Key Findings

Analysis of California Senate Bill 428 Adverse Childhood Experiences Screenings

Summary to the 2021–2022 California State Legislature, April 18, 2021

SUMMARY

California Senate Bill 428 analyzed by CHBRP would require DMHC- and CDI-regulated plans and policies to provide coverage for adverse childhood experiences (ACEs) screenings.

In 2022, of the 21.9 million Californians enrolled in state-regulated health insurance, 21.9 million of them would have insurance subject to SB 428.

Benefit Coverage: Currently, 36% of enrollees with state-regulated health insurance (that would be subject to SB 428) have coverage for ACEs screening. These are enrollees in Medi-Cal Managed Care Programs. DHCS provides reimbursement to providers completing ACEs screenings in Medi-Cal Fee for Service and Managed Care. Postmandate, 100% of all enrollees with health insurance that would be subject to SB 428 would have coverage for ACEs screening. CHBRP does not believe that SB 428 requires coverage for a new state benefit mandate that would exceed essential health benefits in California.

Medical Effectiveness: There is limited evidence that ACEs screening tools overall are valid and/or reliable, and limited evidence that suggests screening for ACEs improves health outcomes. There is a preponderance of evidence that there are effective interventions for adults and children who have experienced ACEs. There is limited evidence that ACEs screening affects referrals. There is insufficient evidence to determine whether ACEs screening affects health care services utilization.

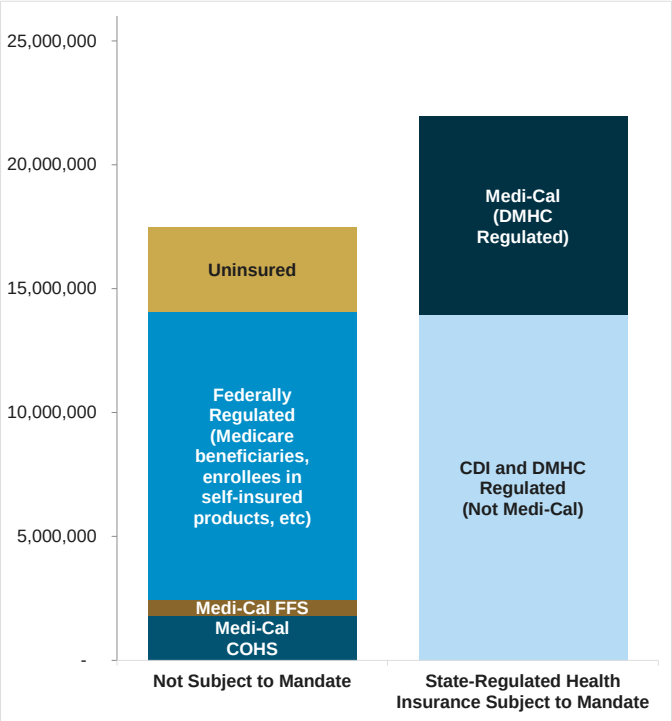
CONTEXT

ACEs are common throughout the United States; 61% of American adults report having experienced at least one ACE, and approximately one in six American adults has had four or more ACEs. Commonly considered ACEs are: abuse (physical, sexual or emotional), neglect (emotional or physical), and household dysfunction (including parental substance abuse). Though legislatures across the country have shifted focus to respond to COVID-19, more than 35 states introduced legislation on ACEs. The presence of ACEs in California/the United States has direct and indirect economic and societal costs. The Centers for Disease Control and Prevention estimates that the economic and social costs of ACES are "hundreds of billions of dollars each year."[1]

BILL SUMMARY

SB 428 would require DMHC and CDI-regulated plans and policies to provide coverage for ACEs screening.

Figure A. Health Insurance in CA and SB 428



Source: California Health Benefits Review Program, 2021.

IMPACTS

Benefit Coverage, Utilization, and Cost

[1] Refer to CHBRP's full report for full citations and references.

For this analysis, CHBRP used data published by the California Office of the Surgeon General and Department of Health Care Services (DHCS) on its ACEs Aware program for Medi-Cal providers to estimate potential utilization change among providers in commercial plans/policies. The ACEs Aware program provides Medi-Cal providers training, clinical protocols, and payment for screening children and adults for ACEs. SB 428 appears to be structured similar to the ACEs Aware program in terms of providing reimbursement for ACEs screening. CHBRP has made an overarching assumption in this analysis that commercial plans/policies would cover ACEs screening the same way it is covered for Medi-Cal providers in the ACEs Aware program. Utilization data from the rollout of the ACEs Aware program in 2020 provide a basis for estimating utilization for the commercial plans/policies impacted by SB 428.

CHBRP has assumed that reimbursement for ACEs screenings by DMHC- and CDI-regulated plans and policies would be made at the same level as that set by DHCS in its ACEs Aware program at $29 per screening. CHBRP has also assumed that ACEs screenings would be conducted via in-person and telehealth visits.

Benefit Coverage

Currently, 36% of enrollees with health insurance that would be subject to SB 428 have coverage for ACEs screening — all of these are enrollees in Medi-Cal Managed Care Programs. DHCS provides reimbursement to providers completing ACEs screenings in Medi-Cal Fee-for-Service and Managed Care. Postmandate, 100% of all enrollees with health insurance that would be subject to SB 428 would have coverage for ACEs screening

Utilization

CHBRP has assumed the following postmandate utilization of ACEs screening due to SB 428 among enrollees in commercial plans/policies: 15% of enrollees under 18 years and 5% of adults 18 to 65 years screened in year 1. Under this assumption, CHBRP estimates an increase in 1,038,648 enrollees receiving ACEs screening postmandate.

