

California Health Benefits Review Program

Executive Summary

Analysis of Senate Bill 320:
Acquired Brain Injury

A Report to the 2013-2014 California Legislature

April 19, 2013



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EXECUTIVE SUMMARY

California Health Benefits Review Program Analysis of Senate Bill 320

The California Senate Committee on Health requested on February 20, 2013, that the California Health Benefits Review Program (CHBRP) conduct an evidence-based assessment of the medical, financial, and public health impacts of Senate Bill (SB) 320 (Beall) on acquired brain injury (ABI). In response to this request, CHBRP undertook this analysis pursuant to the provisions of the program's authorizing statute.¹

In 2014, CHBRP estimates that approximately 25.9 million Californians (67%) will have health insurance that may be subject to a health benefit mandate law passed at the state level.² Of the rest of the state's population, a portion is uninsured (and so will have no health insurance subject to any benefit mandate), and another portion will have health insurance subject to other state laws or only to federal laws.

Uniquely, California has a bifurcated system of regulation for health insurance subject to state benefit mandates. The California Department of Managed Health Care (DMHC)³ regulates health care service plans, which offer benefit coverage to their enrollees through health plan contracts. The California Department of Insurance (CDI) regulates health insurers,⁴ which offer benefit coverage to their enrollees through health insurance policies.

All DMHC-regulated plans and CDI-regulated policies would be subject to SB 320. Therefore, the mandate would affect the health insurance of approximately 25.9 million enrollees (67% of all Californians).

Developing Estimates for 2014 and the Effects of the Affordable Care Act

The Affordable Care Act (ACA)⁵ is expected to dramatically affect health insurance and its regulatory environment in California, with many changes becoming effective in 2014. It is important to note that CHBRP's analysis of proposed benefit mandate bills typically address the marginal effects of the proposed bills—specifically, how the proposed mandate would impact benefit coverage, utilization, costs, and public health, holding all other factors constant. CHBRP's estimates of these marginal effects are presented in this report. Because expanded enrollment will not occur until January 2014, CHBRP relies on projections from the California

¹ Available at: www.chbrp.org/docs/authorizing_statute.pdf.

² CHBRP's estimates are available at: www.chbrp.org/other_publications/index.php.

³ The California Department of Managed Health Care (DMHC) was established in 2000 to enforce the Knox-Keene Health Care Service Plan of 1975; see Health and Safety Code (H&SC) Section 1340.

⁴ The California Department of Insurance (CDI) licenses "disability insurers." Disability insurers may offer forms of insurance that are not health insurance. This report considers only the impact of the benefit mandate on health insurance policies, as defined in Insurance Code (IC) Section 106(b) or subdivision (a) of Section 10198.6.

⁵ The federal "Patient Protection and Affordable Care Act" (P.L.111-148) and the "Health Care and Education Reconciliation Act" (P.L. 111-152) were enacted in March 2010. Together, these laws are referred to as the Affordable Care Act (ACA).

Simulation of Insurance Markets (CalSIM) model⁶ to help set baseline enrollment for 2014. From this projected baseline, CHBRP estimates the marginal impact of benefit mandates proposed that could be in effect after January 2014.

Bill-Specific Analysis of SB 320

The full text of SB 320 can be found in Appendix A.

SB 320 would prohibit DMHC-regulated plans and CDI-regulated policies from denying coverage for medically necessary medical or rehabilitation treatment for ABI at specified facilities, including:

- Hospitals;
- Acute rehabilitation hospitals;
- Long-term acute care hospitals;
- Medical offices;
- Commission on Accreditation of Rehabilitation Facilities (CARF)-accredited postacute residential transitional rehabilitation facilities;⁷ and
- Another “analogous facility” at which appropriate services may be provided.

Additionally, coverage may not be denied because “the treating facility is not near the enrollee’s home.”

The bill would apply to DMHC-regulated plans and CDI-regulated policies amended, renewed, or delivered after January 1, 2014. As introduced, SB 320 appears to prohibit the use of limited panels of providers and institutions by health plans—often referred to as in-network care—for treatment of ABI. SB 320 also appears to allow enrollees to seek facilities outside their service area.

SB 320 approaches coverage by emphasizing (1) a condition—ABI—which itself is a broad category of injuries, and (2) facilities, listing six categories of facilities. The bill does not define specific treatments to be covered, only noting that insurers may not deny coverage for “medically necessary medical and rehabilitative treatments for an acquired brain injury.”

