

# Key Findings

## Analysis of California Assembly Bill 85 Social Determinants of Health: Screening and Outreach

Summary to the 2023–2024 California State Legislature, March 11, 2023



### SUMMARY

The version of California Assembly Bill (AB) 85 analyzed by the California Health Benefits Review Program (CHBRP) would require coverage and reimbursement of social determinants of health (SDOH) screening and would require insurers to provide “primary care providers with adequate access to community health workers...and inform primary care providers of how to access these community health workers.”

In 2024, the 24.9 million Californians enrolled in state-regulated health insurance would have insurance subject to AB 85. This includes commercial and California Public Employees' Retirement System (CalPERS) enrollees, as well as Medi-Cal beneficiaries enrolled in Department of Managed Health Care (DMHC)-regulated Medi-Cal managed care plans and county organized health systems (COHS).

**Benefit Coverage:** Approximately 60% of commercial and CalPERS enrollees and 100% of Medi-Cal beneficiaries have coverage for SDOH screening at baseline. Postmandate, 100% of enrollees would have coverage for SDOH screening. AB 85 would not exceed essential health benefits (EHBs).

**Medical Effectiveness:** There is *limited evidence* that SDOH screening in a clinical setting increases referrals to community health workers, or is associated with improved use of social services, improved social outcomes, or changes in health outcomes. There is *inconclusive evidence* that SDOH screening in a clinical setting is associated with changes in health care utilization. Medical Effectiveness evidence is limited by a lack of studies that examine SDOH screening in a clinical setting with control groups.

**Cost and Health Impacts<sup>1</sup>:** In 2024, AB 85 would result in 211,000 additional enrollees receiving SDOH screenings, for an additional \$9,926,000 in

annual expenditures (0.01%). The public health impact of AB 85 on improved health (or socioeconomic) status and outcomes is unknown.

### CONTEXT

#### Social Determinants of Health

Social determinants of health (SDOH) are nonmedical underlying structural factors that influence health status and health outcomes.<sup>2</sup> These social determinants, also referred to as social drivers,<sup>3</sup> of health, are modifiable conditions, meaning they are fluid and can change during the lifetime. There are multiple definitions of SDOH, but it is commonly defined as “the conditions in which people are born, grow, work, live, and age” in which a “wider set of forces and systems shape the conditions of daily life” and “affect health, functioning, and quality-of-life outcomes and risks.” The determinants themselves are neutral concepts (housing, education, food access) that can positively or negatively influence every person’s health status, longevity, and quality of life depending on their access to and the quality of these determinants (e.g., good or bad education; un/reliable transportation; un/safe, un/affordable housing). SDOH are part of the upstream effects that influence downstream effects including health care and health outcomes.

SDOH are primary drivers of health disparities, which are noticeable and preventable differences between groups of people. Disparities in SDOH such as education, housing, safety, and community development can contribute to up to 20 years difference in longevity, even among individuals who live within a few miles of each other. Moreover, research also demonstrates that discrimination (e.g., racism, ageism, sexism, ableism) prevents equal access to social and economic resources (e.g., housing, education, transportation, wealth, and employment with living wage or better) thereby creating social and health disparities.

<sup>1</sup> Similar cost and health impacts could be expected for the following year.

<sup>2</sup> Refer to CHBRP’s full report for full citations and references.

<sup>3</sup> In the SDOH term, some substitute “determinant” with “driver” to avoid the “finality” or intractability that “determinant” may

connote. Social driver of health, especially in the context of health equity, communicates the ability for an individual, community, or society to change a circumstance. For the purposes of this report, CHBRP will use determinant to comport with the language in AB 85.

SDOH are estimated to account for about 80% of health outcomes while health care accounts for about 20%.

### SDOH Screening Tools

The intention behind using SDOH screening tools in clinical practice is to identify information about social and/or economic risks of patients that was previously unknown to the health care team. That information ideally leads clinical teams to link patients with community resources and/or discussions about changing patient treatment plans to mitigate the social need(s) to improve health outcomes. Screening tools vary widely in the number, classification, and labeling of categories and their specific questions within the categories. They can focus on one category or multiple categories. There is no consensus about the “best” or most appropriate tool. Commonly included domains of social risk include economic stability, social and community context, and neighborhood and physical environment.

