California Health Benefits Review Program

Resource:

Other States' Health Benefit Review Programs, 2013

September 20, 2013

CALIFORNIA
HEALTH BENEFITS REVIEW PROGRAM

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In the summer of 2013, 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, but the 2013 iteration of the survey sought to both update that information and also obtain answers to new questions related to federal health reform. The following section outlines our findings, and provides some national context for how other states are reviewing benefits mandates, as well as implementing the Affordable Care Act (ACA). Several states with notable changes from our last survey are highlighted.

CHBRP had several objectives in conducting interviews with other states' programs:

1. To provide an overview of the focus of other states' programs, as well as their similarities to and differences from CHBRP.
2. To catalog changes to other states' programs, and take note of changes in mission, process, or position within a host organization.
3. To better understand how programs in other states are responding to changes related to the ACA.
4. To maintain contacts at benefit mandate review programs in other states that may be useful for informing CHBRP's work.

In total, 29 states had systematic programs or processes in place to study existing and proposed health benefit mandates in 2013 (see Table 1). State programs generally fell into one of three organizational categories: state insurance departments (or other state agencies, including legislative research services); independent programs, including councils, commissions, or university-based programs; or systems in which sponsors are primarily responsible for this analysis (see Table 2). While 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 reported a significantly changed mission, organizational structure, or analytical scope since 2011, with regard to benefit mandate review. As of 2013, only Maryland appears to have suspended its benefit mandate review program. In 2012 at least five states considered legislation that would have created a benefit mandate review program (see Table 3).

Methods

CHBRP responds to requests from the California Legislature to estimate the medical effectiveness, public health and cost impacts of proposed state health insurance benefit mandates or repeals. In 2013 CHBRP interviewed individuals in other states based on contact information obtained in 2011 or through contacts obtained in the course of CHBRP's efforts to analyze California benefit mandate bills. Where previous contacts had left or were no longer involved with benefit mandate review, CHBRP reached out to the former contact or to the relevant department to find the best new contact. Contacts were asked about the establishment of their program, its organizational goals and structure, analytical process, and the scope of their analyses. Programs with formal procedures for determining

cost and societal/public health impacts were also asked more technical questions about their data collection processes and methodology. All contacts were asked about their organization's involvement in determining essential health benefits for the state and any changes to their work as a result of the ACA. Contacts in 38 states agreed to brief telephone interviews, a figure which includes all of the states with the most robust benefit mandate/repeal review programs (see Table 1).[1]

Table 1. States' Health Benefit Mandate Review Programs – *Analytical Dimensions*

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	✓		

[1] Contacts in Alaska, Florida, Indiana, Kentucky, Louisiana, Michigan, Mississippi, North Carolina, Oklahoma, Rhode Island, South Dakota and Wyoming could not be reached.

Findings

Changes to states' programs since 2011

The largest change since the last iteration of CHBRP's survey is the implementation of parts of the ACA. In 2011, programs were unsure about their role in overseeing provisions of the law. However, in 2013, while many programs continue to express uncertainty about the regulation and enforcement of the ACA, roles are more clearly defined. Insurance departments reported the highest level of involvement with implementation; legislative research services often provided support to the legislature around essential health benefits (EHBs) and broader implementation of the ACA; and councils, commissions and university-based programs typically provided support in more limited ways. Only one program (the Maryland Health Care Commission) reported changes to their role regarding benefit mandate review; other programs continue to study and report on mandates much in the same way they had in the past. States with notable changes are listed in the next section.

Several states reported that the total number of introduced benefit mandate bills had declined somewhat in the past two to three years. In 2012, nine of the states interviewed (Alabama, DC, Maryland, Maine, Montana, New York, Pennsylvania, Vermont, and Wisconsin) had not looked at mandates; in the case of Tennessee, Maryland, and Vermont, the states' legislatures had (formally or informally) frozen mandates due to the ACA's anticipated introduction of EHBs and the requirement that states pay the cost of any mandates that exceeded the state's EHBs. A contact at the Maryland Health Care Commission suggested that mandate bills may be tabled in many places until 2015, when markets have settled and the regulations and authority around the ACA have become clearer. However, as of 2013, on average, states that looked at mandate bills reported between two and five requested analyses. In 2012 at least five states considered legislation that would have created a benefit mandate review program (see Table 3).

Table 2. States' Health Benefit Mandate Review Programs – *Institutional Structure*

State	State Agencies				Independent Programs		Other
	Insurance Department (1)	Other State Agency (2)	Legislative Research Services (3)	Health Insurance Exchange (4)	University (5)	Commission (6)	Sponsor (7)
Arizona							✓
California					✓		
Connecticut					✓		
Florida							✓
Georgia (8)	✓					✓	
Hawaii (9)			✓				
Indiana						✓	
Kansas	✓						
Kentucky	✓						
Louisiana (10)						✓	
Maine	✓						
Massachusetts		✓					
Minnesota		✓					
Missouri			✓				
Nevada			✓				
New Hampshire	✓						
New Jersey						✓	
North Dakota			✓				
Ohio	✓						
Oklahoma						✓	
Oregon		✓					
Pennsylvania						✓	
South Carolina	✓						
Tennessee			✓				
Texas	✓						
Utah	✓						
Virginia				✓		✓	
Washington		✓					
Wisconsin	✓						

Notes:

1. "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.
2. "Other State Agency" programs include those that are housed at another agency under the executive branch besides the Department of Insurance.