⁶ CalSIM was developed jointly and is operated by the University of California, Los Angeles, Center for Health Policy Research and the University of California, Berkeley, Center for Labor Research. The model estimates the impact of provisions in the ACA on employer decisions to offer, and individual decisions to obtain, health insurance.

⁷ The Commission on Accreditation of Rehabilitation Facilities (CARF) is an international organization that has approved and established a common set of “field-driven” standards for rehabilitation facilities, according to their website. To be accredited, facilities need to undergo a “consultative peer-review process,” which is an external review that includes on-site visits by peers. In addition to site observation, the accreditation team will also survey clients and staff, and review documentation. Once accredited, a facility must submit an “Annual Conformance to Quality Report.” As of April 2013, there are 26 CARF-accredited brain injury programs in California, <http://www.carf.org/home/>. Accessed April 2013.

CHBRP focuses this analysis on rehabilitation treatments because CHBRP assumes DMHC-regulated plans and CDI-regulated policies already cover medically necessary medical care.

SB 320's focus on facilities, rather than treatments, presented analytical challenges: first, because coverage of facilities does not necessarily equate to coverage for the treatments and services that are available at that facility, or what an enrollee with ABI may require; second, CHBRP was unable to determine the level of unmet demand for ABI-related rehabilitative treatments and services due to lack of data. These data would allow CHBRP to estimate how utilization would change if benefit coverage were offered.

Background on ABI

CHBRP defines acquired brain injury (ABI) as acute (rapid onset) brain injury of any cause sustained any time after birth. Severity of ABI ranges from a mild concussion—requiring little to no treatment—to coma or death. ABI may result in short-term or long-term impairments that affect physical or cognitive abilities (thinking, memory, and reasoning), sensory processing (using the five senses), communication (expression and understanding), and behavior or mental health (depression, anxiety, personality changes, aggression, and social inappropriateness).⁸

There is no formal clinical diagnosis that exists for ABI, thus there is no corresponding single data source that captures the incidence or prevalence of ABI. However, CHBRP presents the most recent data available for stroke (a type of brain injury) and traumatic brain injury (TBI), which account for the majority of ABIs that would likely require rehabilitation treatments and services.

TBI incidence

- **US.** Nationally, of the 1.7 million TBIs that occur annually, 1.36 million result in emergency department visits (80%), 275,000 hospitalizations (16%), and 52,000 deaths (3%).⁹ It is estimated that about 9% of hospitalized TBI patients were discharged to residential (skilled nursing) facilities, and almost 8% percent were discharged to inpatient rehabilitation.¹⁰
- **California.** The California Department of Public Health reported that Californians experienced 19,164 nonfatal TBI hospitalizations in 2011; 15,515 of those patients were treated and released, 1,144 were transferred to an acute care hospital, and 2,044 transferred to a nonacute care hospital (the remainder were classified as unknown).¹¹ About 350,000 Californians are living with TBI.¹²

Stroke incidence

- **US.** Nationally and in California, stroke is a leading cause of death and disability. The prevalence rate of stroke increases as a person ages; national data show those over age 65

⁸ NINDS, 2013

⁹ CDC, 2013

¹⁰ Coronado et al., 2007

¹¹ CDPH, 2013 EPIC

¹² CDMH, 2010

have the highest stroke prevalence rate (8.3%), followed by those aged 45 to 64 years and those aged 18 to 44 years (2.9% and 0.7%, respectively).

- **California.** In California, there are about 200,000 stroke-related hospital discharges per year (1 in 20 hospital discharges) or 5.9 discharges/1,000 population.¹³ The number of California stroke patients admitted to postacute rehabilitation facilities or programs is unknown.

Data regarding utilization by type of rehabilitation treatment for ABI, and the intensity and duration is not available, nor is there an accounting of those who might not receive rehabilitation treatment because of a lack of coverage, denied coverage (see *Introduction* for details on coverage appeals through the independent medical review (IMR) process), or lack of ability to pay.

Because of data limitations and the lack of specificity in SB 320 regarding specific treatments covered, CHBRP could only draw limited definitive conclusions on the medical effectiveness of multidisciplinary rehabilitation treatment for ABI. In addition, CHBRP found the impact of SB 320 on benefit coverage, utilization, cost, as well as public health, to be unknown.