### Process of Linking Patients with Social Needs to Social Care/Resources

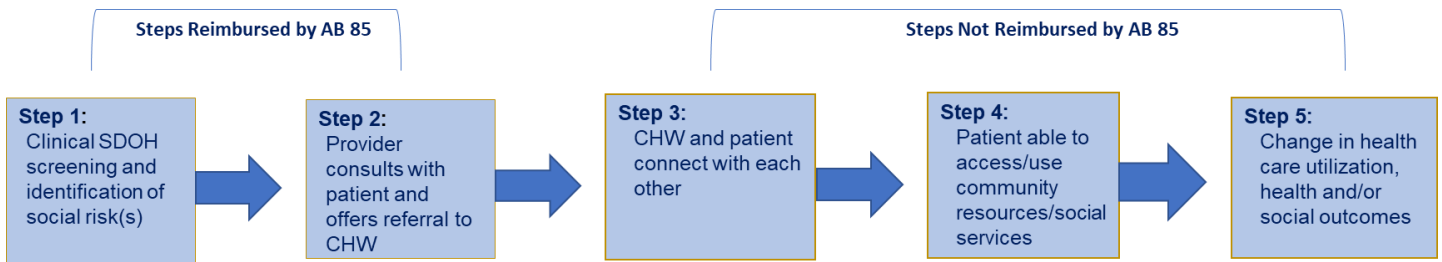
A primary goal of screening for SDOH is to identify unmet social needs and link patients to appropriate nonmedical resources to ultimately improve or maintain

their health. Such information can also inform clinician treatment choices such as using the information about housing security to avoid refrigerated medications.

Figure A maps an idealized process of care from SDOH screening through community health workers (CHWs) to social service acquisition and change in patient health status or outcomes. AB 85 focuses on Step 1 by mandating SDOH screening as a covered benefit, and Step 2 by requiring insurance carriers to provide clinicians adequate access to CHWs to enable referrals to CHWs for interested patients with social need(s).

Steps 3, 4, and 5 fall outside of the AB 85 requirements. Step 3 relates to the CHW and patient connecting (regardless of who initiates contact — the patient or the CHW). Step 3 represents work CHWs do to establish and maintain relationships with patients and with a diverse set of social programs whether publicly funded or nonprofits. Once the patient-to-CHW connection is made, the patient must be able to access the needed services (Step 4). Barriers to obtaining services include incomplete patient hand-off from CHW to agency, lack of eligibility for services due to patient’s income level, and inadequate agency bandwidth or funding to respond to need. Making successful community resource connections (Step 4) are required to achieving changes in social or health outcomes (Step 5).

**Figure A. Process of Care Linking Patients with Social Needs to Social Care/Resources**



Source: California Health Benefits Review Program, 2023.  
 Key: CHW = community health worker; SDOH = social determinants of health.

## BILL SUMMARY

AB 85 would require coverage and reimbursement of SDOH screening for 24,853,000 California enrollees (64% of all Californians). This represents those who have commercial or CalPERS health insurance regulated by DMHC and CDI and Medi-Cal beneficiaries enrolled in DMHC-regulated plans or county organized health system (COHS). Additionally, for DMHC-regulated plans and CDI-regulated policies (does not apply to plans only subject to the Welfare and Institutions Code), the insurer would be required to provide “primary care providers with adequate access to community health

workers...and inform primary care providers of how to access these community health workers.” The bill defines SDOH as “the conditions under which people are born, grow, live, work, and age, including housing, food, transportation, utilities, and personal safety.”

