit Coverage Mandate ²⁰	Markets Subject to the Mandate ²¹	Mandate Category
10	Section 1301, 1302, and Section 1201 modifying Section 2707 of the PHSA	Requires coverage of essential health benefits (EHBs), and, for plans and policies that provide coverage for EHBs, and places limits on cost sharing. The 10 EHB categories are: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services, including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care. ³⁰	Small group and individual ³¹ In 2017, large group sold via Covered California ³²	a, b, d

³⁰ California has laws in place to define EHBs for the state. See Table 19-1 above (categorized with “Essential Health Benefits”).

³¹ The EHB coverage requirement will apply to nongrandfathered plans and policies sold outside of the exchange as well as to qualified health plans (QHPs, see ACA Section 1301) certified by and sold via a health insurance exchange.

³² Effective 2017, states may allow large-group market qualified health plans (QHPs, see ACA Section 1301) to be certified by and sold via a health insurance exchange [ACA Section 1312(f)(2)(B)]. Large-group QHPs would be subject to the EHB coverage requirement.



Appendix 20: Media References of CHBRP or Its Work, 2014–2016

This appendix lists publicly available news articles, reports, or other media that cite or reference CHBRP or its work.

References in Media

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Appendix 21: Published Literature and Other References of CHBRP or Its Work, 2014-2016

This appendix includes lists of references to the California Health Benefits Review Program (CHBRP) or its work. The four lists include citations for:

- Published literature;
- Conference presentations; and
- References by other states, advocacy groups and other stakeholders.

Included at the end of this document is a description of the literature search method used to identify some of the listed references.

It should be noted that the lists below are comprised of references known to CHBRP and so represent an under count of total references.

It should also be noted that CHBRP's analyses and other products are often cited years after publication. For example, in Table 21-2, below, notes the Amputee Coalition's 2014 reference to an analysis CHBRP produced in 2006. It is expected that CHBRP's most recent work will also continue to be quoted in future years.

References in Published Literature

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References in Conference Presentations

Oral Presentation: Policy Options for Limiting Patient Cost-Sharing for Prescription Drugs. June 28, 2016. Boston, MA. CHBRP's experience with cost-sharing for prescription drugs was presented to a national audience at the AcademyHealth Annual Research Meeting.

Poster Presentation: Ending Discriminatory Drug Pricing for HIV/AIDS Patients: A California Case Study. June 27, 2016. Boston, MA. CHBRP's analysis of SB 339 was presented to health policy researchers attending the AcademyHealth Annual Research Meeting poster session.

Oral Presentation: Bridging the Divide: Lessons Learned Providing Evidence-Based Analysis to the California Legislature. June 25, 2016. Boston, MA. CHBRP's work in California was shared with a national audience at the AcademyHealth Annual Research Meeting, State Interest Group.

Poster Presentation: Ending Discriminatory Drug Pricing for HIV/AIDS Patients: A California Case Study. June 25, 2016. Boston, MA. CHBRP's analysis of SB 339 was presented to health policy researchers attending the AcademyHealth Annual Research Meeting State Interest Group poster session.

Poster Presentation: Policy Options for Limiting Patient Cost-Sharing for Prescription Drugs. June 25, 2016. Boston, MA. CHBRP's analysis of legislation related to patient cost-sharing for prescription drugs was presented to health policy researchers attending the AcademyHealth Annual Research Meeting, State Interest Group poster session.

Oral Presentation: Overview of CHBRP and Work on Social Determinants of Health. May 25, 2016. Princeton, NJ. An overview of CHBRP's work was presented to a national audience at the Princeton Conference XXIII: Where Is the US Health Care System Going: Can We Improve Value?

Briefing: CHBRP's Review of Health Insurance Bills. February 6, 2016. Sacramento, CA. CHBRP provided a presentation on health insurance bills to the State Legislature and other California stakeholders.

Oral Presentation: Lessons from Massachusetts for the Next Phase of Health Care Reform: 58% of Previously Uninsured Californians Have Insurance—Now What? March 6, 2015. Sacramento, CA. CHBRP provided an opportunity for California policymakers, researchers, and other stakeholders to learn from the experiences of health care reform implementation in Massachusetts.

Briefing: CHBRP's Review of Health Insurance Bills. January 29, 2015. Sacramento, CA. CHBRP provided a presentation on health insurance bills to the State Legislature and other California Stakeholders.

Briefing: CHBRP's Review of Health Insurance Bills. January 16, 2014. Sacramento, CA. CHBRP provided a presentation on health insurance bills to the State Legislature and other California Stakeholders.