Medical Effectiveness

SB 320 addresses coverage for both medical care and rehabilitation for ABI. The medical effectiveness review focuses on evidence of the effectiveness of multidisciplinary rehabilitation treatments because CHBRP assumes that DMHC-regulated plans and CDI-regulated policies provide coverage for all medically necessary medical treatments for ABI. In addition, the medical effectiveness review summarizes findings from studies of the impact of utilizing packages of multidisciplinary rehabilitation treatments and not on the effects of specific types of treatments. Findings from studies of individual types of treatments are difficult to generalize to the whole population of persons with ABI because specific needs differ depending on the type and severity of injury.

Study Findings

CHBRP terminology for grading evidence of medical effectiveness

CHBRP uses the following terms to characterize the strength of the evidence it identifies regarding the medical effectiveness of a treatment for which a bill would mandate coverage.

- Clear and convincing evidence
- Preponderance of evidence
- Ambiguous/conflicting evidence
- Insufficient evidence

¹³ CDPH, 2007

A grade of *clear and convincing evidence* indicates that there are multiple studies of a treatment and that the large majority of studies are of high quality and consistently find that the treatment is either effective or not effective.

A grade of *preponderance of evidence* indicates that the majority of the studies reviewed are consistent in their findings that treatment is either effective or not effective.

A grade of *ambiguous/conflicting 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.

A grade of *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.

Characteristics of populations and treatments studied

- Studies of multidisciplinary rehabilitation for ABI have compared these interventions to:
 - Minimal intervention (e.g., written information, occasional telephone call)
 - Similar interventions delivered in different settings (e.g., outpatient clinic vs. home)
 - Different interventions delivered in the same setting (e.g., two interventions delivered in inpatient settings that place differing degrees of emphasis on cognitive rehabilitation)
 - More or less intensive interventions (e.g., more vs. fewer hours of rehabilitation)
- Most persons enrolled in studies of multidisciplinary rehabilitation for ABI had a TBI. A few studies also enrolled persons whose ABI was due to stroke or another cause. The extent to which findings from these studies generalize to populations that consist primarily of persons with encephalitis or other types of ABIs is unknown.

Findings from studies of persons with mild ABI

- The preponderance of evidence suggests that among persons with mild TBI, only persons with injuries that require hospitalization benefit from multidisciplinary postacute rehabilitation.
- Evidence from randomized controlled trials (RCTs) suggests that providing all persons who have had a mild TBI with education about symptoms and expectations for recovery reduces the likelihood of persistent symptoms.
- There is also evidence that vestibular rehabilitation is an effective treatment for persistent balance disorders associated with mild TBI and that psychotherapy is an effective treatment for comorbid mental health conditions.

Findings from studies of persons with moderate to severe ABI

- The preponderance of evidence from the three RCTs that have compared multidisciplinary postacute rehabilitation to a minimal intervention or no specific intervention suggests that these multidisciplinary interventions improve functional status and increase participation in everyday activities.
- Evidence from the five RCTs that have compared more intensive to less intensive multidisciplinary rehabilitation is ambiguous. Differences in the treatments provided to the intervention and comparison groups make it difficult to generalize findings across these studies.
- Findings from studies that compared the delivery of inpatient rehabilitation in specialized versus unspecialized settings are ambiguous.
- The preponderance of evidence from studies that compared outpatient rehabilitation that emphasizes cognitive rehabilitation to standard outpatient rehabilitation regarding the likelihood of obtaining employment or pursuing education was ambiguous.
- There is insufficient evidence to determine whether the setting in which multidisciplinary rehabilitation interventions occurs affects patients' outcomes because findings are confounded by differences in intensity of treatment across settings.

Benefit Coverage, Utilization, and Cost Impacts

CHBRP finds that the impact of SB 320 is unknown. Despite CHBRP's efforts to ascertain the level of coverage for ABI, it is unknown how many ABI patients are eligible to receive multidisciplinary rehabilitation treatment at the facilities specified in SB 320. This is due to the wide range of potential rehabilitation treatments that regulators may or may not determine to be "medically necessary," as specified in SB 320. Additionally, there may be differences in treatments offered among facility types, or benefit coverage limitations on number of days or visits covered.

Coverage impacts

- Currently, enrollees appear to have nearly full coverage at the facilities required by SB 320:
 - Carriers reported 100% coverage of facilities specified in SB 320, except for coverage for adult residential or postacute residential transitional rehabilitation facilities, at which carriers reported 58% coverage of facilities.
- Coverage of facilities does not necessarily mean coverage for all treatments and services provided at the facility. Because facilities also vary in the treatments they provide, CHBRP cannot determine current coverage for rehabilitation treatments and services.
- Benefit coverage may include limitations on number of visits or inpatient days or number of treatments. Some enrollees with ABI may reach these limits depending on the extent of their rehabilitation needs.
- CHBRP finds that coverage for treatments at adult residential or postacute residential transitional rehabilitation facilities would increase from 58% to 100%, but it is unknown

which treatments or services would be included in the coverage and whether there would be any limitations on the utilization of those treatments or services.

