



CALIFORNIA
HEALTH BENEFITS REVIEW PROGRAM

Analysis of Assembly Bill 652: Child Health Assessments

A Report to the 2011-2012 California Legislature
April 18, 2011



The California Health Benefits Review Program (CHBRP) responds to requests from the State Legislature to provide independent analyses of the medical, financial, and public health impacts of proposed health insurance benefit mandates and proposed repeals of health insurance benefit mandates. CHBRP was established in 2002 by statute (California Health and Safety Code, Section 127660, et seq). The program was reauthorized in 2006 and again in 2009. CHBRP's authorizing statute defines legislation proposing to mandate or proposing to repeal an existing health insurance benefit as a proposal that would mandate or repeal a requirement that a health care service plan or health insurer (1) permit covered individuals to obtain health care treatment or services from a particular type of health care provider; (2) offer or provide coverage for the screening, diagnosis, or treatment of a particular disease or condition; or (3) offer or provide coverage of a particular type of health care treatment or service, or of medical equipment, medical supplies, or drugs used in connection with a health care treatment or service.

A small analytic staff in the University of California's Office of the President supports a task force of faculty and staff from several campuses of the University of California, as well as Loma Linda University, the University of Southern California, and Stanford University, to complete each analysis within a 60-day period, usually before the Legislature begins formal consideration of a mandate or repeal bill. A certified, independent actuary helps estimate the financial impacts, and a strict conflict-of-interest policy ensures that the analyses are undertaken without financial or other interests that could bias the results. A National Advisory Council, drawn from experts from outside the state of California and designed to provide balanced representation among groups with an interest in health insurance benefit mandates or repeals, reviews draft studies to ensure their quality before they are transmitted to the Legislature. Each report summarizes scientific evidence relevant to the proposed mandate, or proposed mandate repeal, but does not make recommendations, deferring policy decision making to the Legislature. The State funds this work through a small annual assessment on health plans and insurers in California. All CHBRP reports and information about current requests from the California Legislature are available at the CHBRP Web site, www.chbrp.org.

A Report to the 2011-2012 California State Legislature

Analysis of Assembly Bill 652: Child Health Assessments

April 18, 2011

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PREFACE

This report provides an analysis of the medical, financial, and public health impacts of Assembly Bill 652. In response to a request from the California Assembly Committee on Health on February 17, 2011, the California Health Benefits Review Program (CHBRP) undertook this analysis pursuant to the program's authorizing statute.

Janet Coffman, MPP, PhD, Chris Tonner, MPH, of the University of California, San Francisco, prepared the medical effectiveness analysis. Stephen L. Clancy, MLS, AHIP, of the University of California, Irvine, conducted the literature search. Yali Bair, PhD (Consultant), and Dominique Ritley, MPH, of the University of California, Davis, prepared the public health impact analysis. Todd Gilmer, PhD, and Meghan Martinez, MPH, (Consultant) of the University of California, San Diego, prepared the cost impact analysis. Susan Pantely, FSA, MAAA, of Milliman, provided actuarial analysis. Michael Cabana, MD, MPH, of the University of California, San Francisco, and Marilyn Kaufhold, MD, of the Chadwick Center for Children and Families, Rady Children's Hospital, provided technical assistance with the literature review and expert input on the analytic approach. Susan Philip, MPP, and Garen Corbett, MS, of CHBRP staff prepared the background on impact analysis of initial health assessments and 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, Sylvia Guendelman, PhD, LCSW, of the University of California, Berkeley, 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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EXECUTIVE SUMMARY

California Health Benefits Review Program Analysis of Assembly Bill 652

The California Assembly Committee on Health requested on February 17, 2011, that the California Health Benefits Review Program (CHBRP) conduct an evidence-based assessment of the medical, financial, and public health impacts of Assembly Bill (AB) 652, a bill that would impose a health benefit mandate for two services: initial health assessments for children with out-of-home placements, and forensic medical evaluations for potential victims of child abuse. In response to this request, CHBRP undertook this analysis pursuant to the provisions of the program's authorizing statute.¹

Analysis of AB 652: Overall Approach

Approximately 21.9 million Californians (59%) 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 has no health insurance subject to any benefit mandate) and another portion has health insurance subject to other state law or only to federal laws.

Uniquely, California has a bifurcated system of regulation for health insurance subject to state-level 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 insurers⁴, which offer benefit coverage to their enrollees through health insurance policies.

DMHC-regulated plans (including publicly funded plans such as Medi-Cal Managed Care Plans) and CDI-regulated policies for both individual and group policies would be subject to AB 652. Therefore, the mandate would affect the health insurance of approximately 21.9 million Californians (59%).

AB 652 Bill Language and Relevant Definitions

The full text of AB 652 can be found in Appendix A.

AB 652 includes two benefit mandates that fall under CHBRP's purview for analysis. The first would require health plans and insurers to provide an **initial health assessment** for children who have "out-of-home" placements. AB 652 defines initial health assessment as "a medical or dental

¹ CHBRP's authorizing statute is available at: http://www.chbrp.org/documents/authorizing_statute.pdf.

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

³ The DMHC was established in 2000 to enforce the Knox-Keene Health Care Service Plan of 1975; see Health and Safety Code, Section 1340.

⁴ The 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, Section 106(b) or subdivision (a) of Section 10198.6.

examination, or both, performed on a child for whom a case plan must be prepared, pursuant to Section 16501.1 of the Welfare and Institutions Code and who has been placed in an out-of-home placement within the last 30 days, and that is designed to determine the child's medical and dental status and further health care needs." The guidelines for these assessments are established by the Child Health and Disability Prevention Program (CHDP). According to the guidelines, complete health assessments are provided for the early detection and prevention of disease and disabilities for low-income children and youth.

The second benefit mandated by AB 652 pertains to coverage of **forensic medical evaluations**. AB 652 defines forensic medical evaluations per Section 324.5 of the Welfare and Institutions Code (WIC), which states that these examinations are "performed by a medical practitioner who has specialized training in detecting and treating child abuse injuries and neglect, and, whenever possible, shall ensure that this examination take place within 72 hours of the time the child was taken into protective custody."

Section 1 and Section 2 of AB 652 would require DMHC-regulated plans and CDI-regulated policies, including MRMIB programs, CalPERS HMOs, and Medi-Cal Managed Care Plans, to provide reimbursement for these services, and these services must be covered even if they are rendered by a non-plan provider. Furthermore, AB 652 stipulates that prior authorization requirements would be prohibited. Additionally, AB 652 requires that reimbursements that are paid to providers for both benefits be no less than the amount that the Medi-Cal program would pay for the same service when rendered by the same provider to a Medi-Cal beneficiary on a fee-for-service basis.

Section 3 of AB 652 would also require the Medi-Cal program to cover initial health assessments and forensic medical evaluations. CHBRP's authorizing statute requests the program to analyze a health insurance benefit mandate as it relates to DMHC-regulated plans and CDI-regulated policies. Because the Medi-Cal fee-for-service (FFS) program provides reimbursement to Medi-Cal providers directly (rather than through a contracted DMHC-regulated health plan) the provisions affecting the Medi-Cal FFS program does not fall within CHBRP's purview for analysis. Therefore, this analysis does not address the potential impacts of Section 3 of AB 652.

Report Structure and Analytic Approach

Initial health assessments for children who have out-of-home placements are predominantly children who are in the foster care system.⁵ Children in foster care are enrolled in Medi-Cal and health assessments are already a covered benefit under Medi-Cal. This is discussed in the *Background and Potential Impacts of the Mandate to Cover Initial Health Assessments* portion of the report. The *Medical Effectiveness* analysis summarizes the evidence base for those

⁵ Other children who are considered to have an out-of-home placement are those (1) who are on probation or incarcerated or (2) who after a removal order issued by a judge, are waiting for a disposition hearing in court that decides whether the child should be removed or returned home. According to the Center for Social Services Research Child Welfare Dynamic Report System, as of October 2010, there were approximately 62,248 children who were placed out of the home and of those, 4,294 were in probation or categorized as "other." CHBRP's analysis is restricted to children in the child welfare system and considered "in foster care."

services that fall under “initial health assessments.” In addition, the *Medical Effectiveness* section summarizes the protocols for forensic medical evaluations.

Currently, forensic medical evaluations are not generally covered by health plans and policies, therefore the *Benefit Coverage, Utilization, and Cost Impacts* and *Public Health Impacts* sections focus the impact analysis on the provision mandating coverage of forensic medical evaluations.

Medical Effectiveness of Initial Health Assessments

CHBRP examined whether the services delivered in an initial health assessment are considered to be medically effective based on existing literature. Conclusions were drawn from the U.S. Preventive Services Task Force (USPSTF) recommendations, Centers for Disease Control (CDC) recommendations, and National Institutes of Health (NIH) guidelines. When there was no evidence-based recommendation for a service, CHBRP relied on other authoritative sources such as the American Academy of Pediatrics (AAP). Initial health assessment services are delivered through the California’s Child Health and Disability Program, the State of California’s health promotion and disease prevention program for children with Medi-Cal or children whose families are income-eligible. The components of the initial health assessment include health and developmental history; complete physical exam; oral health assessment; nutritional assessment; immunizations; vision screening; hearing screening; screening tests for anemia, lead, urine abnormalities, tuberculosis, and other problems as needed; and health education and anticipatory guidance.

Efficacy of Initial Health Assessment Services

Findings regarding the medical effectiveness of the services included in the initial health assessment for which coverage could be included under AB 652 are as follows:

- There is a *preponderance of evidence*⁶ that the following preventive services for children and adolescents are *effective*:
 - Immunizations recommended by the Centers for Disease Control Advisory Committee on Immunization Practices
 - Screening children younger than 5 years for visual impairment
 - Screening of children age 6 and older for obesity
 - Screening of adolescents for major depressive disorder
 - Screening newborns for hearing loss
 - Providing Pap smears to sexually active adolescent females
 - Screening sexually active females for chlamydial infections
 - Counseling to prevent sexually transmitted infections among sexually active adolescents

⁶Appendix B lists CHBRP’s definitions for the classifications of strength of evidence.

- There is *insufficient evidence*⁷ to recommend for or against the following preventive services:
 - Screening asymptomatic children for iron deficiency anemia
 - Screening for elevated blood lead levels among those at increased risk for it
 - Counseling children and adolescents regarding nutrition
 - Screening for tobacco use or interventions to prevent and treat tobacco use
 - Counseling adolescents regarding alcohol use

- No meta-analyses, systematic reviews, or evidence-based guidelines could be located for some recommended preventive services for children and adolescents. In these cases, CHBRP relied on expert consensus or opinion. These services include:
 - Medical and developmental history
 - Physical examinations
 - Developmental and behavioral assessments
 - Preventive dental examinations
 - Urine testing at 5 years and for adolescents
 - Tuberculin testing for children and adolescents at high risk for tuberculosis
 - Screening for sexual activity and pregnancy risk for adolescent patients

Cost and Public Health Impacts of the Mandate to Cover Initial Health Assessments

AB 652 would require DMHC- and CDI-regulated plans and policies to cover initial health assessments for children who have been placed in an out-of-home placement within the last 30 days. The initial health assessment is to be covered whether it is provided in or out of network. Since most children with out-of-home placements are in foster care, CHBRP restricts this analysis to children in foster care. Initial health assessments for children in foster care are generally covered since children in foster care are enrolled in Medi-Cal and health assessments are already a covered benefit under Medi-Cal. All health plans and policies that are subject to AB 652 would be required to cover these initial health assessments (in or out of network), regardless of whether they are currently covered by Medi-Cal. Therefore, 21.9 million Californians are enrolled in plans and policies subject to AB 652.