References by Other States, by Advocacy Groups, and by Other Stakeholders

CHBRP and its reports are referenced by other states in analyses of proposed health mandate bills. Additionally, CHBRP and its reports are often referenced by advocacy groups and other interested stakeholders. Table 21-2 lists those references known to CHBRP.

Table 21-1. References to CHBRP by Advocacy Groups and Other Stakeholders

Year	Reference	Source	CHBRP Work Referenced
2016	<i>Implementation Guide for AB 374: Prescription Drugs</i>	CAPG	CHBRP Analysis of AB 374 (2015) Step Therapy
2016	<i>New Legislative Benefit Mandates: Now is Not the Time</i>	California Association of Health Plans	CHBRP Analysis of: AB 1763 (2016) Colorectal Cancer AB 1831 (2016) Topical Ophthalmic Refills AB 1954 (2016) Reproductive Services AB 2004 (2016) Hearing Aids AB 2372 (2016) HIV Specialists AB 2507 (2016) Telehealth AB 2764 (2016) Mammography SB 1034 (2016) Autism
2016	<i>Public Funds Account for Over 70 Percent of Health Care Spending in California</i>	UCLA Center for Health Policy Research	CHBRP Analysis of AB 533 (2016) Out-of-Network Coverage Data from CHBRP on expenditures for private insurer payment categories and tax subsidy estimates are referenced.
2015	<i>Accountable Care Organizations in California: Promise & Performance</i>	University of California, Berkeley-School of Public Health	A CHBRP product, <i>Estimates of Sources of Health Insurance</i> , is referenced.
2015	<i>CalChamber Status Update Report on Major Legislation for Business</i>	CalChamber	Reference CHBRP's Reauthorization and independent analyses of proposed health insurance benefit mandates and repeals
2015	<i>Comments to DC Department of Insurance, Securities and Banking on Essential Health Benefits and Selection of New Benchmark Plan</i>	Acupuncture Society of the District of Columbia	CHBRP Analysis of AB 72 (2011) Acupuncture
2015	<i>Estimated Federal Costs of H.R.1608 - The Lymphedema Treatment Act</i>	Lymphedema Advocacy Group	CHBRP Analysis of AB 213 (2005) Lymphedema
2015	<i>Implementation Guide for AB 339: Outpatient Prescription Drugs</i>	CAPG	CHBRP Analysis of AB 339 (2015) Outpatient Prescription Drugs

Year	Reference	Source	CHBRP Work Referenced
2015	<i>In or Out: An Examination of Medicaid's Coverage Determination Policies</i>	California HealthCare Foundation	CHBRP's authorizing statute is referenced. CHBRP is referenced as a program that analyzes both covered benefits and coverage determination.
2015	<i>Rounding Out the Contraceptive Coverage Guarantee: Why 'Male' Contraceptive Methods Matter for Everyone</i>	Guttmacher Policy Institute	CHBRP Analysis of AB 1053 (2014) Contraceptives
2014	<i>Analysis of Cost of Certain ASD Services</i>	Insurance Division, Department of Commerce and Consumer Affairs, State of Hawaii	CHBRP Analysis of SB 126 (2013) Pervasive Developmental Disorder or Autism
2014	<i>Fiscal Note & Local Impact Statement: Insurance and Medicaid coverage for orally administered cancer medications</i>	Ohio Legislative Service Commission	CHBRP Analysis of SB 161 (2009) Chemotherapy Treatment
2014	<i>Healthy Behavior Adoption White Paper</i>	Foundation for Healthy Generations	CHBRP Analysis of SB 189 (2013) Wellness Programs
2014	<i>Impact of California's Autism Insurance Legislation- 2014 Survey</i>	Autism Society of California	CHBRP Analysis of SB 126 (2013) Pervasive Developmental Disorder or Autism Specific citation of CHBRP's estimates of usage of Regional Centers for Autism
2014	<i>Issue Brief: Applied Behavior Analysis for Children with Autism in Medi-Cal</i>	KidsWell	CHBRP Analysis of SB 126 (2013) Pervasive Developmental Disorder or Autism
2014	<i>Network Adequacy Laws in Medi-Cal Managed Care Plans</i>	National Health Law Program	A CHBRP Product, <i>The California Cost and Coverage Model</i> , is referenced.
2014	<i>Policy Statement: Allowing Employers to Opt-Out of Benefit Requirements Would Undermine the ACA's Consumer Protections and Lead to Poorer Health Outcomes</i>	American College of Physicians	A CHBRP Product, <i>Interaction between California State Benefit Mandates and the Affordable Care Act's "Essential Health Benefits,"</i> is referenced.
2014	<i>Promising and Best Practices in Total Worker Health: Workshop Summary</i>	Institute of Medicine	CHBRP Analysis of SB 189 (2013) Wellness Programs
2014	<i>White Paper: Insurance Fairness for Amputees</i>	Amputee Coalition	CHBRP Analysis of AB 2012 (2006) Orthotic and Prosthetic Devices