- CHBRP is unable to estimate SB 320's overall impact on coverage because it is unknown:
 - Which ABI-related treatments and services an enrollee may receive at specified facilities;
 - The intensity of those treatments;
 - Their duration; or
 - Whether regulators will deem these treatments to be medically necessary.

Utilization impacts

- Premandate, CHBRP estimates that approximately 129,700 enrollees with health insurance subject to SB 320 (0.5% of people enrolled in DMHC-regulated plans and/or CDI-regulated policies) have been diagnosed with and treated for ABI.
- Of these enrollees, approximately 4,500 were admitted to a facility that would be subject to SB 320 during the past year; 2,900 patients were seen at medical offices, 1,400 at general acute care hospitals, and the rest at other facilities. These 4,500 patients used approximately 68,200 different treatments.
- The impact of SB 320 on utilization is unknown because:
 - It is not clear whether benefit coverage for treatments administered in these facilities would change postmandate.
 - The current level of unmet demand is unclear. CHBRP could not find a data source or research literature that addressed unmet demand for ABI-related treatments and services. Therefore, CHBRP cannot estimate potential changes in utilization due to the mandate.

Cost impacts

- Because of the uncertainty in the impact of SB 320 on benefit coverage and utilization, CHBRP finds that SB 320 has an unknown impact on costs.

Public Health Impacts

Overall public health impact

- The preponderance of evidence shows that persons with moderate to severe ABI benefit from multidisciplinary postacute rehabilitation treatment as compared to those who receive little or no intervention (see *Medical Effectiveness*). However, CHBRP is unable to estimate a change in coverage or utilization of these rehabilitation treatments at the specified facilities for two reasons: (1) the bill's focus on facilities precludes capturing premandate coverage or utilization of treatments, and (2) CHBRP is unable to estimate the unmet demand for these treatments. Therefore, CHBRP concludes that the overall public health impact of SB 320 is unknown.

Financial burden

- Without literature or data regarding unmet demand as well as an absence of regulator interpretation of SB 320's scope of coverage, CHBRP cannot estimate the possible reduction in financial burden from uncovered expenses that SB 320 might produce for insured Californians who, premandate, pay out of pocket for covered treatments or who pay for uncovered expenses related to rehabilitation treatments.

Disparities

- Although there appear to be gender differences in certain aspects of recovery from ABI, the impact of SB 320 on reducing gender disparities is unknown. Studies of potential racial and ethnic disparities vary considerably in their methodology, outcomes measured, and type of injury; however, the preponderance of evidence indicates disparities in some postacute ABI rehabilitation outcomes by race/ethnicity. Despite the evidence, CHBRP concludes that SB 320 would have an unknown impact on coverage and utilization; therefore, the proposed mandate's impact on reducing racial/ethnic disparities is unknown.

Economic loss

- Although ABI causes economic loss, the impact of SB 320 on economic loss is unknown because evidence of the rehabilitation treatment(s) effectiveness on employment is ambiguous and because CHBRP is unable to estimate a change in coverage or utilization of multidisciplinary rehabilitation treatments.

Premature death

- Although research shows that persons with ABI are at elevated risk for premature death, CHBRP concludes that the impact of SB 320 on premature death is unknown due to a lack of evidence regarding the effectiveness of multidisciplinary rehabilitation on mortality as well as an unknown impact on coverage and utilization for these treatments.

Long-term impacts

- The long-term public health impact attributable to SB 320 is unknown because CHBRP is unable to estimate a change in the coverage or utilization of multidisciplinary rehabilitation treatments.

Interaction With the Federal Affordable Care Act

Below is an analysis of how this proposed benefit mandate may interact with the ACA's requirement for certain health insurance to cover "essential health benefits"¹⁴ (EHBs), as well as other ACA requirements that may interact with this proposed benefit mandate.

SB 320 and essential health benefits

It is unknown whether SB 320 exceeds or falls within essential health benefits, because of ambiguity in the bill language. As written, SB 320 does not specify which benefits an enrollee would receive, but rather, it designates: (1) the condition—ABI; (2) the general category of treatments, of which CHBRP is focusing on rehabilitation; and (3) the facility—listing the types of facilities permitted.