- According to the Center for Social Services Research Child Welfare Dynamic Report System, as of October 2010, there were approximately 57,954 children who were in foster care. To obtain an annual estimate of the number of children who receive an initial health assessment, CHBRP relied on the number of children who *entered* foster care. For the most recent available annual data (time period covering October 2009 to September 2010)

⁷The lack of evidence for the effectiveness of these health education services is not evidence that such services are not beneficial.

approximately 28,244 children entered foster care in California and would have likely had an initial health assessment. Note that this estimate is a likely overestimate since this includes children who have been removed from the home for eight days and some children return home within the first 30 days. Others may have other placements, including at a shelter, with a family member, or with a foster family.

- CHBRP anticipates no measurable impact in terms of coverage, since these children are in the foster care system, are Medi-Cal eligible, and Medi-Cal provides reimbursement for initial health assessments for all children entering foster care regardless of the type of health insurance (if any) they had prior to entering foster care.
- CHBRP estimates no measurable change in utilization, nor any impacts on premiums or health care expenditures.
- Because no measurable changes in utilization are expected, no measurable impacts on public health are expected as a result of this provision in AB 652.
- It is possible for a foster child to also be covered by another form of health insurance while being enrolled in Medi-Cal. Therefore, it is possible that the effect of the mandate to cover initial health assessments would be to shift some costs incurred by Medi-Cal to health plans and policies that are subject to AB 652 for those services that are provided to foster children by out-of-network providers. However, reliable statewide data sources to validate or quantify this potential shift are not available. Therefore, CHBRP is unable to determine the magnitude of potential shifts in costs from Medi-Cal to health plans and insurers for in-network or out-of-network initial health assessments.

Medical Effectiveness of Forensic Medical Evaluations

The standard medical effectiveness evaluation criteria are not applicable for assessing forensic medical evaluations. Forensic medical evaluations are specialized interventions that are conducted to determine whether a child is a victim of child abuse or neglect. CHBRP's medical effectiveness review examines the California state protocols for performing forensic medical evaluations to determine whether children have been victims of physical abuse, neglect, or sexual abuse, and summarizes the methods for performing such evaluations. The literature on performing forensic medical evaluations derives from the following reports: California Medical Protocol for Examination of Child Physical Abuse and Neglect Victims, and California Medical Protocol for Examination of Sexual Assault and Child Sexual Abuse Victims.

Methods for Performing Forensic Medical Examinations

- Physical Abuse
 - Attend to acute and trauma care needs
 - Take a complete history of the child's circumstance, medical history, and injuries from the parent or guardian and separately from the child if the child is verbal

- Perform a comprehensive physical exam including the child's head, eyes, mouth, and musculoskeletal system
 - Indicated laboratory studies and X-rays should be performed to determine the full extent of inflicted injuries
 - Perform an exam of the genitals and anus
 - Collect and preserve the evidence of suspected physical abuse
 - Report suspected child abuse and refer for consultation
 - Complete the form *Medical Report: Suspected Child Physical Abuse and Neglect Examination CalEMA 2-900*
 - Document the transfer of evidence from the medical providers to law enforcement, crime laboratories, and others
- Neglect
 - Take a complete medical history including, but not limited to, immunization history, developmental milestones, and information on schooling, and household information
 - Obtain and review past medical records from other medical providers
 - Perform a comprehensive physical and examine for substandard provision of hygiene, nutrition, medical care, and dental care
 - Perform an exam of the genitals and anus
 - Collect and preserve the evidence of suspected neglect
 - Complete the form *Medical Report: Suspected Child Physical Abuse and Neglect Examination CalEMA 2-900*
 - Document the transfer of evidence from the medical providers to law enforcement, crime laboratories, and others
- Sexual Abuse
 - Provide a coordinated approach to patient care when such care is available
 - Provide developmentally and psychologically appropriate care
 - Attend to acute and trauma care needs
 - Take a history of the sexual acts as reported by the historian and separately from the child
 - Take a medical history that assesses pre-existing abuse and sexual activity (among adolescents only)
 - Perform a general physical, rectal, and genital exam
 - Obtain tests for sexually transmitted diseases as indicated based on the history of contact

- Offer postcoital contraceptive medication to appropriate adolescents at risk of pregnancy from the sexual assault
- Offer prophylactic antibiotics to prevent sexually transmitted disease if indicated as well as prophylactic antiviral medication to prevent HIV if indicated
- Collect and preserve the evidence of sexual abuse
- Complete the form *Medical Report: Acute (<72 hours) Child/Adolescent Sexual Abuse Examination* when the incident of abuse occurred within the past 72 hours or the form *Medical Report: Acute (>72 hours) Child/Adolescent Sexual Abuse Examination* when the incident of abuse occurred more 72 hours ago
- Record the names of persons to whom the evidence is distributed and obtain the signature of the officer receiving the evidence

Benefit Coverage, Utilization, and Cost Impacts of the Mandate to Cover Forensic Medical Evaluations

AB 652 would require DMHC- and CDI-regulated plans and policies to cover forensic medical evaluations at the request of local child welfare agencies or law enforcement. Table 1 provides a summary of the impact of this mandate on premiums paid by private and public employers and employees in the first year after implementation of the mandate. Among individuals in all plans subject to state regulation, AB 652 is estimated to increase premiums by about \$6.86 million. Note that the total population in Table 1 reflects the full 21.9 million enrollees in DMHC- or CDI-regulated plans or policies that are included in the mandate under AB 652. The premium increases are estimated to be spread among all enrollees in all plans or policies, even though the forensic medical evaluations are assumed to be provided to enrolled children aged 0 through 17 years.

Table 1 summarizes the expected benefit coverage, cost, and utilization impacts for AB 652.

Benefit Coverage Impacts

- Of the population subject to the mandate, 13.5% of enrollees have coverage for forensic medical evaluations (Table 1). If AB 652 were enacted, 100% of this population would have full coverage for forensic medical evaluations paid for by their health insurance.
- CHBRP estimates no measurable impact of the mandate on the number of uninsured due to premium increases.

Utilization Impacts

- CHBRP estimated that 9.1% of physical and sexual abuse allegations receive a forensic medical evaluation each year. According to the Center for Social Services Research Child Welfare Dynamic Report System, in 2009 there were 133,169 child abuse allegations (for physical and sexual abuse) in California. Therefore, among individuals in health plans and policies affected by the mandate, CHBRP estimates that there are approximately 9,000

forensic medical evaluations performed yearly and of those, about 1,000 enrollees receiving an evaluation currently have coverage.

- Postmandate, for enrollees affected by AB 652, forensic medical evaluations could be paid for by health insurance plans and policies, representing a possible maximum shift from local child welfare agencies and law enforcement funding to insurance of an estimated \$5.95 million.

Cost Impacts

- CHBRP estimated the average per-unit cost of forensic medical evaluations to be \$735.
- The mandate is estimated to increase premiums by about \$6.86 million. The distribution of the impact on premiums is as follows:
 - Total employer premium expenditures for CalPERS HMOs are estimated to increase by \$177,000, or 0.0051%.
 - Of the amount CalPERS would pay in additional premium, about 58% or \$103,000 would be state expenditures for CalPERS HMO members who are state employees or their dependents.
 - Enrollee contributions toward premiums for group insurance are estimated to increase by \$817,000, or 0.0054%.
 - Total premiums for purchasers of individual market health insurance are estimated to increase by \$464,000, or 0.0069%.
- Expenditures for Medi-Cal Managed Care Plans are estimated to increase by \$2.17 million, or 0.0250%.
- Expenditures for MRMIB Plans are estimated to increase by \$737,000, or 0.0701%.
- Increases in per member per month (PMPM) total premiums for the newly mandated benefit coverage vary by market segment. Increases as measured by percentage changes in PMPM premiums are estimated to range from an average of 0.0022% (for CDI-regulated large-group market) to an average of 0.0701% (for MRMIB plans) in the affected market segments. Increases as measured by PMPM premiums are estimated to range from an average of \$0.01 to \$0.08.
- Total health expenditures are projected to increase by approximately \$911,000 (0.0010%) for the year following implementation of the mandate (Table 1).

Public Health Impacts of the Mandate to Cover Forensic Medical Evaluations

- The standard public health outcomes for evaluating health benefit coverage are not applicable in the case of forensic medical evaluations. Forensic medical evaluations are a specialized

type of medical intervention used for the purposes of determining and documenting whether a child is a victim of child abuse or neglect.

- CHBRP found no evidence in the literature related to forensic exams and health outcomes. Therefore, the public health impact is unknown. Please note that the “absence of evidence” is not “evidence of no effect.” It is possible that an impact—positive or negative—could result. However, currently available scientific evidence does not allow CHBRP to project either.
- Although AB 652 could impact utilization of forensic medical evaluations, CHBRP is unable to estimate any change in utilization. Therefore, the public health impact is unknown.

Potential Effects of the Federal Affordable Care Act

The federal “Patient Protection and Affordable Care Act” (P.L.111-148) and the “Health Care and Education Reconciliation Act” (H.R.4872) were enacted in March 2010. These laws— together referred to as the “Affordable Care Act” (ACA)—are expected to dramatically affect the California health insurance market and its regulatory environment, with most changes becoming effective in 2014. How these provisions are implemented in California will largely depend on pending legal actions, funding decisions, regulations to be promulgated by federal agencies, and statutory and regulatory actions to be taken by California state government. The provisions that go into effect during these transitional years would affect the baseline, or current, enrollment, expenditures, and premiums. It is important to note that CHBRP’s analysis of specific mandate bills typically address the marginal effects of the mandate bill—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.