Literature Review Methods

In order to identify additional citations of CHBRP and its work, a Google Scholar search was conducted using the following keywords:

- California Health Benefits Review Program
- California Health Benefit Review Program

Additional references were found through a standard Google search. All searches were searched twice, first with "California Health Benefits Review Program" and then with "CHBRP." All

searches with bill titles were completed first with “Assembly Bill” or “Senate Bill” and then with “AB” or “SB.” The results from the standard Google search were narrowed by changing the search date to search for documents that were published between 2014 and August 2016.

The searches then used the following keywords:

- Estimates of Sources of Health Insurance in California
- Health Insurance Benefit Mandates in California State and Federal Law
- California’s EHB Base Benchmark Options
- Background on Cost Sharing for Outpatient Prescription Drugs
- Outpatient Prescription Drug Coverage 101
- What is Cost Sharing in Health Insurance?
- Federal Preventive Services Benefit Mandate and California Benefit Mandates
- Primer on Insurance Provider Networks
- Pediatric Dental and Pediatric Vision Essential Health Benefits
- Survey and Analysis of Other States' Health Benefit Review Programs
- Assembly Bill 533
- Assembly Bill 796
- Assembly Bill 1763
- Assembly Bill 1831
- Assembly Bill 1954
- Assembly Bill 2004
- Assembly Bill 2050
- Assembly Bill 2084
- Assembly Bill 2209
- Assembly Bill 2372
- Assembly Bill 2507
- Assembly Bill 2764
- Senate Bill 999
- Senate Bill 1034
- Assembly Bill 339
- Assembly Bill 374
- Assembly Bill 502
- Assembly Bill 623
- Assembly Bill 796
- Assembly Bill 1102
- Assembly Bill 1305
- Senate Bill 190
- Senate Bill 289
- Assembly Bill 1771
- Assembly Bill 1917
- Assembly Bill 2041
- Assembly Bill 2418
- Senate Bill 1053
- Senate Bill 1239



Appendix 22: Other States' Health Benefit Review Programs

In 2013 and 2014, the California Health Benefits Review Program (CHBRP) contacted every state and the District of Columbia to explore the status of benefit mandate review programs and processes outside of California. Similar surveys were completed in 2004, 2009, and 2011. The 2014 survey provided information about how the programs were addressing implementation of the Affordable Care Act (ACA).

The 2014 Survey Had the Following Objectives:

- To provide an overview of the scope of other states' programs, specifically whether the programs are focused solely on costs or, like CHBRP, also summarize information on medical effectiveness and project public health impact.
- To catalog changes to other states' programs since 2013 in scope, process by which analyses are completed, or kind of organization that conducts the benefit reviews, for example, state agencies in the executive or legislative branches, private organizations such as independent research groups or private consulting firms, or universities.
- To better understand how programs in other states are responding to changes related to the ACA and to gauge whether there has been an increase in such activity since the 2013 benchmark data on the involvement of state benefit review programs with ACA implementation.
- Maintain contacts at benefit mandate review programs in other states so that CHBRP may call upon such programs to inform CHBRP's work in the upcoming year.

Methodology

The 2013 survey was mainly focused on other states' selection of "benchmark plans" related to defining Essential Health Benefits (EHBs), as outlined in the ACA. For the 2014 survey, we followed up on a few ACA related question, but focused more on other states' report content and structure. All contacts were asked about their organization's involvement in determining essential health benefits for their state and any changes to their work. Contacts in 31 states agreed to brief telephone interviews; the 31 include all of the states with the most extensive benefit mandate review programs.

Results From the 2013 Survey

The 2013 survey of other states found 29 states had systematic programs or processes in place to study existing and proposed health benefit mandates in 2013 (see Table 22-2). State programs generally fell into one of three organizational categories: state insurance departments (or other executive branch departments); legislative research services; or independent councils, commissions, or university-based programs (see Table 22-3). Although many of these entities

(most significantly insurance departments) reported spending a great deal of time on policy changes related to the ACA, none of the programs, in terms of benefit mandate review, reported a significantly changed mission, organizational structure, or analytical scope since 2011. As of 2013, only Maryland appears to have suspended its benefit mandate review program.

