



Other States' Health Benefit Review Programs, 2011

EXECUTIVE SUMMARY

During July and August of 2011, CHBRP staff contacted every state and the District of Columbia to determine if they have organizations, processes, or requirements in place to evaluate health insurance benefit mandates. CHBRP previously conducted this review in 2004 and 2009. The 2011 survey updates prior information and also includes new questions related to national health care reform. Specifically, respondents were asked about any role their organization might be playing in comparing current state health insurance benefit mandates with the essential health benefits (EHBs) offered in qualified health plans (QHPs) in the upcoming state-based health insurance exchanges. It should be noted that the federal government had not released EHB requirements at the time the survey was conducted.

The number of states with systematic processes or programs in place increased from 27 in 2009 to 30 in 2011. In both years, all these states analyzed cost impact, defined as analyzing impact on the private health insurance sector as opposed to the fiscal impact on the state budget. There was no change in the states analyzing public health, defined as reporting on the impact of the mandate on the health of the population; five analyzed public health in 2009 and the same 5 analyzed public health in 2011. In 2009, 15 states analyzed medical effectiveness, defined broadly as reviewing and reporting on the medical literature, which increased to 16 in 2011. Since Colorado's commission was repealed in 2010, there is now one fewer state analyzing social impact, defined as impacts on coverage and utilization levels; seventeen states analyzed social impact in 2009 and 16 analyzed social impact in 2011.

Of the 30 states with formal health benefit mandate review programs, the biggest challenges they are facing include:

- Short timeframe for analyses
- Lack of financial resources and resources to develop staff's skill set to complete these analyses
- Added workload related to health care reform

While many states have been involved in informal and more formal discussions about health care reform in general, none of the states with health benefit mandate review programs know if their programs will have a role in evaluating how state health insurance benefit mandates compare with federal EHB requirements. It should be noted that the federal government had not released EHB requirements at the time the survey was conducted.

OBJECTIVES

The objective of this project is to gather and synthesize information about other states' programs that analyze health insurance benefit mandates. Information collected updates and expands upon the 2004 and 2009 findings.

This information is to be used for five main purposes:

1. To foster ongoing relationships with similar organizations in other states
2. To identify other states' analyses of benefit mandates
3. To provide an overview of other states' activities to analyze health insurance benefit mandates and identify practices that might be applicable/useful in California
4. To better understand the gaps between authorizing legislation and the implementation of benefit review processes
5. To understand any new or changing roles these entities might have with respect to federal health care reform implementation.

METHODS

Identifying Key Informants

CHBRP contacted key informants interviewed in 2009. In some cases, the key informant was the same interviewee in 2004, 2009, and 2011. If 2009 key informants had left their roles or organizations, which was fairly common, CHBRP staff contacted their direct successor or a recommended colleague. These key informant interviews were used to update and expand upon 2009 information.

Interview Design

Interview questions were designed to update and expand upon specific information about each state's systems or processes to conduct mandate evaluations, including:

- whether a particular state had a systematic evaluation process or formal program in place;
- how each program came into being;
- the institutional structure of existing programs;
- the scope, process, report format, and dissemination methods for completed analyses;
- whether the organization has or anticipates having a role in evaluating how state health insurance benefit mandates compare with federal EHB requirements.

Most of the 2009 interview questions were kept, with some edits made to the questions to improve clarity. Additional questions were added related to federal health care reform implementation as well as the largest upcoming challenge the organization faces. See Table 1 in the Appendix for survey questions.



Interviews and Information Collection

- The key informant interview format was a conversation between the CHBRP staff and the state representative identified as a knowledgeable source. The interview questions acted as conversation guides.
- Key informants were asked the complete set of interview questions.
- Staff documented interview responses in a database.
- A contact tracking log was maintained during the scheduling and interview phases.