Essential Health Benefits for Qualified Health Plans Sold in the Exchange and Potential Interactions with AB 652

Beginning 2014, the ACA requires states to “make payments...to defray the cost of any additional benefits” required of qualified health plans (QHPs) sold in the Exchange. In addition, the U.S. Department of Health and Human Services is to ensure that the definition of essential health benefits (EHBs) “is equal to the scope of benefits provided under a typical employer plan.” It is likely that EHBs may be defined to include many components of an initial health assessment under the EHB categories “preventive and wellness services” and “pediatric services, including oral and vision care.”⁸ It is conceivable that EHBs may be defined to include forensic medical examinations for children (e.g., under “pediatric services”); however, these services are typically not provided by employer-sponsored health insurance. Therefore, it is unclear whether EHBs would be defined to include all the services mandated by AB 652 and it is unclear that whether, beginning in 2014, AB 652 would incur a fiscal liability for the state for QHPs sold in the Exchange. This potential liability would depend on three factors:

- Differences in the scope of benefits in the final EHB package and the scope of mandated benefits in AB 652;

⁸ The ACA creates four benefit tiers for the state exchange; bronze, silver, gold, and platinum. All tiers include a pediatric dental requirement for all levels of coverage.

- The number of enrollees in QHPs; and
- The methods used to define and calculate the cost of additional benefits.

All of these factors are unknown at this time, and are dependent upon the details of pending federal regulations, state legislative and regulatory actions, and enrollment into QHPs after the Exchange is implemented.

Table 1. AB 652 (Forensic Medical Evaluations) Impacts on Benefit Coverage, Utilization, and Cost, 2011

	Before Mandate	After Mandate	Increase/ Decrease	Change After Mandate
Benefit Coverage				
Total enrollees with health insurance subject to state-level benefit mandates (a)	21,902,000	21,902,000	0	0%
Total enrollees with health insurance subject to AB 652	21,902,000	21,902,000	0	0%
Percentage of enrollees with coverage for the mandated benefit	13.5%	100.0%	86.5%	639%
Number of enrollees with coverage for the mandated benefit	2,963,000	21,902,000	18,939,000	639%
Utilization and cost				
Enrollees having undergone a forensic medical evaluation—with coverage	976	9,068	8,093	829%
Enrollees having undergone a forensic medical evaluation—without coverage	8,093	-	-8,093	-100%
Average per unit cost of forensic medical evaluation	\$735	\$735	-	0%
Expenditures				
Premium expenditures by private employers for group insurance	\$52,713,266,000	\$52,715,761,000	\$2,495,000	0.0047%
Premium expenditures for individually purchased insurance	\$6,724,851,000	\$6,725,315,000	\$464,000	0.0069%
Premium expenditures by persons with group insurance, CalPERS HMOs, Healthy Families Program, AIM or MRMIP (b)	\$15,173,472,000	\$15,174,289,000	\$817,000	0.0054%
CalPERS HMO employer expenditures (c)	\$3,465,785,000	\$3,465,962,000	\$177,000	0.0051%
Medi-Cal Managed Care Plan expenditures	\$8,657,688,000	\$8,659,855,000	\$2,167,000	0.0250%
MRMIB Plan expenditures (d)	\$1,050,631,000	\$1,051,368,000	\$737,000	0.0701%
Enrollee out-of-pocket expenses for covered benefits (deductibles, copayments, etc.)	\$7,548,415,000	\$7,548,415,000	\$0	0.0000%
Enrollee expenses for noncovered benefits (e)	\$0	\$0	\$0	0.0000%
Expenses incurred by County (f)	\$5,946,000	\$0	-\$5,946,000	-100%
Total Expenditures	\$95,340,054,000	\$95,340,965,000	\$911,000	0.0010%

Source: California Health Benefits Review Program, 2011.

Notes: (a) This population includes persons with privately funded and publicly funded (e.g., CalPERS HMOs, Medi-Cal Managed Care Plans, Healthy Families Program, AIM, MRMIP) health insurance products regulated by the DMHC or CDI. Population includes enrollees aged 0 to 64 years and enrollees 65 years or older covered by employment-sponsored insurance.

(b) Premium expenditures by enrollees include employee contributions to employer-sponsored health insurance and enrollee contributions for publicly purchased insurance.

(c) Of the increase in CalPERS employer expenditures, about 58% or \$103,000 would be state expenditures for CalPERS members who are state employees or their dependents.

(d) MRMIB Plan expenditures include expenditures for 874,000 enrollees of the Healthy Families Program, 8,000 enrollees of MRMIP, and 7,000 enrollees of the AIM program.

(e) Includes only those expenses that are paid directly by enrollees to providers for services related to the mandated benefit that are not currently covered by insurance. This only includes those expenses that will be newly covered, postmandate. Other components of expenditures in this table include all health care services covered by insurance.

(f) Includes only expenses relating to forensic medical evaluations that are currently paid by the requesting party, typically either law enforcement agencies or local child welfare agencies.

Key: AIM=Access for Infants and Mothers; CalPERS HMOs=California Public Employees' Retirement System Health Maintenance Organizations; CDI=California Department of Insurance; DMHC=Department of Managed Health; MRMIB=Managed Risk Medical Insurance Board; MRMIP=Major Risk Medical Insurance Program.

INTRODUCTION

The California Assembly Committee on Health requested on February 17, 2011, that the California Health Benefits Review Program (CHBRP) conduct an evidence-based assessment of the medical, financial, and public health impacts of Assembly Bill (AB) 652, a bill that would impose a health benefit mandate for two services: initial health assessments for foster children and forensic medical evaluations for potential victims of child abuse. In response to this request, CHBRP undertook this analysis pursuant to the provisions of the program's authorizing statute.⁹

Analysis of AB 652: Overall Approach

Approximately 21.9 million Californians (59%) have health insurance that may be subject to a health benefit mandate law passed at the state level.¹⁰ Of the rest of the state's population, a portion is uninsured (and so has no health insurance subject to any benefit mandate) and another portion has health insurance subject to other state law or only to federal laws.

Uniquely, California has a bifurcated system of regulation for health insurance subject to state-level benefit mandates. The California Department of Managed Health Care (DMHC)¹¹ regulates health care service plans, which offer benefit coverage to their enrollees through health plan contracts. The California Department of Insurance (CDI) regulates health insurers¹², which offer benefit coverage to their enrollees through health insurance policies.

DMHC-regulated plans (including publicly funded plans such as Medi-Cal Managed Care Plans) and CDI-regulated policies for both individual and group policies would be subject to AB 652. Therefore, the mandate would affect the health insurance of approximately 21.9 million Californians (59%).

AB 652 Bill Language and Relevant Definitions

The full text of AB 652 can be found in Appendix A.

AB 652 includes two benefit mandates that fall under CHBRP's purview for analysis. The first would require health plans and insurers to provide an **initial health assessment** for children who have "out-of-home" placements. AB 652 defines initial health assessment as "a medical or dental examination, or both, performed on a child for whom a case plan must be prepared, pursuant to Section 16501.1 of the Welfare and Institutions Code and who has been placed in an out-of-home placement within the last 30 days, and that is designed to determine the child's medical and dental status and further health care needs." The guidelines for these assessments are

⁹ CHBRP's authorizing statute is available at http://www.chbrp.org/documents/authorizing_statute.pdf.

¹⁰ CHBRP's estimates are available at: http://www.chbrp.org/other_publications/index.php.

¹¹ The DMHC was established in 2000 to enforce the Knox-Keene Health Care Service Plan of 1975; see Health and Safety Code, Section 1340.

¹² The 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, Section 106(b) or subdivision (a) of Section 10198.6.

established by the Child Health and Disability Prevention Program (CHDP). According to the guidelines, complete health assessments are provided for the early detection and prevention of disease and disabilities for low-income children and youth. According to the guidelines, the components of the initial health assessment include: health and developmental history, complete physical exam, oral health assessment, nutritional assessment, immunizations, vision screening; hearing screening; screening tests for anemia, lead, urine abnormalities, tuberculosis, and other problems as needed, and health education and anticipatory guidance (DHCS, 2007a).

The second benefit mandated by AB 652 pertains to coverage of **forensic medical evaluations**. AB 652 defines forensic medical evaluations per Section 324.5 of the Welfare and Institutions Code (WIC), which states that these examinations are “performed by a medical practitioner who has specialized training in detecting and treating child abuse injuries and neglect, and, whenever possible, shall ensure that this examination take place within 72 hours of the time the child was taken into protective custody.” Per current Section 324.5 of WIC, examinations are to be provided in situations when an allegation of physical or sexual abuse of a child is brought to the attention of a local law enforcement agency or the local child welfare agency. The child is then taken into protective custody and law enforcement or the local child welfare agency may consult with a specially trained medical practitioner to determine whether an examination of the child is appropriate. If deemed appropriate, then law enforcement or the local child welfare agency shall have the child undergo the forensic medical evaluation.

Section 1 and Section 2 of AB 652 would require DMHC-regulated plans and CDI-regulated policies, including MRMIB programs, CalPERS HMOs, and Medi-Cal Managed Care Plans to provide reimbursement for these benefits, and these services must be covered even if they are rendered by a non-plan provider. Furthermore, AB 652 stipulates that prior authorization requirements would be prohibited. Additionally, AB 652 requires that reimbursement be paid to providers for both benefits should be no less than the amount that the Medi-Cal program would pay for the same service when rendered by the same provider to a Medi-Cal beneficiary on a fee-for-service basis.

Section 3 of AB 652 would also require the Medi-Cal program to cover initial health assessments and forensic medical evaluations. CHBRP’s authorizing statute requests the program to analyze a health insurance benefit mandate as it relates to DMHC-regulated plans and CDI-regulated policies. Because the Medi-Cal fee-for-service (FFS) program provides reimbursement to Medi-Cal providers directly (rather than through a contracted DMHC-regulated health plan) the provisions affecting the Medi-Cal FFS program does not fall within CHBRP’s purview for analysis. Therefore, this analysis does not address the potential impacts of Section 3 of AB 652 as it pertains to the Medi-Cal fee-for-service program.

Report Structure and Analytic Approach

Initial health assessments for children who have “out-of-home placements” are predominantly children who are in the foster care system.¹³ Children in foster care are enrolled in Medi-Cal and

¹³ Other children who are considered to have an out-of-home placement are those (1) who are on probation or incarcerated or (2) who after a removal order issued by a judge, are waiting for a disposition hearing in court that decides whether the child should be removed or returned home. According to the Center for Social Services Research Child Welfare Dynamic Report System, as of October 2010, there were approximately 62,248 children

health assessments are already a covered benefit under Medi-Cal. This is discussed in the *Background and Potential Impacts of the Mandate to Cover Initial Health Assessments* portion of the report. The *Medical Effectiveness* analysis summarizes the evidence base for those services that fall under “initial health assessments.” In addition, the *Medical Effectiveness* section summarizes the protocols for forensic medical evaluations.

CHBRP conducted phone interviews with seven county child welfare agencies¹⁴, and the California Child Welfare Director’s Association. Based on these interviews, CHBRP’s Bill-Specific Coverage Survey, and other data, CHBRP confirmed that coverage for forensic medical evaluations by health plans and policies is quite limited. In every county CHBRP interviewed, forensic medical evaluations are conducted in situations when an allegation of physical or sexual abuse of a child is brought to the attention of a local law enforcement agency or the local child welfare and typically paid for by a combination of child welfare services and law enforcement funds at the county level.¹⁵ Therefore, the *Benefit Coverage, Utilization, and Cost Impacts* and *Public Health Impacts* sections focus the impact analysis on the provision mandating coverage of forensic medical evaluations.