The bill language of AB 85 does not define the terms “SDOH screening,” “adequate,” and “access.” Therefore, CHBRP assumes interpretation and definition of these terms would be made by clinicians, insurers, and regulators and may vary. CHBRP provides a broad overview of SDOH screening in this analysis, and a range of possibilities regarding the interpretation of

“adequate” and “access.” CHBRP discusses multidomain SDOH screening tools, although single-domain screening tools exist and since the bill does not clarify eligible tools, may qualify as eligible under AB 85 (see more information in the *Background on Screening for Social Determinants of Health* section). Frequency of screening is also not defined so will depend on clinical resources, individual clinician decisions, and possibly the characteristics of the patient or patient population, but CHBRP generally assumed screening would occur annually in a clinical setting. Additionally, providing adequate information about and access to CHWs may include information available to clinicians within a directory-type format, telephone or email handoffs between clinicians/CHWs and externally employed CHWs, or handoffs to CHWs who are employed in the clinical setting or employed by an insurer.

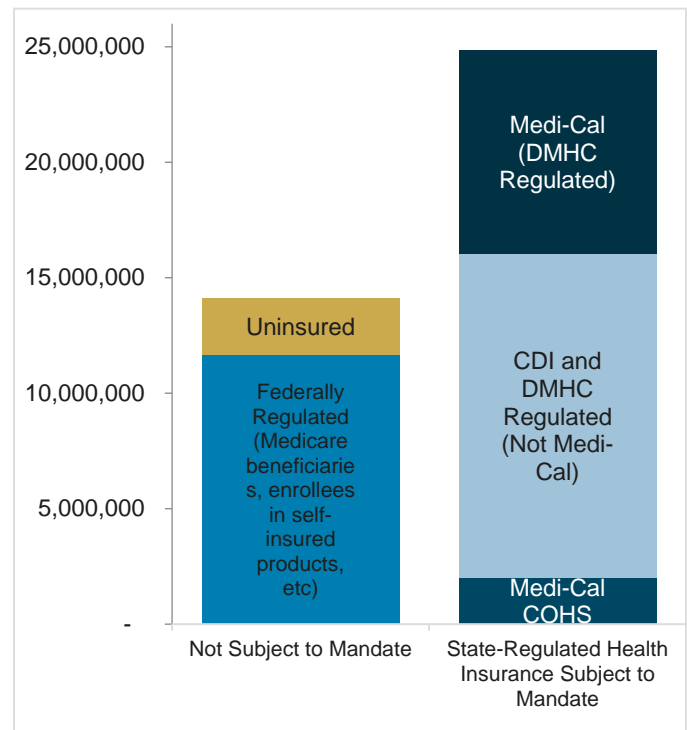
## Policy Context

There are several existing or forthcoming requirements around SDOH screening for plans and policies in California.

- Medi-Cal currently requires that Medi-Cal plans identify and manage social risks and needs of Medi-Cal beneficiaries using whole person care approaches to mitigate adverse SDOH (e.g., lack of stable housing or food) as part of CalAIM’s Population Health Management component. New Medi-Cal managed care contracts require plans to identify and track “social drivers of health” and develop partnerships with local agencies to support community needs, including supports like housing and other non-health-related programs.
- Assembly Bill 133 (2021) requires that DMHC-regulated plans and Medi-Cal managed care plans obtain National Committee for Quality Assurance (NCQA) Health Plan Accreditation by January 1, 2026. Beginning in 2023, the NCQA accreditation requires plans to report the number of enrollees who were screened, using prespecified instruments, at least once during the measurement period and received a corresponding intervention within 30 days if they screened positive for at least one food, housing, or transportation need.
- Covered California requires insurers that offer plans and policies through the Marketplace to obtain or maintain NCQA Health Plan Accreditation by the end of 2024.

Figure B notes how many Californians have health insurance that would be subject to AB 85.

**Figure B. Health Insurance in CA and AB 85**



Source: California Health Benefits Review Program, 2023.

Key: CDI = California Department of Insurance; COHS = County Organized Health System; DMHC = Department of Managed Health Care.

## IMPACTS

### Benefit Coverage, Utilization, and Cost

#### Analytic Approach and Key Assumptions

CHBRP assumes AB 85 would allow for reimbursement of one SDOH screening per year as part of typical preventive and wellness care visit. Therefore the additional cost would be reimbursed by the health plan or health insurance policy, but no cost sharing would be collected due to the Affordable Care Act’s preventive services provisions.