FINDINGS

In the summer of 2011, CHBRP contacted all 49 other states and the District of Columbia to update records on their processes for evaluating health insurance benefit mandates. The response rate was 88%, including California; CHBRP staff had phone conversations or received responses via email from 44 states and the District of Columbia.¹ The following are the findings (inclusive of California):

2011 Updates

1. Thirty states have some form of systematic process or program in place, defined as follows:

- a. program/process must at least evaluate the financial (beyond fiscal) impact of a mandate. This may include proposed mandates in bill form or retrospective analyses of existing mandates on private insurers and/or insured;
- b. process must be “regular” in that 1) those who are responsible for conducting the evaluations do so per the provisions of state law (if applicable), 2) the process is automatically triggered by the nature of the legislative process (e.g., when bill is proposed; when bill gets a 2nd hearing; when it is being heard in committee with jurisdiction), 3) the process is triggered by request of the state legislature or a state agency or 4) the process occurs at some regular interval defined by policies or law (e.g., annually, every 5 years).

See Table 2 for a summary of these programs and where they are housed in each state.

2. The following fall within the scope of states’ analysis:

- a. All 30 states with a systematic process/program analyze cost impact – defined as analyzing impact on the private health insurance sector, as opposed to the fiscal impact on state budget.
- b. Five analyze public health – defined as reporting on the impact of the mandate on the health of the population.
- c. Sixteen analyze medical effectiveness – defined broadly as reviewing and reporting on the medical literature.
- d. Sixteen analyze “social impact” – defined as impacts on coverage and utilization levels.

¹ Although some email communication was established between CHBRP and contacts in Indiana, Louisiana, and New York, no response about the programs was received via phone or email by the end of August 2011. CHBRP did not receive a response from the Texas contact. Contacts in Indiana and Michigan indicated that they did not have time for an interview.



See Table 3 in the Appendix for further detail.

3. Significant changes in states' processes/programs since 2009:

- a. The number of states with systematic processes or programs in place increased from 27 in 2009 to 30 in 2011. In both years, all these states analyzed cost impact. There was no change in the states analyzing public health; five analyzed public health in 2009 and the same 5 analyzed public health in 2011. Fifteen states analyzed medical effectiveness in 2009, which increased to 16 in 2011. As Colorado's program ended (see below), there is now one fewer state analyzing social impact; seventeen states analyzed social impact in 2009 and 16 analyzed social impact in 2011.
- b. Key informants' dominant perspective was that their states' mandate evaluation processes/programs had not changed substantively in the past 2 years. Five cases stand as notable exceptions:
 - i. *Colorado*: The Colorado Mandated Health Insurance Benefits Commission was repealed by operation of law in 2010. As a consequence, the Commission no longer exists and the Division of Insurance no longer staffs evaluation of health insurance benefit mandates.
 - ii. *Georgia*: While the Department of Insurance is still currently doing financial/cost impact analyses in Georgia, a Special Advisory Commission on Mandated Health Insurance Benefits will begin conducting more comprehensive analyses, effective February 1, 2012.
 - iii. *Kansas*: There was an organizational change in Kansas. The 9-member board of the Kansas Health Policy Authority (KHPA) no longer exists. Now that the board is gone, when reports are completed they go to the Secretary of Health and the Environment, who reports directly to the Governor.
 - iv. *Missouri*: SB 62 of the 2011 legislative session (chapter 375, section 1190, subsection 3) tasks the Oversight Division of the Joint Committee on Legislative Research to do an actuarial analysis of mandates proposed after August 28, 2011.
 - v. *South Carolina*: The South Carolina Department of Insurance is charged with doing a mandate analysis in Section 2-7-73 of South Carolina code.

4. Of the 30 states with formal health benefit mandate review programs, the biggest challenges they are facing include:

- Short timeframe for analyses
- Lack of financial resources and resources to develop staff's skill set to complete these analyses
- Added workload related to health care reform

5. While many states have been involved in informal and more formal discussions about health care reform, none of the states with health benefit mandate review programs know exactly what, if any, role they will play once essential health benefits (EHBs) are decided upon by the federal government. It should be noted that the federal government had not released EHB requirements at the time the survey was conducted.