Requirements in Other States

CHBRP is unaware of similar mandates in other states.

Potential Effects of Federal Affordable Care Act

The federal “Patient Protection and Affordable Care Act” (P.L.111-148) and the “Health Care and Education Reconciliation Act” (H.R.4872) were enacted in March 2010. These laws— together referred to as the “Affordable Care Act” (ACA)—are expected to dramatically affect the California health insurance market and its regulatory environment, with most changes becoming effective in 2014. How these provisions are implemented in California will largely depend on pending legal actions, funding decisions, regulations to be promulgated by federal agencies, and statutory and regulatory actions to be taken by California state government.

The provisions that go into effect during the transitional years (2011-2013) would affect the baseline, or current, enrollment, expenditures, and premiums. It is important to note that CHBRP’s analysis of specific mandate bills typically address the marginal effects of the mandate bill—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. Each of the provisions that have gone into effect by January 2011 has been considered to determine whether they may affect CHBRP’s 2011 Cost and Coverage Model. There are still a number of provisions that have gone into effect for which data

who were placed out of the home and of those, 4,294 were in probation or categorized as “other.” CHBRP’s analysis is restricted to children in the child welfare system and considered “in foster care.”

¹⁴The seven counties include Fresno, Los Angeles, Orange, Riverside, Sacramento, San Bernardino, and San Diego. See Appendix B for further details.

¹⁵ While all the counties contacted confirmed that forensic medical evaluations were not billed to or covered by health plans and policies, there were some small variations in how the counties absorbed these costs. There were also variations in the frequency and process with which law enforcement or child welfare services initiated these evaluations.

are not yet available. Where data allows, CHBRP has made adjustments to the Cost and Coverage model to reflect changes in enrollment and/or baseline premiums. These adjustments are discussed in further detail in Appendix C.

A number of ACA provisions will need regulations and further clarity. One example is the ACA's requirement for certain health insurance to cover "essential health benefits" (EHBs). Effective 2014, Section 1302(b) will require small group and individual health insurance, including "qualified health plans" (QHPs) that will be sold in the California Exchange, to cover specified categories of benefits. These EHBs are defined as ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. The Secretary of Health and Human Services (HHS) is charged with defining these categories through regulation, ensuring that the EHB floor "is equal to the scope of benefits provided under a typical employer plan." In addition, the ACA would allow a state to "require that a qualified health plan offered in [the Exchange] offer benefits in addition to the essential health benefits." If the state does so, the state must make payments to defray the cost of those additionally mandated benefits, either by paying the individual directly, or by paying the qualified health plan. This ACA requirement could interact with existing and proposed California benefit mandates, especially if California decided to require qualified health plans to cover California-specific mandates, and those mandates were determined to go beyond the EHB floor. Federal regulations regarding which benefits are to be covered under these broad EHB categories and other details, such as how the subsidies for purchasers of qualified health plans are structured, are forthcoming.¹⁶

Essential Health Benefits for Qualified Health Plans Sold in the Exchange and Potential Interactions with AB 652

Beginning 2014, the ACA requires states to "make payments...to defray the cost of any additional benefits" required of QHPs sold in the Exchange. In addition, HHS is to ensure that the definition of EHBs "is equal to the scope of benefits provided under a typical employer plan." It is likely that EHBs may be defined to include many components of an initial health assessment under the EHB categories "preventive and wellness services" and "pediatric services, including oral and vision care."¹⁷ It is conceivable that EHBs may be defined to include forensic medical examinations for children (e.g., under "pediatric services"). However, these services are typically not provided by employer-sponsored health insurance. Therefore, it is unclear whether EHBs would be defined to include all the services mandated by AB 652 and it is unclear that whether, beginning in 2014, AB 652 would incur a fiscal liability for the state for QHPs sold in the Exchange. This potential liability would depend on three factors:

¹⁶ For further discussion on EHBs and potential interaction with state mandates, please see, *California's State Benefit Mandates and the Affordable Care Act's "Essential Health Benefits"* available here:

http://www.chbrp.org/other_publications/index.php.

¹⁷ The ACA creates four benefit tiers for the state exchange; bronze, silver, gold, and platinum. All tiers include a pediatric dental requirement for all levels of coverage.

- Differences in the scope of benefits in the final EHB package and the scope of mandated benefits in AB 652;
- The number of enrollees in QHPs; and
- The methods used to define and calculate the cost of additional benefits.

All of these factors are unknown at this time, and are dependent upon the details of pending federal regulations, state legislative and regulatory actions, and enrollment into QHPs after the Exchange is implemented.

BACKGROUND AND POTENTIAL IMPACTS OF THE MANDATE TO COVER INITIAL HEALTH ASSESSMENTS

AB 652 states that initial health assessment are to be covered pursuant to Section 16501.1 of the Welfare and Institutions Code (WIC) and are for children placed outside of their home within the last 30 days. Since most children who are placed out of their home are in foster care, CHBRP restricts this analysis to refer to children aged 0 to 17 years who have been placed in foster care.^{18,19}

Children in Foster Care and Rates of Initial Health Assessments

All children who enter the foster care system are to undergo an initial health assessment to determine the child's medical and dental status and further health care needs, and so that a case plan may be prepared.

According to the Center for Social Services Research Child Welfare Dynamic Report System, as of October 2010, there were approximately 57,954 children who were in foster care. Table 2 shows the current number of foster children in California by age and Table 3 show the current number of foster children in California by ethnicity. Table 3 suggests that Black children face a higher prevalence rate for entering foster care than any other ethnic group in California.

Table 2. Children in Foster Care by Age, California, October 2010

Age Group	In Foster Care
Under 1	3,313
1-2	7,586
3-5	8,747
6-10	11,925
11-15	15,069
16-17	8,812
Total	57,954

Source: CWS/CMS 2010 Quarter 3 Extract.

Population Data Source: California Department of Finance annual population projections (Based on the 2000 U.S. Census) (Needell et al., 2011).

Note: This excludes children who are under probation or categorized as "other."

¹⁸ Other children who are considered to have an out-of-home placement are those (1) who are on probation or incarcerated or (2) who after a removal order issued by a judge, are waiting for a disposition hearing in court that decides whether the child should be removed or returned home. According to the Center for Social Services Research Child Welfare Dynamic Report System, as of October 2010, there were approximately 62,248 children who were placed out of the home and of those, 4,294 were in probation or categorized as "other."

¹⁹ Personal Communication, C. Senderling-McDonald, County Welfare Directors Association of California, March 2011.

Table 3. Children in Foster Care by Ethnicity, California, October 2010

Ethnic Group	In Foster Care	Prevalence per 1,000 Children (a)
Black	14,616	24.4
White	14,434	4.6
Hispanic	26,596	5.1
Asian/Pacific Islander	1,444	1.4
Native American	779	16.6
Total	57,954	5.5

Source: CWS/CMS 2010 Quarter 3 Extract.

Population Data Source: California Department of Finance annual population projections (Based on the 2000 U.S. Census) (Needell, 2011).

Notes: The total of the counts of children in foster care does not add up to the “Total” due to missing data for 85 children. This excludes children who are under probation or categorized as “other.” (a) Prevalence rates are based on July 2010 data run.

To obtain an annual estimate of the number of children who receive an initial health assessment, CHBRP relied on the number of children who *entered* foster care. For the most recent available annual data (time period covering October 2009 to September 2010) approximately 28,244 children entered foster care in California and would have likely had an initial health assessment. Note that this estimate is a likely overestimate since this includes children who have been removed from the home for eight days and some children return home within the first 30 days. Others may have other placements, including at a shelter, with a family member, or with a foster family.

Foster children have health insurance through Medi-Cal. Depending on the county in which the child resides, he or she is enrolled in the Medi-Cal program on a fee-for-service basis (Medi-Cal FFS) or enrolled in Medi-Cal Managed Care.²⁰ As of 2007, the distribution of foster children by type of Medi-Cal coverage is as follows:

- 75.0% had Medi-Cal FFS
- 25.0% were enrolled in one of three models of Medi-Cal Managed Care Plans:
 - The Two-Plan: 15.5%
 - Geographic Managed Care: 2.3%
 - County Organized Health System (COHS): 7.2% (DHCS, 2007b).

²⁰ There are three primary sources of health insurance funding for foster care children. The first source, Federal Title IV-E/AFDC Foster Care, is based on the old Aid for Families with Dependent Children (AFDC) requirements of the household income prior to the child/youth’s removal; these children are eligible for full-scope Medi-Cal. The second source, State Funded Foster Care, applies if the income of the child/youth’s home prior to removal does not meet the AFDC eligibility criteria. These children/youth are State Funded and are eligible for full scope Medi-Cal coverage. And finally, County Foster Care is used for children/youth who do not have satisfactory immigration status. These children are eligible for emergency and pregnancy services through Medi-Cal.

In California, each of the 58 counties is responsible for administering their own child welfare program. The California Department of Social Services provides regulatory oversight, and administrative support to the local child welfare agencies (Reed, 2009). Since the local child welfare agencies are responsible for ensuring that the health care needs of children under its jurisdiction and supervision are met, children in foster care are granted expedited Medi-Cal eligibility upon removal from their homes so they can quickly access any needed health care.²¹ In other words, the county needs to process the Medi-Cal application for foster children much faster than the 45 days required under state and federal law.²² In addition, if a child was already on Medi-Cal when removed from home, but does not have access to his or her Medi-Cal card, the county must issue immediate proof of Medi-Cal eligibility at the request of the child's authorized representative (foster care worker or foster parent).

Medical Effectiveness of Initial Health Assessments

CHBRP examines whether the services delivered in an initial health assessment are considered to be medically effective based on existing literature. While the health care needs of children in foster care may differ from the general pediatric population, there are no studies that examine the effectiveness of health assessment services in the foster care population. Therefore, CHBRP relied on the existing literature of the effectiveness of health assessment services among general pediatric populations. Conclusions are drawn from the U.S. Preventive Services Task Force (USPSTF) recommendations, Centers for Disease Control (CDC) recommendations, National Institutes of Health (NIH) guidelines. When there is no evidence-based recommendation for a service, CHBRP relied on other authoritative sources such as the American Academy of Pediatrics.

Initial health assessment services are delivered through the California's Child Health and Disability Program (CHDP), the State of California's health promotion and disease prevention program for children with Medi-Cal or children whose families are income-eligible. The components of the initial health assessment include: health and developmental history, complete physical exam, oral health assessment, nutritional assessment, immunizations, vision screening; hearing screening; screening tests for anemia, lead, urine abnormalities, tuberculosis, and other problems as needed, and health education and anticipatory guidance (DHCS, 2007a).