The ACA's essential health benefits explicitly include "rehabilitative and habilitative services and devices." In addition, both proposed rules¹⁵ and final rules¹⁶ on EHBs have specified that mandates relating to provider types (such as facilities) do not fall under the ACA's interpretation of state-required benefits.

However, rehabilitation treatments and services offered at facilities mentioned in SB 320 may differ from the specific treatments outlined in California's EHB package, as defined by the Kaiser HMO 30 plan. Additionally, the medical necessity of such treatments may also be in dispute, and contested through the state's existing independent medical review (IMR) process at each state health insurance regulatory agency, DMHC or CDI.

As such, state regulators would first need to determine whether each type of ABI rehabilitation service provided at a listed facility—which range from a hospital to an "analogous facility"—is medically necessary. Then, the regulators need to determine if those treatments differ from California's EHB package. To the extent that those treatments exceed EHBs as defined in the Kaiser HMO 30 plan, the state would be required to defray the additional cost for Qualified Health Plans (QHPs) purchased in Covered California.

Therefore, it is unknown whether SB 320 falls within essential health benefits, or exceeds EHBs because regulator guidance is required to make determinations on as-yet undefined treatments.

¹⁴ Resources on EHBs and other ACA impacts are available on the CHBRP website: www.chbrp.org/other_publications/index.php.

¹⁵ Department of Health and Human Services, "Proposed Rule: Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation," *Federal Register*, Vol 77, No. 277, November 26, 2012, at <http://www.gpo.gov/fdsys/pkg/FR-2012-11-26/pdf/2012-28362.pdf>.

¹⁶ Department of Health and Human Services, "Final Rule: Proposed Rule: Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation," *Federal Register*, Vol. 78, No. 37, February 25, 2013, at <http://www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf>.

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Janet Coffman, MPP, PhD, Gina Evans-Young, and Margaret Fix, MPH, all of the University of California, San Francisco, prepared the medical effectiveness analysis. Min-Lin Fang, MLIS, of the University of California, San Francisco, conducted the literature search. Diana Cassady, DrPH, and Dominique Ritley, MPH, all of the University of California, Davis, prepared the public health impact analysis. Shana Lavarreda, PhD, MPP, of the University of California, Los Angeles, prepared the cost impact analysis. Robert Cosway, FSA, MAAA, Scott McEachern, and Tim Wilder, FSA, MAAA, of Milliman, provided actuarial analysis. Content experts Gary Abrams, MD, of the University of California, San Francisco, and Cassie Spalding-Dias, MD, of the University of California, Davis, provided technical assistance with the literature review and expert input on the analytic approach. Hanh Kim Quach of CHBRP staff prepared the *Introduction* and synthesized the individual sections into a single report. A subcommittee of CHBRP's National Advisory Council (see final pages of this report) and a member of the CHBRP Faculty Task Force, Susan Ettner, PhD, of the University of California, Los Angeles, reviewed the analysis for its accuracy, completeness, clarity, and responsiveness to the Legislature's request.

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

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California Health Benefits Review Program Committees and Staff

A group of faculty and staff undertakes most of the analysis that informs reports by the California Health Benefits Review Program (CHBRP). The CHBRP **Faculty Task Force** comprises rotating representatives from six University of California (UC) campuses. In addition to these representatives, there are other ongoing contributors to CHBRP from UC. This larger group provides advice to the CHBRP staff on the overall administration of the program and conducts much of the analysis. The **CHBRP staff** coordinates the efforts of the Faculty Task Force, works with Task Force members in preparing parts of the analysis, and coordinates all external communications, including those with the California Legislature. The level of involvement of members of the CHBRP Faculty Task Force and staff varies on each report, with individual participants more closely involved in the preparation of some reports and less involved in others. As required by CHBRP's authorizing legislation, UC contracts with a certified actuary, Milliman Inc., to assist in assessing the financial impact of each legislative proposal mandating or repealing a health insurance benefit. Milliman also helped with the initial development of CHBRP methods for assessing that impact.

The **National Advisory Council** provides expert reviews of draft analyses and offers general guidance on the program to CHBRP staff and the Faculty Task Force. CHBRP is grateful for the valuable assistance and thoughtful critiques provided by the members of the National Advisory Council. However, the Council does not necessarily approve or disapprove of or endorse this report. CHBRP assumes full responsibility for the report and the accuracy of its contents.

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