Changes to States’ Programs Since 2013

In 2013, although many programs expressed uncertainty about the potential impact of the ACA on benefit mandates within the states, several reported that their role with respect to assessing the impact of the ACA had become clearer. Of note, CHBRP found that state insurance departments reported the highest level of involvement with implementation issues. Legislative research services often provided support to their legislatures concerning the interaction between the EHBs and existing mandates. Such services also provided information on the implementation of the ACA. Benefit review programs housed in independent research groups such as in university settings typically provided information about the implementation of the ACA in more limited ways.

In the 2014 survey, state benefit review programs reported that the states were hesitant to pass mandate legislation because states would be responsible for the potential cost of exceeding essential health benefits as defined by their state under the ACA. The benefit review programs indicated that they and the states for which they prepare reports found it difficult to determine whether costs will exceed EHBs and, if so, by how much. States with notable changes are listed in table 1.

Table 22-1. States With Notable Changes

State	Benefit Review Work	General Health Care Related
Colorado	The state repealed the mandate review commission.	
Idaho		Plans to establish their own health care exchange rather than relying on healthcare.gov for the insured population in Idaho
Massachusetts		Started using all payer database in benefit review rather than relying on insurance carrier responses to survey requests
Washington, DC		Received grants to fund health care exchange initiatives that will support improved IT tools, such as better websites to inform consumers, and better analytics to address the following: 1) how rates are generated; 2) the reasons consumers are sharing the costs; and 3) the reasons rates are increasing from year to year

New Survey Questions for 2014

As part of the 2014 survey, CHBRP asked other states several new questions regarding the benefit mandate review programs, most dealt with specific details regarding report content, as well as process.

CHBRP is currently working with its state legislature to reauthorize the program, and fine-tune its mandate. As part of this process, CHBRP is working on new ways better serve the state. CHBRP is developing new report templates that are easier to read and draw findings from to best accommodate the constrained timelines of the legislature. Some of these new approaches have been gleaned from other states.

Summary of 2014 findings:

Readability of reports: CHBRP asked states whether they used infographics to enhance their reports, and the vast majority of states did not. Some states used charts or graphs at times to show marginal change, but only two states were able to provide examples of recently used graphics. CHBRP has been exploring the use of infographics in an effort to streamline its reports and make information that is difficult to digest easier to understand.

Length of reports: One of CHBRP's organizational goals is to shorten the overall length of its reports to enhance readability. Approximately 25% of the respondents' reports were between 1-5 pages, while another 25% reported 15-30 pages, including cost tables. Many states were unable to give us any specific numbers as they have not prepared any benefit mandate reports in recent years.

Best practices for dissemination: We asked other states about their methods of dissemination. States almost unanimously said posting the information on their website was the best practice. One state uses town hall meetings to distribute findings, and others use e-mail blasts and social media.

More specific questions regarding medical effectiveness and public health procedures: We were curious to know specifically how states conducted a literature search if they provided information on medical effectiveness, as well as how medical topics with very little research were handled. We found that whereas some states conduct in-depth literature searches similar to CHBRP, most do not, and when that information is provided, it is a quick summary of the disease/test/treatment mainly to acclimate those with little knowledge of the topic. For the analysis, we probed deeper to find out how PH was defined, and whether or not there was a focus on specific populations. For those states who did conduct a public health analysis, most reported on incidence and prevalence only.

Table 22-2. States' Health Benefit Mandate Review Programs—Analytical Dimensions (2013)

State	Cost	Medical	Social/Public Health
Arizona	✓	✓	✓
California	✓	✓	✓
Connecticut	✓	✓	✓
Florida	✓		✓
Georgia	✓	✓	✓
Hawaii	✓		✓
Indiana	✓	✓	✓
Kansas	✓		✓
Kentucky	✓		
Louisiana	✓		
Maine	✓	✓	✓
Massachusetts	✓	✓	
Minnesota	✓	✓	✓
Missouri	✓		
Nevada	✓		
New Hampshire	✓	✓	✓
New Jersey	✓	✓	✓
North Dakota	✓		
Ohio	✓		✓
Oklahoma	✓	✓	
Oregon	✓	✓	✓
Pennsylvania	✓	✓	✓
South Carolina	✓		
Tennessee	✓		
Texas	✓		
Utah	✓	✓	✓
Virginia	✓	✓	✓
Washington	✓	✓	✓
Wisconsin	✓		