AB 85 allows insurance carriers to determine criteria for coverage of SDOH screening and allows clinicians to be reimbursed for medically necessary screening. CHBRP assumes the voluntary nature of screening for both patients and clinicians would not result in universal screening. Instead, the use of screening by clinicians would vary across patient populations. CHBRP estimates that 3.2% of employer-sponsored and CalPERS commercial enrollees would obtain an annual SDOH screening, while 6.4% of individual insurance

market enrollees, and 20% of Medi-Cal enrollees would use the service.

Despite other state policy efforts to link SDOH screening with care management and coordination activities to address high-cost, high-need populations, AB 85 does not require enrollment or reimbursement for those activities by a plan or clinician. Therefore, the impact of AB 85 is limited to the new utilization of SDOH screening itself and the resulting reimbursement for screenings due to new benefit coverage and use of SDOH screening.

## Benefit Coverage

At baseline, 75% (or 17,202,000) of the 22,842,000 enrollees with health insurance regulated by DMHC or CDI already have coverage for SDOH screening. As a result of AB 85, 5,640,000 enrollees (25% of the enrollees with state-regulated health insurance) would gain coverage for SDOH screening, representing a 32.79% increase in benefit coverage postmandate. All of the enrollees who would gain SDOH screening coverage have commercial insurance or insurance through CalPERS; this group represents 40% of the commercial and CalPERS population.

## Utilization

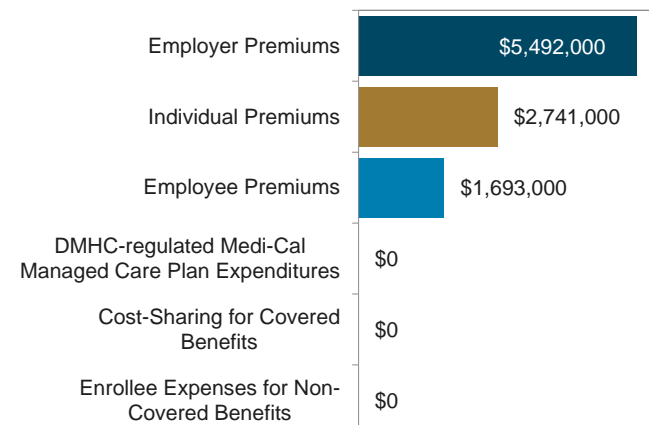
At baseline, 325,700 enrollees in the large-group, small-group, CalPERS, and individual insurance market with existing coverage received SDOH screening. Approximately 1,763,400 Medi-Cal enrollees received SDOH screening.

Postmandate, based on 25% of the state-regulated enrollee population gaining coverage for SDOH screening, CHBRP estimates that use of SDOH screening would increase by 210,949 among enrollees with commercial or CalPERS insurance (a 64.77% increase). There is no increase in the Medi-Cal managed care or COHS market because of existing coverage.

## Expenditures

AB 85 would increase total net annual expenditures by \$9,926,000 or 0.01% for enrollees in state-regulated insurance. For most commercial market segments, this would translate to increasing premiums by 0.01%. However, enrollees with insurance purchased outside of Covered California would experience the largest proportional increase in enrollee premiums (0.03%) due to lower levels of benefit coverage at baseline.

**Figure C. Expenditure Impacts of AB 85**



Source: California Health Benefits Review Program, 2023.

Key: DMHC = Department of Managed Health Care.

## Covered California – Individually Purchased

Premiums for enrollees in individual plans purchased through Covered California would increase by \$0.05 per member per month (0.01%).

## Medi-Cal

Because all Medi-Cal plans reported providing and paying for SDOH screening at baseline, no increase is estimated due to AB 85. Due to the combination of Medi-Cal contracting requirements, NCQA accreditation requirement changes, and the upcoming CalAIM Medicaid Waiver, CHBRP estimates that AB 85 would not result in new benefit coverage or increased use of SDOH screening in Medi-Cal managed care plans.

## CalPERS

For enrollees associated with CalPERS in DMHC-regulated plans, premiums would increase by 0.01% (\$0.04 per member per month, \$415,000 total increase in expenditures).

## Number of Uninsured in California

Because the change in average premiums does not exceed 1% for any market segment, CHBRP projects no measurable change in the number of uninsured persons due to the enactment of AB 85.