Efficacy of Initial Health Assessment Services

Health and developmental history

- No studies of the effectiveness of taking a health and developmental history were identified.

²¹ Welfare & Inst. Code §14007.45 (which exercises a federal Medicaid option under 42 U.S.C. §1396r-1a); DHS ACL 01-41 ("Each county should appoint a Foster Care Coordinator in the Medi-Cal eligibility agency to ensure that foster care workers and child protective service workers who are involved in the removal of a child from the home, have a contact within the eligibility agency to expedite the issuance of proof of eligibility for the child." Id. at p. 2.). Some counties have adopted their own policies to issue Medi-Cal cards within 24 hours.

²² 42 U.S.C. § 1396a(a)(8); Cal. Code Regs. Title 22, § 50177.

- Recommendations regarding the frequency and content of performing medical and developmental history vary depending on the child's age (e.g., recommends more frequent visits for infants and toddlers than for older children) (Tanski et al., 2010).

No meta-analyses, systematic reviews, or evidence-based guidelines could be located on the medical effectiveness of taking a health and developmental history. In this case, CHBRP relied on the Tanski et al. (2010) recommendation. It stands to reason that obtaining a health and developmental history could provide useful information for assessing the health care needs of children entering foster care.

Complete physical exams

- No studies of the effectiveness of periodic physical examinations for children were identified.
- Recommendations regarding the frequency and content of physical examinations vary depending on the child's age (i.e., recommends more frequent visits for infants and toddlers than for older children) (Tanski et al., 2010).

No meta-analyses, systematic reviews, or evidence-based guidelines could be located on the medical effectiveness of performing a physical exam. In this case, CHBRP relied on the Tanski et al. (2010) recommendation. It stands to reason that performing a complete physical examination could reveal information that would be helpful for identifying the health care needs of children entering foster care.

Oral health assessment

- The American Academy of Pediatrics (AAP) recommends that infants be scheduled for an initial oral examination within 6 months of the eruption of the first primary tooth but by no later than 12 months of age. After one year of age a dental check-up at least twice a year is recommended for most children (AAP, 2008).

No meta-analyses, systematic reviews, or evidence-based guidelines could be located on the medical effectiveness of an oral health assessment. In this case, CHBRP relied on the AAP (2008) recommendation. It stands to reason that a dental checkup could help identify children entering foster care who need further dental services.

Nutritional assessment

- Insufficient evidence on counseling children and adolescents regarding nutrition (USPSTF, 2010).
- Recommendation for screening children aged 6 years and older for obesity (USPSTF, 2010).

The *preponderance of evidence*²³ suggests that screening children age 6 or older for obesity is effective. There is *insufficient evidence* to recommend for or against counseling children and adolescents regarding nutrition.

Immunizations

The Centers for Disease Control and Prevention recommends the following immunizations²⁴ for children, based on evidence from RCTs and nonrandomized studies:

- Haemophilus influenza type B conjugate vaccine—all children
- Hepatitis A vaccine—all children
- Hepatitis B vaccine—all children
- Human papillomavirus vaccine—all females age 11 to 26 years
- Influenza vaccine—annually for all children age 6 months to 18 years
- Measles-mumps-rubella vaccine—all children
- Meningococcal conjugate vaccine— all children age 11 to 12 years plus younger children at increased risk
- Pneumococcal conjugate vaccine—all children
- Pneumococcal polysaccharide vaccine—children at increased risk
- Inactivated poliovirus vaccine—all children
- Rotavirus vaccine—all children
- Tetanus and diphtheria toxoid and pertussis vaccine—all children plus booster every 10 years for adolescents
- Varicella (i.e., chicken pox) vaccine—all children

The *preponderance of evidence* suggests that the above immunizations for children and adolescents are *effective*.

Vision screening

- No studies were identified that compared prevalence of amblyopia (i.e., lazy eye) or refractive error (i.e., nearsightedness, farsightedness, and astigmatism) among screened and unscreened children were identified. The lack of evidence for the effectiveness of screening for amblyopia and refractive error is not evidence that screening provides no benefit.

²³ Appendix B lists CHBRP's definitions for the classifications of strength of evidence.

²⁴ The frequencies and dosages of administering vaccines are based on age-specific recommendations.

- Evidence from a large, well-designed RCT suggests that children who are screened multiple times as infants or toddlers are less likely to have amblyopia (i.e., lazy eye) at age 7.5 years than children who are screened only once (USPSTF, 2004).
- The USPSTF recommends screening to detect amblyopia, strabismus, and defects in visual acuity in children younger than age 5 years (USPSTF, 2010).

The *preponderance of evidence* suggests that vision screening for children younger than age 5 years is *effective*.

Hearing screening

- Evidence from nonrandomized studies with comparison groups suggest that participation in a universal newborn screening program increases the likelihood that a child with permanent congenital hearing loss will be diagnosed by age 9 months (USPSTF, 2008).
- Children with permanent congenital hearing loss diagnosed through universal screening programs have higher scores on tests of receptive and expressive language than children with permanent hearing loss who did not participate in a universal screening program (USPSTF, 2008).
- The USPSTF recommends screening for hearing loss in all newborn infants (USPSTF, 2010).
- No studies of the effectiveness of hearing screening for older children were identified.

The *preponderance of evidence* suggests that screening newborns for hearing loss is *effective*.

Screening tests for anemia, lead, urine abnormalities, tuberculosis, and other problems as needed

- There is insufficient evidence for screening asymptomatic children for iron deficiency anemia (USPSTF, 2010).
- There is a preponderance of evidence to recommend against routine screening for elevated blood lead levels among average risk and insufficient evidence to screen for those at increased risk (USPSTF 2010).
- Urine testing is recommended at 5 years and adolescents (Tanski et al., 2010).
- Tuberculin testing is recommended for children and adolescent at high risk for tuberculosis (Tanski et al., 2010).

The *preponderance of evidence* suggests that screening for elevated blood lead levels is *not effective* among average risk children; there is *insufficient evidence* on screening among children at high risk for elevated blood lead levels. There is *insufficient evidence* on the medical effectiveness of screening for anemia. No meta-analyses, systematic reviews, or evidence-based guidelines could be located on the medical effectiveness for urine and tuberculin testing. CHBRP relied on the aforementioned recommendations for such services.

Health education and anticipatory guidance

- There is a recommendation for screening of adolescents (12-18 years of age) for major depressive disorder (MDD) when appropriate systems of care are in place (USPSTF, 2010).
- There is a recommendation for counseling to prevent sexually transmitted infections among sexually active adolescents (USPSTF, 2010).
- There is a recommendation for screening sexually active females for chlamydial infections (USPSTF, 2010).
- There is a recommendation for screening for sexual activity and pregnancy risk for adolescent patients (Tanski et al., 2010).
- There is insufficient evidence to determine whether brief counseling interventions prevent or reduce alcohol use among adolescents. (USPSTF, 2010).
- There is insufficient evidence to determine whether screening and treatment and for tobacco use prevents tobacco use among children or adolescents (USPSTF, 2010).
- There are recommendations regarding the frequency and content of performing anticipatory guidance vary depending on the child's age (Tanski et al., 2010).

The *preponderance of evidence* suggests that health education and anticipatory screening for major depression and transmission of sexually infections is *effective*. There is *insufficient evidence* to determine whether behavioral counseling prevents or reduces alcohol and tobacco use among adolescents. No meta-analyses, systematic reviews, or evidence-based guidelines could be located on the medical effectiveness for screening for sexual activity and pregnancy risk. CHBRP relied on the Tanski et al. (2010) recommendations for such services.

Current Benefit Coverage of Initial Health Assessments

Sections 1 and 2 of AB 652 would require DMHC-regulated plans and CDI-regulated policies, including MRMIB programs, CalPERS HMOs, and Medi-Cal Managed Care Plans to provide reimbursement for initial health assessments even if they are rendered by an out-of-network provider, and they must do so without prior authorization.

As mentioned, AB 652 states that an initial health assessment “shall meet, and may exceed, the guidelines established by the CHDP for well-child exams and includes, but is not limited to,

diagnostic testing to the extent necessary to provide a complete assessment.” For the purposes of analysis, CHBRP uses the CHDP guidelines to assess current coverage of initial health assessments. According to these guidelines, a health assessment consists of a health history, physical examination, developmental assessment, nutritional assessment, dental assessment, vision and hearing tests, a tuberculin test, laboratory tests, immunizations, health education/anticipatory guidance, and referral for any needed diagnosis and treatment (DHCS, 2007a).

To determine current coverage rates among health plans and policies subject to state-level benefit mandates, CHBRP queried:

- California’s seven largest health plans and insurers to determine benefit coverage rates in the privately insured market.²⁵
- Department of Health Care Services (DHCS) and the largest Medi-Cal Managed Care Plans to determine benefit coverage rates for Medi-Cal Managed Care enrollees.
- Managed Risk Medical Insurance Board (MRMIB) to determine benefit coverage rates among those enrolled in the Healthy Families Program (HFP) and Major Risk Medical Insurance Program (MRMIP) plans.
- The California Public Employees’ Retirement System (CalPERS) regarding coverage rates for their CalPERS HMO enrollees.

The table below summarizes the current coverage rates by enrollees in various market segments.

DMHC-regulated plans and CDI-regulated policies that do not cover “initial health assessment” in-network tend to exclude services required to be provided by a government agency or ordered by a court. When “initial health assessments” or their components are considered covered, it is usually because they are part of a “well-child” visit that is already covered under a plan’s or policy’s preventive services benefits and when they are furnished in-network. Initial health assessments are generally not covered out-of-network.

Dental or oral health assessments, which are a component of “initial health assessments,” are generally not covered. However, Medi-Cal Managed Care plans and Healthy Families do provide basic dental assessments in-network.

²⁵ Responses to this survey represent approximately 72% of the CDI-regulated and 85% of DMHC-regulated market. Combined, responses to this survey represent 82% of enrollees in the privately funded market subject to state mandates. For further details regarding CHBRP’s analytic methods to determine coverage rates, see Appendix C.

Table 4. Current Coverage of Initial Health Assessments by Market Segment, California, 2011

	Initial Health Assessment Services In-network	Initial Health Assessment Services Out-of-network	Dental Assessment In-network	Dental Assessment Out-of-network
DMHC-regulated plans				
Large group	40%	6%	0%	0%
Small group	52%	10%	0%	0%
Individual	15%	0%	0%	0%
All	41%	6%	0%	0%
CDI-regulated policies				
Large group	73%	24%	0%	0%
Small group	100%	27%	0%	0%
Individual	33%	0%	0%	0%
All	62%	14%	0%	0%
CalPERS HMO	44%	0%	0%	0%
Medi-Cal Managed Care	100%	0%	100%	0%
Healthy Families	100%	0%	100%	0%
MRMIP	100%	0%	0%	0%
AIM (1)	N/A	N/A	N/A	N/A
Total	57%	6%	21%	0%

Source: CHBRP, 2011

Note: (1) Access to Infants and Mothers does not include enrollees under age 18.