Expenditures

CHBRP has assumed $29 reimbursement per each ACEs screening for commercial plans/policies. Under this assumption, SB 428 would increase total net annual expenditures by $36,060,000, or 0.03%, with no projected cost offsets.

Medi-Cal

CHBRP has assumed no new fiscal impact to Medi-Cal Managed Care Plans due to the present availability of reimbursement for ACEs screening through DHCS, which is funded via an annual state appropriation.

CalPERS

CHBRP projected an estimated $1,983,000 impact, or 0.03%, for CalPERS HMO employer expenditures.

Number of Uninsured in California

No measureable impact is projected. CHBRP would expect no measurable change in the number of uninsured persons due to the enactment of SB 428.

Medical Effectiveness

The Medical Effectiveness review reached the following conclusions regarding ACEs screening:

Psychometric Properties of ACEs Screening Tools

- There is *limited evidence* that ACEs screening tools that screen children demonstrate face validity and concurrent validity.
- There is *insufficient evidence* that ACEs screening tools that screen children demonstrate predictive validity.
- There is *insufficient evidence* that ACEs screening tools that screen adults demonstrate convergent validity.
- There is *limited evidence* that ACEs screening tools that screen adults demonstrate predictive validity.
- There is *limited evidence* that ACEs screening tools that screen adults demonstrate internal consistency reliability.
- There is *limited evidence* that ACEs screening tools that screen adults demonstrate test-retest reliability.
- There is *insufficient evidence* to determine whether shorter versions of ACEs screening tools that screen adults or children have levels

of sensitivity and specificity that are similar to those of longer screening tools.

Availability of Effective Interventions to Address the Effects of ACEs

- There is a *preponderance of evidence* that there are effective home visiting interventions for children who experience ACEs.
- There is *limited evidence* that there are effective low-intensity interventions for children who experience ACEs.
- There is *insufficient evidence* that there are effective interventions for adults who experience ACEs.

Impact of ACEs Screening on Referrals and Use of Services

- There is *limited evidence* that ACEs screening increases referrals to community resources and decreases Child Protective Services (CPS) reports for children.
- There is *insufficient evidence* on the impact of ACEs screening on referrals to community resources for adults.
- There is *insufficient* evidence on the impact of ACEs screening on referrals to health services for children and adults.
- There is *insufficient evidence* to determine whether ACEs screening affects health care services utilization for children or adults.

Impact of ACEs Screening on Health Outcomes

- There is *limited evidence* that ACEs screening improves health outcomes for high-risk children, and *insufficient evidence* on the impact of ACEs screening on the health outcome of low-risk children and adults.

Harms Associated With ACEs Screening

- There is *insufficient evidence* to determine whether ACEs screening harms children or adults.

Public Health

In the first year postmandate, a public health impact of SB 428 is expected for the subset of the children aged 0–5 years who are able to access effective interventions after ACEs screening. CHBRP is unable to estimate patterns of ACEs screening or access to effective interventions by individual gender, race, or sexual orientation. For this reason, CHBRP concludes that the impact of SB 428 on disparities in health outcomes by gender, race/ethnicity, or sexual orientation is unknown.

There is not enough evidence available to determine whether the process of screening for ACEs has an effect on public health outcomes or health care utilization. Although utilization of ACEs screening will likely rise, it is unclear whether those who do receive screening and are considered high risk will have access to effective interventions.

When data are available, CHBRP estimates the marginal change in relevant harms associated with interventions affected by the proposed mandate. Potential harms associated with the use of ACEs screening include discomfort sharing sensitive information and concerns about potential risks from disclosing ACEs. Qualitative studies have demonstrated that pediatric screening for ACEs is acceptable to families, as long as an integrated model of care with relevant and accessible services is in place prior to screening.

Long-Term Impacts

It is possible that screening will increase over time as provider and patient awareness of ACEs and interest in trauma-informed care and addressing social needs grows. However, CHBRP posits that ACEs screening uptake is likely to be curbed by the limitations of ACEs screening and the ability to refer to effective interventions as discussed in the *Background* and *Medical Effectiveness* sections.

Given that the body of literature on potential harms and benefits is still growing, CHBRP is unable to estimate the degree to which ACEs screening will be taken up by providers over time. The long-term public health impacts are unknown.

Essential Health Benefits and the Affordable Care Act

Currently, there is no requirement in the federal Medicaid statute to screen for trauma in adults. Medicaid-eligible children are entitled to interperiodic

screenings in order to identify a suspected illness or condition not present or discovered during the periodic exam.

CHBRP does not believe that SB 428 requires coverage for a new state benefit mandate that exceeds the definition of essential health benefits in California. This conclusion is based on two considerations: the first being that SB 428 would affect the terms and conditions of existing coverage (additional reimbursement for a specific completion of the screening tool for a visit already covered); and second, SB 428 impacts reimbursement for a habilitative screening tool that is used to assess referral for needed mental health and ambulatory care services.