## Postmandate Administrative Expenses and Other Expenses

The additional requirement of AB 85 for health plans and insurance policies to ensure adequate information about and access to community health workers could vary in

terms of implementation, and because there is no requirement to create a new contracted network or reimburse community health workers for visits related to SDOH screening, CHBRP does not estimate additional administrative costs beyond the percentage already built into the CHBRP Cost and Coverage Model.

## Other Considerations for Policy Makers

AB 85 would reimburse clinicians for SDOH screening and require insurers to provide referring clinicians with access to CHWs. However, AB 85 does not mandate reimbursement for or coverage of social services that patients with social needs would be linked to through CHWs. It is possible that SDOH screening and identification of social needs would result in referrals to publicly financed housing, homeless shelters, foods stamps, food banks, WIC, and other social supports that are not paid for by insurance carriers and therefore are beyond the scope of this analysis. Public and community-based social resource organizations may see an increase in utilization and associated costs. Although the California Department of Health Care Access and Information is convening a workgroup to develop recommendations around licensure and reimbursement for CHWs, AB 85 does not require reimbursement for CHWs or social services that CHWs may refer to.

## Medical Effectiveness

The medical effectiveness review summarizes findings from 2019 to present on the evidence that multi-domain clinical screening for SDOH leads to referrals to CHWs or other social service navigators, to use of social services, and to changes in social outcomes, health care utilization, or health outcomes. CHBRP also reviewed evidence of harms of SDOH screening in a clinical setting.

Studies on screening for SDOH in a clinical setting were limited in number and quality; there were few RCTs and the observational studies lacked control arms. It is hard to generalize the findings of this research across studies because of the variety of populations included in studies, the various social needs, the variety of SDOH screening tools, and the variety of referral interventions used in the studies. Therefore, taken together, the evidence on the effectiveness of screening for SDOH in a clinical setting, referral to navigators/social services, and downstream

<sup>4</sup> *Limited evidence* indicates that the studies have limited generalizability to the population of interest and/or the studies have a fatal flaw in research design or implementation.

<sup>5</sup> *Inconclusive evidence* indicates that although some studies included in the medical effectiveness review find that a treatment is effective, a similar number of studies of equal quality suggest the treatment is not effective.

outcomes after screening is a mixture of limited, inconclusive, and insufficient. The lack of evidence due to limited research literature is not evidence of lack of effect.

The medical effectiveness review was structured based on the idealized steps included in Figure A above. Identified literature did not address the effectiveness of each step.

## Steps 1 and 2

CHBRP found *limited evidence*<sup>4</sup> that SDOH screenings in a clinical setting increase referrals to community health workers/navigators/social services.

## Step 4

CHBRP found that there is *limited evidence* that SDOH screening in a clinical setting is associated with improved use of social services.

## Step 5

CHBRP found *inconclusive evidence*<sup>5</sup> that SDOH screening in a clinical setting is associated with changes in health care utilization.

CHBRP found *limited evidence* that SDOH screening in a clinical is associated with improvements in social outcomes or with changes in health outcomes.

## Harms

CHBRP found *insufficient evidence*<sup>6</sup> on harms to patients, families, and clinicians of using any SDOH screening tool in a clinical setting.

## Public Health

The public health impact of AB 85 on improved health (or socioeconomic) status and outcomes is unknown. Although CHBRP estimates that an additional ~211,000 commercially insured enrollees would receive SDOH screening in a clinical setting; and of those, ~25,000 are likely to screen positive for  $\geq 1$  social need; and of those, ~7,300 might connect with a CHW, *it is unknown*:

- If the supply of CHWs in California is sufficient;

<sup>6</sup> *Insufficient evidence* indicates that there is not enough evidence available to know whether or not a treatment is effective, either because there are too few studies of the treatment or because the available studies are not of high quality. It does not indicate that a treatment is not effective.