3. "Legislative Research Services" programs include those that are housed at the departments or agencies designed to support the legislature.
4. "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.
5. 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).
6. 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.
7. 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.
8. 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.
9. Hawaii's mandate evaluation is conducted by the State Auditor, who reports to and is considered part of the legislative branch
10. 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 3. States' Health Benefit Mandate Review Programs – *Proposals in Other States*

State	Year	Bill	Description	Bill status
Louisiana	2012	HB 954	Would place the Louisiana Mandated Health Benefits Commission within the Department of Insurance.	Enrolled July 2012
Montana	2012	HB 563	Would require cost-benefit analysis of mandated health insurance coverage of service. Any bill reported out of a committee of the legislature that contains a mandate for health insurance coverage of specific services or payment for specified providers of services would include a cost-benefit analysis incorporating an estimate of the extent to which the proposed mandate would: • increase or decrease the cost of the coverage or the service; • increase the appropriate use of the service; • increase or decrease the administrative expenses of insurers and the premium and administrative expenses of insureds; and • increase or decrease the total cost of health care.	Died in committee
		HB 673	Would provide for a review of mandated health insurance benefits. The bill would require that a proposed mandated benefit, a proposed change to a mandated benefit, or an amendment to a proposal for a mandated benefit be reviewed by the commissioner. The commissioner would provide the legislature with information, including an actuarially based review, about the proposal's medical efficacy and cost benefits.	Died in committee
New York	2012	HB 2770	Would create a health benefit and cost commission to conduct a comprehensive review of all current mandated benefits and an accurate cost analysis of proposed benefits.	Died in committee
Rhode Island	2012	HB 7364	Would require a mandated benefit review by the health insurance commissioner of any mandated benefit introduced after January 1, 2013, contingent on the review being paid for by health care providers authorized to do business in Rhode Island.	Held back for further study
West Virginia	2012	HB 2214	Would amend the Code of West Virginia by adding a new article relating to the "Mandated Benefits Review Act." The Act would also require the Insurance Commissioner to review and report to the Legislature in an actuarially-based fashion the financial and other related impacts of any proposed legislation to mandate medical or health-related benefits.	Died in committee

States with notable changes

Maryland: The Maryland Health Care Commission (MHCC) is a public regulatory commission that annually assesses the medical, social, and financial impacts of proposed mandated health insurance services that fail passage during the preceding legislative session or that are submitted to the MHCC by a Legislator. When CHBRP contacted MHCC in 2013, the commission's director informed CHBRP that Maryland had suspended activity related to mandates as a result of the ACA, since states are required to pay for any mandates that exceed federal essential health benefits. MHCC's future role in performing the clinical, social, and financial impact of proposed mandates has not been defined.

Massachusetts: Previously, mandates in Massachusetts were reviewed by the Division of Health Care Finance and Policy (DHCFP), within the Massachusetts Executive Office of Health and Human Services. In 2012, the Division of Health Care Finance and Policy was reestablished as the Center for Health Information and Analysis (CHIA), an independent state agency with an executive director appointed by the Governor, State Auditor, and Attorney General. CHIA is charged with collecting and analyzing health care data for the state of Massachusetts. As part of its role, it also analyzes health benefit mandate bills, in addition to performing retrospective reviews of mandates that have passed (typically every four years). CHIA's process for bill analysis is generally the same as it was in 2011—CHIA contracts with an actuarial firm to analyze cost information, and staff members conduct literature reviews and write the medical effectiveness section of reports.

Virginia: The law authorizing Virginia's Special Advisory Commission on Mandated Health Insurance Benefits has been repealed, and the benefit mandate review program is being absorbed into Virginia's new Health Insurance Reform Commission (HIRC). The HIRC is charged with establishing the state's health insurance exchange, deciding Virginia's EHBs package, and providing assessments of existing and proposed mandate legislation. At this time, the transition is still in progress.

Delaware: In 2011, the Delaware Health Care Commission (HCC) was the main venue for policy discussions on the implementation of the ACA. Now, the HCC has become the primary site for state-wide implementation of the ACA. The HCC is in charge of determining EHBs and setting up the state's health insurance exchange. The commission still examines the effect of new mandates (in 2013 they looked at a bill regarding specialty tier drugs[2]), but its primary focus has shifted toward the implementation of the ACA.