2009 Survey Notes

This section presents observations from the 2009 survey that are still relevant.

6. Differences between laws that authorize mandate evaluation processes and programs and the actual processes implemented occur frequently because:



- a. The laws do not always explicitly dictate the criteria and steps for mandate evaluations. Therefore the implementation of such laws and policies are subject to interpretation and can vary (for example, with changes in administration).
- b. State governments and their various departments do not always uniformly implement laws related to mandate evaluation programs or processes even when criteria and steps for evaluations may be explicitly defined. This may occur for several reasons, including limits on data availability, limits on staff and funding resources, or the political climate in the state.
- c. When the mandate evaluation law places the onus of conducting the evaluation on the sponsor of the legislation, it is difficult for any one state entity to enforce; the responsibility to enforce the law becomes diffuse.

7. The steps involved in performing the analyses vary considerably in two main regards:

- a. Independent research, contracted services, information from interested parties
- b. Nature of questions addressed

8. Observations on Cost:

- a. Defined as analyzing impact on the private health insurance sector, as opposed to the fiscal impact on state budget
 - i. For example, if a state were to estimate only the cost impact of mandates on insurance provided to state employees then this would be excluded
- b. Many appear to analyze the total cost of the benefit versus the mandate's potential effect on premiums and costs to the state.
- c. Focus of most states' cost analysis tends to emphasize the mandate's potential effect on premiums and costs to the state.
- d. Most states analyze the mandate's potential effect on coverage and utilization levels (which is also sometimes caused "social impact").

9. Observations on Medical Effectiveness:

- a. Defined broadly as reviewing and reporting on the medical literature.
- b. Wide variation in whether/how states routinely analyze medical effectiveness.
- c. No states report having express criteria for analyzing the literature. Note: As some contract for medical analytic services, the systematic nature of their approach is difficult to assess.
- d. Some states noted the difficulty of conducting such analyses without appropriate content expertise represented on staff.



10. Observations on Public Health:

- a. Defined broadly as reporting on the impact of the mandate on the health of the population. None appear to systematically quantify public health outcomes based on the medical literature and analysis on changes in utilization.
- b. “Social impacts” typically include coverage and utilization criteria.
- c. Very few states perform public health impact analysis; only 5 were identified at the time of this update.

11. All states with a systematic process/program for performing mandate evaluations said that their records are publicly available, with some states only having their analyses available upon request and others available on websites.



Appendix

TABLE 1: Interview Questions to Key Informants in Other States

<i>Basic contact</i>	
1	Organization's name, contact's name, address, phone number, email, website
<i>History</i>	
2	When and how were you established (e.g. legislation? charged by Governor? charged by State Insurance Commissioner?)
<i>Organizational Structure</i>	
3	What is your charge/mission/organizational goal (with respect to benefit mandates)?
4	Where does the organization fit within the state's governmental framework? (related: Is it independent?)
5	How are you funded? What is your operational budget?
<i>Analytical Process</i>	
6	What is the trigger to perform an assessment? Is it only by request? If by request, who makes it and when does it have to be received?
7	In what timeframe do you complete your analyses?
8	What fields of expertise do you have represented on staff? Do you employ independent consultants? Do you employ/contract with academic researchers, economists, actuaries, and/or clinicians?
9	Do you use assessments performed by other groups or organizations?
10	Do you have a process for obtaining input on draft analyses before they are finalized? Is the draft sent to external parties (e.g., non-authors and/or those who do not have a direct stake in the outcome of the mandate)?
11	What is the format of your output? (e.g., reports, testimony)
12	Are the findings of your assessments publicly available? Do you have a website?
13	How are your assessments generally used and by whom?
<i>Analytical Content</i>	
14	Do you study proposed legislation, passed legislation, and/or repeals? Do you examine cumulative impacts of existing mandates?
15	How many assessments have been completed to date and are completed on average annually?
16	What type of analyses do you perform (i.e. actuarial, public health, medical effectiveness, other)? <ol style="list-style-type: none"> a. Do you examine changes in utilization, coverage levels, and costs (premiums, out-of-pocket)? Do you breakdown what portion of the cost is paid by employers, employees, or the government? Do you project costs over time (e.g., 5 years from now)? b. What is the content and focus of the public health/societal impact analysis?
17	Are you required to examine mandates' effects on other state programs such as Medicaid, CHIP, etc.? Do you examine transfer or secondary effects (e.g., private sector to Medicaid or private sector to uninsured?)
18	Do you make recommendations? (related: Are there any constraints on reporting of findings?)
<i>Health Insurance Exchanges</i>	
19	Does your office plan to evaluate the Essential Health Benefits (EHBs) offered in Qualified Health Plans (QHPs) through your state's health insurance exchange (or through the federal government's exchange if your state is not setting one up)? <ol style="list-style-type: none"> a. If yes, has your organization been involved in formal or informal discussions about your role in evaluating EHBs? With whom? b. Are you aware of any activity the state may undertake to align your states' mandates with EHBs (e.g., repealing any specific laws)? If so, please elaborate.
<i>Other</i>	
20	Have you heard of the California Health Benefits Review Program (CHBRP)? If so, have you used or referenced any of its work? Please explain your experience.
21	What is your program's biggest challenge(s)?
22	If there have been other changes to your organization's structure, scope of work, or analytical process that we have not yet addressed, please discuss.