- If CHWs can successfully connect patients to  $\geq 1$  needed social resources;
- If social services/community-based organizations have adequate resources to meet increased needs;
- If these commercially insured enrollees would qualify for social services or community-based resources, most of which are income tested;
- If these commercially insured enrollees, if eligible for social services, would be able to use them (e.g., geographic, time, transportation or other barriers to their use);
- Whether health outcomes would improve within 12 months and to what extent; and
- If and to what extent new social needs would develop and be addressed.

To the extent that some screened enrollees would be linked to and use social resource(s), real changes in *individual* health status and outcomes could occur during the first year postmandate.

CHBRP finds *inconclusive evidence* of harms associated with SDOH screening in a clinical setting and referral to CHWs; therefore, harms associated with AB 85 postmandate are unknown. However, CHBRP does not project serious problems arising from clinicians administering SDOH screening tools or referring patients to CHWs, whether the referrals are successful or not, based on one review that found general acceptance of SDOH screening and CHW referrals among clinicians and patients.

The impact of AB 85 on health disparities is unknown. Because AB 85 does not alter baseline coverage or utilization of SDOH screening among Medi-Cal beneficiaries, and it is projected to increase screening for ~211,000 newly covered enrollees with commercial insurance or coverage through CalPERS, it is unlikely that this bill would reduce disparities by race, ethnicity, and income. This bill would increase utilization of SDOH screening among commercially insured people of which an estimated 12% would screen positive for social risks, and an estimated 33% would express interest in CHW assistance in obtaining social resources. However, the racial/ethnic distribution of the newly screened is unknown. Moreover, the number of social resources available to the commercially insured population is less than those available to Medi-Cal beneficiaries (who already have coverage for SDOH screening). Because eligibility for social services (WIC, Section 8 housing, CalFresh, etc.) is often limited to lower-income people, many commercially insured people might not qualify. This may pose challenges to linking them with services that can sustainably address their social needs.

## Long-Term Impacts

Because AB 85 only reimburses for screening, CHBRP predicts that AB 85 would not contribute to long-term changes in health care utilization partly due to the unknown mechanism for establishing a reliable clinician-CHW network system for patient referral. Additionally, multiple policy changes mitigate the potential effect of AB 85 including recent changes in Medi-Cal (new Medi-Cal managed care contracts and CalAIM activities), state-mandated NCQA accreditation of health insurance plans, and other clinician-led initiatives to address social needs through SDOH screening. These factors are likely to increase SDOH screening without passage of AB 85. In addition, the California Department of Health Care Access and Information (HCAI) is convening a workgroup on licensure and reimbursement for CHWs that could change the use of and payment for CHW services in the long-term. However, that workgroup is focused on Medi-Cal coverage to create a mechanism for billing for CHW services and will not directly affect the commercial insurance market unless separate legislation or decisions to require coverage for CHW-related services are adopted in the commercial market.

For reasons similar to CHBRP's unknown short-term public health impact finding, there is also an unknown long-term public health impact finding. Although screening is projected to increase among a concentrated group of commercially insured enrollees (Medi-Cal beneficiaries have baseline benefit coverage), outstanding questions remain about clinician decisions to screen and refer patients, the type and quality of CHW referrals and networks established (including the definition of "adequate" and "access" to CHWs by clinician), and whether there are adequate social resources available for the new influx of commercially insured enrollees with unmet social needs.

However, AB 85 does require a workgroup to issue a report to the legislature by January 1, 2025, that creates a standardized model to connect patients with community resources. Depending on the outcome of that report and subsequent legislative and regulatory changes, AB 85 could have a larger impact on mitigating social needs among the newly covered commercially insured with unmet social needs. Workgroup outcomes could provide more answers and direction to the unknown factors in Steps 3-5 (Figure A). CHBRP acknowledges that, even without Workgroup recommendations or CHW or community resource involvement, SDOH screening could improve patient health status by increasing the information available to clinical teams about patients' social risk, which might then be used to influence treatment plans for patients experiencing social needs. For example, a clinician learns about housing insecurity, which leads to a

different medication. Over time, broadening the clinical care approach to routinely incorporate social data could become standard. However, the magnitude of this type of change is unknown.

## **Essential Health Benefits and the Affordable Care Act**

AB 85 does not exceed the definition of EHBs in California because screenings are a preventive service and are therefore included in the definition of EHBs.