Academic Rigor on a Legislature's Timeline

Drawing heavily on faculty and researchers based at the University of California, the California Health Benefits Review Program (CHBRP) provides the California Legislature with timely, independent, and rigorous evidence-based analyses of proposed health insurance-related legislation (bills).

Health Insurance Benefit Mandates. As defined by CHBRP's authorizing statute, a benefit mandate bill requires health insurance to: (1) cover screening, diagnosis, or treatment of a specific disease or condition; (2) cover specific types of health care treatments or services; (3) cover services by specific types of health care providers. A mandate may also (4) specify acceptable terms of benefit coverage, such as cost-sharing, visit limits, prior authorization protocols, etc. A list of mandates current in California is available at www.chbrp.org.

Affordable Care Act. Despite the presence of a number of "benefit floors," California's Legislature has continued to introduce related legislation. As noted below, some benefit floors have been applicable for quite some time.

- Since 1975, California law and regulation have required health insurance regulated by the Department of Managed Health Care (DMHC) to cover medically necessary Basic Health Care Services (BHCS).
- Since 2010, the Affordable Care Act (ACA) has required a portion of health insurance to cover federally specified preventive services (FPS).
- Since 2014, the ACA has also required portions of the small group and the individual health insurance markets to cover Essential Health Benefits (EHB).

Despite new benefit floors, the number of analyses requested by the California Legislature is once again on the rise (see Table A, below). The trend may reflect authors' awareness of expanding federal guidance, guidance indicating that changes in the terms of benefit coverage (as opposed to requiring new benefit coverage) is unlikely to exceed the ACA's EHBs. Many recent bills analyzed by CHBRP focused on such terms of benefit coverage.

Table A: Benefit Floors and Recent Bill Analyses

		Year	Bill Number - Topic
BHCS		2015	AB 339 – Outpatient Prescription Drugs AB 374 – Step Therapy: Coverage AB 502 – Dental Hygienists AB 623 – Abuse-deterrent Opioid Analgesics AB 796 – Coverage: Autism AB 1102 – Special Enrollment Periods AB 1305 – Cost Sharing SB 190 – Acquired Brain Injury SB 289 – Telephonic and Electronic Services
	FPS	2014	AB 1771 – Telephonic Services AB 1917 – Outpatient Prescription Drugs AB 2041 – Developmental Services AB 2418 – Prescription Drug Refills SB 1053 – Contraceptives SB 1239 – School Nurses
	EHB		

Key: Assembly Bill = AB; Basic Health Care Services = BHCS; Essential Health Benefits = EHB; Federally Specified Preventive Services = FPS; Senate Bill = SB

CHBRP's Reports. CHBRP has completed reports on more than 100 bills from the California Legislature, all available at www.chbrp.org. Each report:

- Summarizes scientific evidence regarding the medical effectiveness of clinical interventions relevant to the proposed benefit mandate or repeal,
- Estimates the impact on benefit coverage, costs, utilization, and public health.

To ensure objectivity, CHBRP's reports do not offer recommendations, deferring all policy decision-making to the Legislature. The table above includes a partial list of topics addressed, organized by legislative cycle.

CHBRP's Other Publications. CHBRP regularly produces and updates various resources, as well as issue and policy briefs, all of which are available at www.chbrp.org:

- *Estimates of Sources of Health Insurance in California*
- *Current Mandates: Health Insurance Benefit Mandates in California State Law*
- *Federal Preventive Services Benefit Mandate and California Benefit Mandates*
- *Pediatric Dental and Pediatric Vision Essential Health Benefits*
- *California's Mandates and the ACA's EHBs*

History and Methods. CHBRP was initially authorized by the passage of Assembly Bill (AB) 1996 (Chapter 795, Statutes of 2002). It has been reauthorized three times: by the passage of Senate Bill (SB) 1704 (Chapter 684, Statutes of 2006), by the passage of AB 1540 (Chapter 298, Statutes of 2009), and by the passage of SB 125 (Chapter 9, Statutes of 2015). The state funds CHBRP's work through a small annual assessment on health plans and insurers in California.

CHBRP is comprised of a small team of staff in the University of California's Office of the President, working with its Faculty Task Force and contracted actuaries. The task force is drawn from several University of California campuses, a list that currently includes Berkeley, Davis, Irvine, Los Angeles, San Diego, and San Francisco. Each analysis is completed within a 60-day period. This strict timeline ensures that reports are submitted before the Legislature formally considers the bill.

A strict conflict-of-interest policy ensures that no financial or other interest biases the reports. Experts in pertinent areas of clinical practice, clinical controversies, and research are retained to advise CHBRP on each bill. Advice is also provided by a National Advisory Council, made up of health care experts from outside of California.

Detailed descriptions of the methods developed to evaluate the effects of proposed health insurance benefit mandates are available at www.chbrp.org. The following are brief descriptions of CHBRP's analytic approach.

Medical Effectiveness. CHBRP applies the principles of evidence-based medicine to assess clinical issues pertinent to benefit mandates. During the analysis, systematic literature reviews document the medical effectiveness (as measured by proven effect on health outcomes) of the screening, diagnostic, or treatment interventions likely to be affected by the mandate or repeal.

Cost Impacts. Using an annually updated actuarial model, CHBRP presents cost impacts as three sets of information: (1) coverage for the specified benefit; (2) utilization of benefit-relevant screening, diagnostic, or treatment interventions; and (3) cost of health insurance and utilization of the benefit. CHBRP presents current estimates and projects changes that would be expected after implementation of the mandate or repeal.

Public Health Impacts. CHBRP reviews pertinent health statistics, and then pairs Medical Effectiveness findings with expected postmandate utilization to project impacts on health outcomes for the affected populations (e.g., the effect of asthma self-management training on the reduction of hospitalizations for asthma). CHBRP also considers each bill's potential impact on disparities related to race, gender, and other social determinants of health.