Current Utilization Rates and Per-Unit Costs

As mentioned, approximately 28,244 children entered foster care in California in 2009-10 and would have likely had an initial health assessment. The average per-unit cost is estimated to be about \$41 to \$62 and this is based on the CHDP Provider Manual (DHCS, 2003), which lists the maximum allowable reimbursement rates to providers. This estimate varies depending on whether related laboratory tests or immunizations are included.

AB 652 would require that “reimbursement paid to providers for both benefits should be no less than the amount that the Medi-Cal program would pay for the same service when rendered by the same provider to a Medi-Cal beneficiary on a fee-for-service basis.” The average Medi-Cal reimbursement rate for a “well-child” visit and the average Medi-Cal reimbursed rate for a health assessment as reported by local child welfare agencies is estimated to be approximately \$55. Again, this estimate would vary, for example depending on whether laboratory and vaccinations are included. Based on an analysis of Milliman claims data, the average commercial reimbursement rate of a well-child visit is approximately \$125.

Potential Cost and Public Health Impacts of Mandating Benefit Coverage of Initial Health Assessments

CHBRP anticipates no measurable impact in terms of coverage, since these children are in the foster care system, are Medi-Cal eligible, and Medi-Cal provides reimbursement for initial health assessments. Therefore, CHBRP estimates no measurable change in utilization, nor any impacts on premiums or health care expenditures.

As described in the *Medical Effectiveness* section, there is evidence that some components of the initial health assessments are effective. However, because no measurable changes in utilization are expected, no measurable impacts on public health are expected as a result of this provision in AB 652.

A child may have another form of insurance before entering the foster care system—for example, a private CDI-regulated policy through his/her parent. It is technically possible for the child to retain that health insurance and also be enrolled in Medi-Cal. In such cases, it is permissible for the child’s insurance to be billed first and Medi-Cal to be the “payor of last resort.” However, for this to occur, local child welfare agencies must be aware of and track the insurance status and sources of insurance of children entering the system.

In addition, there must be incentives for the provider to bill another source of insurance other than Medi-Cal. Because AB 652 allows reimbursement rates to providers to be the same as (but not less than) the Medi-Cal FFS service rate, plans and insurers may opt to reimburse providers for the initial health assessments at Medi-Cal FFS rates rather than at typically higher commercial reimbursement rates associated with well-child visits. Thus, if providers of initial health assessments obtain the same reimbursement regardless of what insurance they bill, there may be little incentive to change current billing practices.

To determine whether local child welfare agencies are aware of health insurance status and to determine the potential shifts in costs to health plans and insurers, CHBRP conducted key informant interviews of several individuals knowledgeable about county-level reimbursements for initial health assessment for children in foster care (see Appendix B). Interviewees indicated variation at the county level in terms of capacity and resources to obtain information about the child’s prior insurance status/source of insurance and to track that information in order allow providers to bill the primary insurance for that child. Interviewees indicated that the primary focus is to enroll the child in Medi-Cal as soon as possible to ensure adequate access to health care services.

Interviewees provided anecdotal evidence regarding administrative and process issues as it relates to Medi-Cal Managed Care and Medi-Cal FFS enrollment and payment. For example, depending on the county, a child who already has Medi-Cal Managed Care would likely be disenrolled from their Medi-Cal Managed Care plan and either (1) re-enrolled in the same plan, (2) enrolled in another Medi-Cal Managed Care plan, or (3) enrolled in Medi-Cal FFS.²⁶ The initial disenrollment/enrollment process may lead to confusion in terms of processing health care

²⁶Enrollment in Medi-Cal Managed Care is not mandatory and a foster child’s family may elect to have the child be enrolled in Medi-Cal FFS.

claims especially during the initial days of foster care eligibility (which coincides with when the initial health assessments are usually provided). Another example relates to Medi-Cal Managed Care plans not paying for out-of-network initial health assessments for a foster child who may have been enrolled with the plan at the point the child was taken into protective custody. If the initial health assessment was delivered by a provider who contracts with the local child welfare service agency but not with the plan, the plan considers that service out-of-network.

Interviews with county officials indicate that these administrative and process issues are rare. Statewide data to verify whether these were systemic issues was not available.

Given the lack of statewide information, CHBRP is unable to determine magnitude of the cost-shifting effect of AB 652 from Medi-Cal to Medi-Cal Managed Care Plans, Healthy Families, or privately purchased health plans and policies for initial health assessments, especially over the long term.

MEDICAL EFFECTIVENESS OF FORENSIC MEDICAL EVALUATIONS

The standard medical effectiveness evaluation criteria are not applicable for evaluating forensic medical evaluations, since forensic medical evaluations are not a standard medical intervention, per se. Instead, they are used for the purposes of determining whether a child is a victim of child abuse or neglect. Therefore, this medical effectiveness review summarizes the methods for performing a forensic medical examination to determine physical abuse, neglect, and sexual abuse for child victims. CHBRP examines the California state protocols for performing a forensic medical examination and summarizes the methods for performing such exams. The literature on performing a forensic medical examination derives from the following reports: California Medical Protocol for Examination of Child Physical Abuse and Neglect Victims, and California Medical Protocol for Examination of Sexual Assault and Child Sexual Abuse Victims.

According to the Child Health Bureau of the U.S. Health and Human Services Agency, in 2009 approximately 3.3 million child abuse referrals were made to child welfare agencies nationwide, with a total of approximately 702,000 children identified as victims of abuse. In California, there were approximately 133,169 allegations of child maltreatment in 2009, with approximately 79,799 children ultimately identified as victims of maltreatment. Of these, approximately 8,459 experienced physical abuse and 5,506 were victims of sexual abuse (HHS, 2010a).

Methods for Performing Forensic Medical Examinations

In 1995, SB 857 generated Penal Code Section 13820-13825, which set to establish protocols and the use of standard forms in the forensic medical examination of child sexual abuse. In 2002, the enactment of SB 580 amended Penal Code Section 11171 to enhance the procedure for forensic medical examinations of physically abused and neglected children. The State of California forensic medical instructions, procedures, and forms for the examination of child sexual abuse, physical abuse, and neglect are available at the California Clinical Forensic Medical Training Center (CCFMTC)²⁷, housed at the University of California, San Diego. The settings in which a child presents with signs of abuse vary (e.g., school, pediatrician's office, law enforcement visit). But once there has been a determination that a forensic medical examination is needed, the medical providers are to follow the methods for performing medical evaluations detailed in the following reports: California Medical Protocol for Examination of Child Physical Abuse and Neglect Victims, and California Medical Protocol for Examination of Sexual Assault and Child Sexual Abuse Victims. In some circumstances a forensic conclusion cannot be reached in one visit. A second visit may be needed to observe whether there is a change in a finding that would suggest that finding is related to an injury.

The legal definitions of child sexual abuse, physical abuse and neglect, per California Penal Codes, are listed and the methods for performing a medical examination of each form are summarized below.

²⁷See <http://ccfmmc.org.s110224.gridserver.com/about-us/>

Child Physical Abuse

Legal definition child physical abuse

California Penal Code Section 11165.2 states, “the willful harming or injuring of a child or the endangering of the person or health of a child,” means a situation in which any person willfully causes or permits any child to suffer, or inflicts thereon, unjustifiable physical pain or mental suffering, or having the care or custody of any child, willfully causes or permits the person or health of the child to be placed in a situation in which his or her person or health is endangered.

Evaluation of child physical abuse

When a child presents as a victim of child physical abuse, the medical provider first responds to any acute and trauma care needs. The next step in the examination of child physical abuse requires a medical professional to take a complete history the child’s circumstance, medical history, and injuries. It is recommended to take the history from the parent or guardian and to separately take the history from the child if the child is verbal. During this information gathering, the provider compares the report of the reported medical histories to the medical findings. When a reported history is not consistent with the medical evidence, these discrepancies may suggest that the reported history is false and imply culpability. Providers are trained to extensively probe for the explanation for the events, including probing when there is no explanation of the event; challenge incomplete histories; note when there are inconsistencies in the reporting of the history; and push for details that may be indicative of an apparent mechanism of injury.

The medical professional then performs a comprehensive physical exam. The height and weight of the child is measured and compared with growth to age-based norms (for a child under two, measurement of the head circumference is used). An assessment of the child’s behavioral, mental, language, and motor development are also compared to age-based norms.

The “head-to-toe” medical exam should be more thorough than in a regular well-visit checkup and includes particular exam elements that may elucidate possible child abuse. All surfaces of the skin must be examined and the following cutaneous patterns may be suggestive of child abuse, including but not limited to: bruises or burns that present in a shape that may be likened to a recognized object; bruises or burns that are not associated with a particular shape but are repeated; bruises in children who are not ambulatory; facial bruises (two or more) with no explanation on how they were acquired; burns; untreated healing fractures; and new fractures. The child’s head, eyes, and mouth should also be more closely examined than in a regular well-visit checkup as head injuries are more likely to result in serious and fatal injuries to children. Special scrutiny of the child’s scalp, teeth, lips, tongue, ears, jaw, and facial structure as well as the palms of hands and soles of feet are required. When there are signs of injury to the surface of the body, the injuries are measured, documented, and when possible, photographed. Proper use of photographic techniques is required and is described in the protocols. The exam of the child’s musculoskeletal system includes the observation of any deformities, and palpitation of the chest and extremities for feeling of tenderness or mass. If signs of trauma to the musculoskeletal system exist, a radiological assessment is required. Per the physician’s assessment of the child, laboratory testing may be ordered. If there are signs of emotional trauma, the physician may make referrals for mental health services.

Other forms of physical abuse are classified as syndromes, or patterns of findings that are associated with an etiology. Two syndromes that are suggestive of possible child abuse are the Battered Child Syndrome and the Shaken Baby Syndrome, which is also called Abusive Head Trauma. Battered Child Syndrome may present clinically as multiple injuries that appear to be caused by separate events. It is hypothesized that injuries are inflicted by an abuser who has a tendency for violence or loss of control. Abusive Head Trauma presents clinically as an intracranial traumatic injury that is not accompanied by a corresponding history of severe trauma.

The medical examination of child physical abuse also calls for an examination of the child's genitals and anus. If there is evidence of sexual abuse, the protocols for the examination of child sexual abuse victims are followed, which are described later in this text.

Medical providers are required to collect and preserve the evidence of suspected physical abuse. Examples of evidence may include clothing, blood, and saliva samples; laboratory studies; and diagnostic imaging studies and photography. The protocol describes methods to ensure the integrity of the collected evidence.

After completing the medical evaluation, the provider must decide if there is a reasonable suspicion of abuse. When suspicion is reasonable the state of California mandates the provider to make an immediate telephone report to either the county children's protective services or local law enforcement agencies.