Georgia: In 2011, Georgia passed legislation[3] 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.

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[2] Bill text of Delaware SB 35 available at http://legis.delaware.gov/LIS/lis147.nsf/vwLegislation/SS+1+for+SB+35/$file/legis.html?open

[3] Bill text of Georgia SB 17 available at http://www.legis.ga.gov/Legislation/20112012/116650.pdf

New survey questions related to the Affordable Care Act

As part of its survey for 2013, CHBRP asked the following new questions of the benefit mandate review programs:

1. For 2013 bills, did you project 2014 enrollment as "baselines" (or for any other purpose)? If so, how did you make the projections? What about premiums?[4]

2. Was your office involved in selecting and/or defining the EHBs in your state? If so, how?

    a. Has your office adjusted its analyses in any way to incorporate an analysis of a mandate's interaction with the ACA and/or EHBs? If yes, in what ways?
    b. Have you encountered any mandates that you think will exceed EHBs?
    c. Has there been any formal adjustment of your charge as a result of the ACA and/or EHBs?

Whether or not entities were involved in EHB selection generally depended on their institutional context. Typically, insurance departments were highly involved in the selection of the benchmark plan that helped define their state's EHBs. Staff interviews with legislative research services generally revealed a lower level of involvement with EHBs; most research services provided support and information to the legislature about EHBs if requested. Independent health policy commissions and university programs, such as the New Jersey Mandated Health Benefits Advisory Commission, Pennsylvania's Health Care Cost Containment Council, and the University of Connecticut's Center for Public Health and Public Policy generally reported minimal involvement, although similar to CHBRP, these programs had provided briefs and reports to inform the decision making.

Of the benefit mandate review programs CHBRP interviewed, nearly all of them stated that they planned to incorporate an analysis of how a new mandate would interact with the state's EHBs. Many states interviewed believed that any new mandates in their state would exceed EHBs, a belief which does not perfectly align with CHBRP's expectations. For example, CHBRP has been asked to review benefit mandate bills that would restrict cost-sharing,[5] a restriction that would not interact or exceed EHBs.[6] Other than adding consideration of a mandate's possible interaction with EHBs or other aspects of the ACA, none of the entities interviewed had adjusted their charge to review benefit mandates as the result of ACA.

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[4] Most states had not projected 2014 enrollments or premiums. Those who did typically used an actuarial firm such as Milliman to make projections about a 2013 mandate's effect on 2014 premiums.

[5] For more information see http://chbrp.ucop.edu/index.php?action=read&bill_id=136&doc_type=3

[6] The Federal Department of Health and Human Services' proposed rule on essential health benefits, which was made final in February 2013, specified that "… state rules related to … cost-sharing … would not fall under our interpretation of state-required benefits. Even though plans must comply with those state requirements, there would be no federal obligation for states to defray the costs associated with those requirements," Department of Health and Human Services. Patient Protection and Affordable Care Act: Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation. Final Rule. Available at: http://www.gpo.gov/fdsys/pkg/FR-2012-11-26/pdf/2012-28362.pdf

Difficulties facing review programs

Programs generally reported similar problems to 2011, although many are dealing with more uncertainty due to changes from the ACA. The main issues facing programs are:

- Limited time—programs often find it difficult to complete their analyses in the period of time needed; in some legislative research services, the turnaround is sometimes as short as a matter of days.
- ACA implementation—many state insurance departments are primarily concerned about the implementation of ACA provisions on a tight timeline. Some cited a lack of federal guidance, or large workloads, as their concerns.
- Financial resources—several programs cited issues with state hiring freezes or lack of resources to train staff or build skills.
- Mandate bill volume variability—several programs said that the number of introduced mandate bills fluctuates year to year, which can cause problems in regards to properly reserving adequate staff time.

Other states reports

While all states had reports available upon request, several also make their products available online (see Table 4).

Table 4. States' Health Benefit Mandate Review Programs – *Reports Available Online*

State	Program	Website
Connecticut	Center for Public Health and Public Policy	http://www.publichealth.uconn.edu/connecticut-insurance-department.html
Hawaii	Office of the State Auditor	http://www.state.hi.us/auditor/Categories/HTH.htm
Maine	Bureau of Insurance	http://maine.gov/pfr/legislative/index.htm#insurance
Massachusetts	Center for Health Information and Analysis	http://www.mass.gov/chia/researcher/archived-publications.html#mandated_benefits
New Hampshire	New Hampshire Insurance Department	http://www.nh.gov/insurance/reports/
New Jersey	The New Jersey Mandated Health Benefits Advisory Commission	http://www.nj.gov/dobi/division_insurance/mhbac/mhbacdone.htm
Pennsylvania	Health Care Cost Containment Council	http://www.phc4.org/reports/mandates/
Texas	Texas Department of Insurance	http://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.aspx
Wisconsin	Commissioner of Insurance	http://oci.wi.gov/finimpct.htm