Table 22-3. States’ Health Benefit Mandate Review Programs—Institutional Structure (2013)

State	State Agencies				Independent Programs		Other
	Insurance Department (a)	Other State Agency (b)	Legislative Research Services (c)	Health Insurance Exchange (d)	University (e)	Commission (f)	Sponsor (g)
Arizona							✓
California					✓		
Connecticut					✓		
Florida							✓
Georgia (h)	✓					✓	
Hawaii (i)			✓				
Indiana						✓	
Kansas	✓						
Kentucky	✓						
Louisiana (j)						✓	
Maine	✓						
Massachusetts		✓					
Minnesota		✓					
Missouri			✓				
Nevada			✓				
New Hampshire	✓						
New Jersey						✓	
North Dakota			✓				
Ohio	✓						
Oklahoma						✓	
Oregon		✓					
Pennsylvania						✓	
South Carolina	✓						
Tennessee			✓				
Texas	✓						
Utah	✓						
Virginia				✓		✓	
Washington		✓					
Wisconsin	✓						

Notes:

- (a) “Insurance Department” programs include the “Insurance Commissioner,” “Office of Insurance,” or the equivalent agency in that respective state. These are housed in the executive branch of the state government.
- (b) “Other State Agency” programs include those that are housed at another agency under the executive branch besides the Department of Insurance.
- (c) “Legislative Research Services” programs include those that are housed at the departments or agencies designed to support the legislature.

- (d) “State Exchange” refers to the state’s health insurance exchange. In Virginia, the mandated benefits commission has been repealed, and merged into the state’s exchange; as other states begin to implement their exchanges, we may see more programs subsumed into exchanges.
- (e) Health benefit review programs are housed at universities in California (CHBRP at the UC Office of the President) and in Connecticut (at University of Connecticut’s Center for Public Health and Public Policy).
- (f) Commission-based programs usually consist of individuals appointed by the executive or the legislative branch, and represent different industry and consumer interests. Commissions that evaluate health insurance benefits often conduct other types of analysis related to health care programs in the state.
- (g) The requirement for conducting evaluations falls primarily on the bill sponsors. Sponsors may mean a member of the state legislature but usually mean an outside organization or association advocating for passage of the bill.
- (h) Georgia passed legislation to create a new Mandated Benefits Commission, which was intended to go into effect in December 2012. However, the Assistant Director of the Life and Health Division at the Insurance Department, who was formerly responsible for benefit mandate analyses, has informed CHBRP that the Commission has not taken over this work yet, and that mandate analyses are still being completed by the Insurance Department.
- (i) Hawaii’s mandate evaluation is conducted by the State Auditor, who reports to and is considered part of the legislative branch
- (j) In 2010, Louisiana created the Louisiana Mandated Health Benefits Commission, to review mandate bills and report on the cost, social impact, and medical effectiveness of the proposed legislation. CHBRP has not been able to reach the commission for further information.

Table 22-4. States’ Health Benefit Mandate Review Programs: Reports Available Online (2016)

State	Program	Website
Connecticut	Center for Public Health and Public Policy	www.publichealth.uconn.edu/connecticut-insurance-department.html
Hawaii	Office of the State Auditor	http://auditor.hawaii.gov/reports/
Maine	Bureau of Insurance	http://www.maine.gov/pfr/legislative/index.html#insurance
Massachusetts	Center for Health Information and Analysis	http://www.chiamass.gov/mandated-benefit-reviews/
New Hampshire	New Hampshire Insurance Department	www.nh.gov/insurance/reports/
New Jersey	The New Jersey Mandated Health Benefits Advisory Commission	www.nj.gov/dobi/division_insurance/mhbac/mhbacdone.htm
Pennsylvania	Health Care Cost Containment Council	www.phc4.org/reports/mandates/
Texas	Texas Department of Insurance	www.tdi.texas.gov/reports/report5.html
Virginia	Joint Legislative Audit and Review Commission	http://jlarc.virginia.gov/reports.shtml
Washington	Department of Health Systems Quality Assurance	http://www.doh.wa.gov/AboutUs/ProgramsandServices/HealthSystemsQualityAssurance/SunriseReviews/AZList
Wisconsin	Commissioner of Insurance	https://oci.wi.gov/Pages/Regulation/SocialAndFinancialImpactStudies.aspx