TABLE 2: States' Health Benefit Mandate Review Programs – Institutional Structure

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

Notes:

(1) States listed here have a formal mandate evaluation program or process, or they have a law requiring evaluation of health insurance mandate bills by sponsors of a bill.

(2) 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.

(3) “Department of Insurance” 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.



(4) “Legislative Services” programs include those that are housed at the departments or agencies designed to support the legislature.

(5) 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.

(6) “Other State Agency” programs include those that are housed at another agency under the executive branch besides the Department of Insurance.

(7) Note that in Georgia the responsibility for health insurance benefit mandate analysis will shift from the Department of Insurance to a Commission. A bill passed in 2011 (SB 17) establishes a Special Advisory Commission on Mandated Health Insurance Benefits, effective February 1, 2012. This change is not reflected in the chart as it is not effective until 2012.

(8) Hawaii’s mandate evaluation is conducted by the State Auditor, who reports to and is considered part of the legislative branch.

(9) Indiana has a “Mandate Health Benefit Task Force” whose members are appointed by the Governor and is staffed by the Insurance Commissioner.

(10) In Missouri, SB 62 of the 2011 legislative session (chapter 375, section 1190, subsection 3) tasks the Oversight Division of the Joint Committee on Legislative Research to do an actuarial analysis of mandates proposed after August 28, 2011.



TABLE 3: States' Health Benefit Mandate Review Programs – Analytical Dimensions

STATE (1)	Financial/Cost Impact	Medical Effectiveness	Social Impact	Public Health Impact
Arizona	✓	✓	✓	
California	✓	✓	✓	✓
Connecticut	✓	✓	✓	
Florida	✓		✓	
Georgia	✓			
Hawaii	✓		✓	
Indiana	✓	✓	✓	
Kansas	✓		✓	
Kentucky	✓			
Louisiana	✓			
Maine	✓	✓	✓	
Maryland	✓	✓	✓	✓
Massachusetts	✓	✓		
Minnesota	✓	✓		✓
Missouri	✓			
Nevada	✓			
New Hampshire	✓	✓	✓	
New Jersey	✓	✓	✓	
North Dakota	✓			
Ohio	✓		✓	
Oklahoma	✓	✓		
Oregon	✓	✓	✓	
Pennsylvania	✓	✓	✓	
South Carolina	✓			
Tennessee	✓			
Texas	✓			
Utah	✓	✓		✓
Virginia	✓	✓	✓	
Washington	✓	✓	✓	✓
Wisconsin	✓			

Notes:

(1) States listed here have a formal mandate evaluation program or process, or they have a law requiring evaluation of health insurance mandate bills by sponsors of a bill.