Following the mandatory reporting for suspected child abuse and neglect, the medical provider is required to record the results of the medical examination in the standard medical report, *Suspected Child Physical Abuse and Neglect Examination*.

Child Neglect

Legal definition of child neglect

California Penal Code Section 11165.2 defines child neglect as the negligent treatment or the maltreatment of a child by a person responsible for the child's welfare under circumstances indicating harm or threatened harm to the child's health or welfare. The term includes both acts and omissions on the part of the responsible person. "Severe neglect" means the negligent failure of a person having the care or custody of a child to protect the child from severe malnutrition or medically diagnosed nonorganic failure to thrive. "Severe neglect" also means those situations of neglect where any person having the care or custody of a child willfully causes or permits the person or health of the child to be placed in a situation such that his or her person or health is endangered, as proscribed by Section 11165.3, including the intentional failure to provide adequate food, clothing, shelter, or medical care. "General neglect" means the negligent failure of a person having the care or custody of a child to provide adequate food, clothing, shelter, medical care, or supervision where no physical injury to the child has occurred.

Evaluation of child neglect

When a child presents with any condition suspected of being the result of neglect, a medical evaluation of child neglect is required. The medical evaluation begins with the medical provider obtaining a complete medical history of the child, including birth history, immunization history,

developmental milestones, information on schooling, primary care provider information, household information, and social history of the child's family.

A complete physical exam is performed that also includes particular exam elements that may elucidate neglect. The provider assesses the following: whether there are substandard provisions of nutrition, hygiene, and clothing; healthcare; dental care; and whether there are developmental problems in motor skills, speech, and language. If the medical provider identifies untreated conditions, laboratory tests or imaging studies may be ordered for diagnosis. It is also recommended to conduct a hemoglobin test for anemia and lead testing for children under the age of six years.

After performing the medical history, exam, and diagnostic tests (if needed), the provider assesses whether the child is at risk for ongoing neglect or if the neglect was associated with a single episode of neglected care that has been resolved. When neglect is known or suspected, the state of California mandates the provider to make an immediate telephone report to county children's protective services. If there are signs of emotional trauma, the physician may make referrals for mental health services.

The procedures for collecting and preserving the evidence, reporting suspected child neglect, and completing the medical report are the same as those described above for child physical abuse.

The medical examination of child neglect also calls for an examination of the child's genitals and anus. If there is evidence of sexual abuse, the protocols for the examination of child sexual abuse victims are followed, which are described later in this text.

Sexual Abuse

Legal definition of sexual abuse

California Penal Code Section 11165.1 defines sexual abuse as (1) any penetration, however slight, of the vagina or anal opening of one person by the penis of another person, whether or not there is the emission of semen; (2) any sexual contact between the genitals or anal opening of one person and the mouth or tongue of another person; (3) any intrusion by one person into the genitals or anal opening of another person, including the use of any object for this purpose; except that, it does not include acts performed for a valid medical purpose; (4) the intentional touching of the genitals or intimate parts (including the breasts, genital area, groin, inner thighs, and buttocks) or the clothing covering them, of a child, or of the perpetrator by a child, for purposes of sexual arousal or gratification, except that, it does not include acts which may reasonably be construed to be normal caretaker responsibilities interactions with, or demonstrations of affection for, the child, or acts performed for a valid medical purpose; or (5) the intentional masturbation of the perpetrator's genitals in the presence of a child.

California Penal Code 11165.1 also includes sexual exploitation under the legal definition of sexual abuse. Sexual exploitation refers to any of the following: (1) Conduct involving matter depicting a minor engaged in obscene acts in violation of Section 311.2 (preparing, selling, or distributing obscene matter) or subdivision (a) of Section 311.4 (employment of minor to

perform obscene acts); (2) Any person who knowingly promotes, aids, or assists, employs, uses, persuades, induces, or coerces a child, or any person responsible for a child's welfare, who knowingly permits or encourages a child to engage in, or assist others to engage in, prostitution or a live performance involving obscene sexual conduct, or to either pose or model alone or with others for purposes of preparing a film, photograph, negative, slide, drawing, painting, or other pictorial depiction, involving obscene sexual conduct. For the purpose of this section, "person responsible for a child's welfare" means a parent, guardian, foster parent, or a licensed administrator or employee of a public or private residential home, residential school, or other residential institution; (3) Any person who depicts a child in, or who knowingly develops, duplicates, prints, or exchanges, any film, photograph, video tape, negative, or slide in which a child is engaged in an act of obscene sexual conduct, except for those activities by law enforcement and prosecution agencies and other persons described in subdivisions (c) and (e) of Section 311.3.

Evaluation of sexual abuse

The California protocols for the examination of child sexual abuse describe methods for a coordinated approach to patient care. Many communities have developed specialized forensic medical examination teams that include highly trained medical examiners who are available to provide prompt and coordinated medical exams. In addition to a coordinated approach to performing a medical exam, many communities also are coordinating the specialized forensic work that typically is performed by law enforcement officers, investigative social workers, and deputy district attorneys. The aim of this coordinated specialized forensic work is to gain the forensic information in a developmentally appropriate way, conduct the interviews in a child-friendly setting, and to avoid unnecessary multiple interviews of the child.

Medical providers who perform the sexual abuse medical exams for children and adolescents are trained in developmentally and psychologically appropriate care. This includes having knowledge of how a child's exposure to sexual abuse may affect behavioral and psychological reactions and how to provide the medical exam with a supportive approach. If there are signs of emotional trauma, the physician may make referrals for mental health services.

When a child presents as a victim of child sexual abuse, the medical provider first responds to any acute and trauma care needs. Only after the assessment and treatment of the acute conditions should the provider perform the forensic medical exam. When there are no signs of acute conditions, the medical examination should begin immediately at the time of entry to the clinical setting.

A patient history is taken and information is recorded on the time of the incident, evidence of physical surrounding on the child (e.g., grass, sand), and any report of the identity of the alleged perpetrators. The sexual acts, as reported by the adult and the child, are recorded separately. If there are reports of contact, oral copulation, or fondling of the genitals or anus, the medical provider assesses whether there was penetration or attempted penetration, and whether there was associated pain or bleeding. Acts of nongenital fondling, licking, kissing, suction injury, and biting and other acts should be recorded. The provider also records any reports of force, threats,

weapons, picture/videotapes, drugs, alcohol, loss of memory, vomiting after the act, and behavioral changes in the child.

Following the description of acts by the adult and the child, a medical history is taken that assesses pre-existing physical abuse, neglect, and sexual abuse, intercourse history (adolescents only), and the date of last menstrual period. If the child has performed hygienic activities (e.g., shower, brush teeth) is also noted.

The medical provider then performs a general physical exam and a genital exam. The general physical exam begins with an assessment of vital signs, the general physical appearance, demeanor, and the condition of clothing of the child. All findings from the physical exam, including a rectal exam, are recorded and assessed. Any injuries and findings are documented and photographed. The following materials may be collected as evidence that will be submitted to the crime laboratory: child's clothing, dried or moist secretion, foreign materials, fingernail scraping from under the fingernails, and sample of head hair.

For females, the genital exam requires an examination of the inner thighs, external genitalia, and perineal area. The following materials may be collected as evidence that will be submitted to the crime laboratory: dried or moist secretions, foreign materials, vaginal swabs, and a sample of pubic hair. Testing for sexually transmitted diseases and pregnancy may be ordered. The male genital exam includes an examination of the inner thighs, external genitalia, and perineal area; recording whether circumcised or not; collection of dried or moist secretion, foreign materials, penile and scrotal swabs, and a sample of pubic hair.

If the incident of sexual abuse occurred greater than 72 hours ago, the medical professional should consider whether the quality of evidence has deteriorated or been lost in the case of bathing or washing of clothes. In such cases a modified evidentiary exam may be conducted due to lack of evidence.

The methods for the collection and preservation of the evidence of sexual abuse are described in detail in the sexual abuse protocol.

After performing the medical and genital exams, the provider completes the appropriate form: *Medical Report: Acute (<72 hours) Child/Adolescent Sexual Abuse Examination* or *Medical Report: Acute (>72 hours) Child/Adolescent Sexual Abuse Examination*. The provider records the name of the persons to whom the evidence is distributed and obtains the signature of the officer receiving the evidence.

BENEFIT COVERAGE, UTILIZATION, AND COST IMPACTS OF THE MANDATE TO COVER FORENSIC MEDICAL EVALUATIONS

AB 652 would require DMHC-regulated plans and CDI-regulated policies, including MRMIB programs, CalPERS HMOs, and Medi-Cal Managed Care Plans, to provide reimbursement for forensic medical evaluations performed by a qualified medical professional at the request of a local child welfare agency or law enforcement. According to CHBRP's estimates, there are 21.9 million enrollees in California with health insurance subject to AB 652 (Table 1). The detailed provisions of AB 652 are described in the *Introduction*.

This section will present, first, the current (baseline) benefit coverage, utilization, and costs related to forensic medical evaluations, and then provide estimates of the impacts on coverage, utilization, and cost if AB 652 is enacted. For further details on the underlying data sources and methods, please see Appendix C at the end of this document.

Current (Baseline) Benefit Coverage, Utilization and Cost

Current Coverage of the Mandated Benefit

Approximately 21.9 million individuals in California are enrolled in health plans or policies that would be subject to the mandate; this includes approximately 7.5 million children aged 0 through 17 years. Although AB 652 does not specify an age group for the forensic medical evaluation coverage, CHBRP chose to focus only on the child population for the cost impact analysis because the bill defines a forensic medical evaluation as "an examination performed by a qualified medical professional at the request of a local child welfare agency or local law enforcement agency pursuant to Section 324.5 of the Welfare and Institutions Code." By definition, these services are for children aged 0 through 17 who are suspected victims of child abuse.

CHBRP conducts a Bill-Specific Coverage Survey of California's largest health plans and insurers. Responses to this survey represent approximately 72% of the CDI-regulated and 85% of privately funded, DMHC-regulated market. Combined, responses to this survey represent 82% of enrollees in the privately funded market subject to state mandates.

Current coverage for forensic medical evaluations was determined by a survey of the seven largest providers of health insurance in California. On the basis of the responses of four health plans and insurers, currently 13.5% of enrollees (3.0 million) have coverage for forensic medical evaluations. . CalPERS HMO, Medi-Cal Managed Care, and MRMIB plans (including Healthy Families) all indicated that they do not provide coverage for forensic medical evaluations.

Current Utilization Levels

According to the Center for Social Services Research Child Welfare Dynamic Report System at UC Berkeley, in 2009, the most recent year that data is available, there were 133,169 child abuse allegations (including physical and sexual abuse) in California (Needell et al., 2011). However,

there is no statewide data available on the number of forensic medical evaluations performed each year. In order to get an estimate of current utilization levels, CHBRP spoke with seven of the largest counties in California, representing 60.7% of the California population. Based on the responses, CHBRP found the proportion of allegations resulting in forensic medical evaluations to be 4% for physical abuse and 20% for sexual abuse, or 9.1% overall. One study on sexual abuse victims and forensic medical examinations from 2007 noted that 10 to 25% of children with reported sexual abuse received forensic medical examinations, supporting CHBRP's findings (Walsh et al., 2007). Applying this percentage to the number of allegations among individuals affected by the mandate, CHBRP estimated that 9,068 forensic medical evaluations would be performed within a year. Of these, 976 individuals receiving evaluations are already covered by health insurance and 8,093 individuals do not have coverage.

Per-Unit Cost

The cost per forensic medical evaluation is estimated at \$735. This estimate is a weighted average of the cost of physical (\$350) and sexual (\$900) abuse evaluations based on data and interviews with experts in the field in California (see Appendix B for the list of experts and Appendix C for cost analysis methods). An analysis of the literature generally supports this estimate. For example, in New York, the rate paid providers for forensic medical examinations, including the forensic examiner service, facility services related to the forensic medical examination, and related labs and pharmaceuticals, does not exceed \$800 (New York State Office of Victim Service, 2011). In 2009 in North Dakota, providers were paid a flat fee for sexual assault examinations with colposcope of \$700 (North Dakota Attorney General, 2009).²⁸ Overall, the cost for children suspected of experiencing abuse or neglect ranges from \$600 to \$900 per evaluation (Kairys et al., 2006). AB 652 is not expected to affect the per-unit cost of forensic medical evaluations because this bill will not alter the California protocols and the required elements of a forensic medical exam.

The Extent to Which Costs Resulting from Lack of Coverage Are Shifted to Other Payors, Including Both Public and Private Entities

A lack of coverage for forensic medical evaluations may currently result in a shift of costs for these evaluations from health insurance plans and policies to local child welfare agencies and law enforcement. CHBRP estimated that 9,068 forensic medical evaluations occur annually, of which about 8,093 are not currently covered by insurance. This may indicate costs currently incurred by local law enforcement and child welfare agencies of an estimated \$5.95 million per year that may be shifted to health plans and policies postmandate; however, this is highly dependent on a variety of administrative implementation factors, such as tracking health insurance source information of children undergoing forensic medical evaluations, coding for the various services provided under forensic medical evaluations, and local child welfare and law enforcement billing practices.

²⁸ Colposcopy, or examinations using a colposcope, is a medical procedure to examine an illuminated, magnified view of the cervix and the tissues of the vagina and vulva.

Current (Baseline) Premiums and Expenditures

Table 5 (at the end of this section) summarizes per member per month (PMPM) premiums and expenditures for DMHC- and CDI-regulated plans and policies prior to the mandate. Prior to the mandate, total expenditures PMPM for DMHC-regulated plans are \$422.34 for the large group market, \$383.22 for the small group, and \$484.48 for the individual market. The total expenditures PMPM for CDI-regulated policies are \$560.68 for the large group market, \$457.57 for the small group, and \$257.68 for the individual market. Total expenditures, PMPM for CalPERS HMO are estimated at \$456.86; for MRMIB plans: \$117.02; and for Medi-Cal Managed Care Plans, Under age 65: \$176.04. The final column in Table 5 gives the total annual premiums and expenditures for all DMHC-regulated plans and CDI regulated policies.

Public demand for coverage

Considering the criteria specified by CHBRP's authorizing statute, CHBRP reviews public demand for benefits relevant to a proposed mandate in two ways. CHBRP considers the bargaining history of organized labor and compares the benefits provided by self-insured health plans or policies (which are not regulated by the DMHC or CDI and so not subject to state-level mandates) with the benefits that are provided by plans or policies that would be subject to the mandate. On the basis of conversations with the largest collective bargaining agents in California, and publicly funded self-insured health insurance policies, forensic medical evaluations are generally not covered. In this case, however, these proxies to judge public demand may not be appropriate, given that forensic medical evaluations are not typical health insurance benefits but rather a service provided to investigate child abuse allegations by local law enforcement and child welfare services.

Impacts of Mandated Benefit Coverage

How Would Changes in Benefit Coverage Related to the Mandate Affect the Availability of the Newly Covered Treatment/Service, the Health Benefit of the Newly Covered Treatment/Service, and the Per-Unit Cost?

Impact on access and health treatment/service availability

Forensic medical evaluations are to be performed by medical providers who have special training in developmentally and psychologically appropriate care for children and adolescents. This includes having knowledge of how a child's exposure to abuse may affect behavioral and psychological reactions and how to provide the medical exam with a supportive approach. As discussed in this section, it is possible that there may be an increase in the use of forensic medical evaluations and thus, demand for these providers' services may increase. There is no available data on the number and availability of these specially trained providers and there is no data to verify any potential increase in use of forensic medical exams. Therefore, the impact of AB 652 on access or availability of services is unknown.

Impact on the health benefit of the newly covered treatment/service

Currently, forensic medical evaluations are administered by medical personnel at the request of local child welfare agencies or law enforcement for child victims of physical and sexual abuse, and paid for out of law enforcement budgets and/or child welfare agency budgets. As discussed,

the reason for requesting a forensic medical evaluation is to determine whether there has been child abuse or neglect. There is some anecdotal evidence that budget constraints on law enforcement or local child welfare agencies may have a small affect on the number of forensic medical evaluations requested. CHBRP has no data and no literature to support such a claim. Therefore, CHBRP was not able to quantify any dampening effect of budget constraints on the number of forensic medical evaluations performed. To the extent that law enforcement budget or local child welfare agencies constraints are currently limiting the number of forensic medical evaluations performed, passage of AB 652 may increase the total number of evaluations. Because this effect is likely to be small and is not quantifiable, CHBRP assumed that all children in need of a forensic medical evaluation are currently receiving one.

Impact on per-unit cost

As there is no evidence in the literature that increasing coverage for forensic medical evaluations increases the prices of those evaluations, CHBRP assumes that the unit cost of forensic medical evaluations would stay the same after the mandate. However, it is important to note that there is variation among California counties in terms of level of reimbursement rates of forensic medical evaluations and how these rates are established. For example, in some counties providers may negotiate directly with law enforcement, local child welfare agencies, or both to establish reimbursement rates; these rates are therefore subject to change based on regular negotiations. It is possible that health plans would elect not to reimburse at the same levels and opt to reimburse per procedure or to reimburse per procedure up to a set amount. Furthermore, the mandate may require health plans and policies to cover procedures not typically covered, such as forensic photographs and the collection of evidence kits for sexual abuse. Doing so may alter the average per-unit cost of forensic medical evaluations, but CHBRP has no way of determining what the change would be. Additionally, AB 652 does state that payments made to providers must be the same as or greater than Medi-Cal reimbursement rates for forensic medical evaluations when rendered by the same provider to a Medi-Cal beneficiary on a fee-for-service basis. However, this requirement would not impact the per-unit cost of forensic medical evaluations because Medi-Cal does not currently reimburse for forensic medical evaluations.

How Would Utilization Change As a Result of the Mandate?

AB 652 could result in a shift of payment for forensic medical evaluations from law enforcement organizations and child welfare agencies to health insurance plans and policies. The change in payment is not estimated to alter the number of forensic medical evaluations given each year to children who are suspected victims of child abuse in California. While there is some anecdotal evidence that current budget constraints may be limiting the number of evaluations performed each year, CHBRP has no data or literature to support such a claim and therefore CHBRP assumes there will be no change in utilization as a result of the mandate.

To What Extent Would the Mandate Affect Administrative and Other Expenses?

CHBRP assumes that if health care costs increase as a result of increased utilization or changes in unit cost, there is a corresponding proportional increase in administrative costs. CHBRP assumes that the administrative cost proportion of premiums is unchanged. All health plans and insurers include a component for administration and profit in their premiums. CHBRP estimates

that the increase in administrative costs of DMHC-regulated plans and CDI-regulated group policies would remain proportional to the increase in premiums.

AB 652 may result in some administrative changes; however, CHBRP is unable to quantify any associated administrative costs. Possible changes could be associated with building processes to reimburse for forensic medical evaluations, including, but not limited to, developing a definition for what is included in the evaluations (e.g., evidence kits) and determining who to reimburse (e.g., providers contracted by law enforcement).

Impact of the Mandate on Total Health Care Costs

Changes in total expenditures

AB 652 would increase total net annual expenditures by \$911,000 or 0.0010% (see Table 1 in *Executive Summary*). For the affected market segments, the impact of AB 652 on changes in total expenditures ranges from 0.0003% to 0.0081% (Table 6).

Potential cost offsets or savings in the short-term

In some cases, an increase in cost due to an expansion in benefit coverage is accompanied by a decrease in the cost for other health care services, known as a “cost offset.” There is not sufficiently strong evidence to support health cost savings within the one-year time frame of this cost analysis. Therefore, CHBRP does not estimate a cost offset in the first year following implementation.

Impact on long-term costs

CHBRP estimates no measurable long-term impacts of the mandate in addition to the one-year impacts presented early in this section.

Impacts for Each Category of Payor Resulting from the Benefit Mandate

Changes in expenditures and PMPM amounts by payor category

Table 1 in the Executive Summary provides a summary of the impact of the mandate on premiums paid by private and public employers and employees in the first year after implementation of the mandate. Among enrollees in all plans and policies subject to state regulation, AB 652 is estimated to increase premiums by about \$6.86 million and total net expenditures by \$911,000. Note that the total population in Table 1 reflects the full 21.9 million enrollees in DMHC- or CDI-regulated plans or policies that are included in the mandate under AB 652. The premium increases are estimated to be spread among all enrollees in all plans or policies, even though the forensic medical evaluations are assumed to be provided to enrolled children aged 0 through 17 years.

- The total premium contributions from private employers who purchase group insurance are estimated to increase by \$2.50 million, or 0.0047%.

- Enrollee contributions toward premiums for those in privately funded group insurance subject to the bill are estimated to increase by \$817,000, or 0.0054%.
- Total employer premium contributions for CalPERS HMOs are estimated to increase by \$177,000, or 0.0051%.
- The total premiums for enrollees who purchase their own DMHC-regulated plan contracts or CDI-regulated policies would increase by about \$464,000, or 0.0069%.
- Expenditures for MRMIB plans are estimated to increase by \$737,000, or 0.0701%.
- Expenditures for Medi-Cal Managed Care plans are estimated to increase by \$2.17 million or 0.0250%.

Table 6 in this section shows the projected impact of AB 652 on PMPM total premiums (including both employer and individual shares) by market segment and is as follows:

- \$0.02 (0.0047%) for the DMHC-regulated large-group market.
- \$0.02 (0.0058%) for the DMHC-regulated small-group market.
- \$0.02 (0.0047%) for the DMHC-regulated individual market.
- \$0.02 (0.0051%) for CalPERS HMO.
- \$0.05 (0.0290%) for Medi-Cal Managed Care, Under age 65 plans.
- \$0.00 (0.0000%) for Medi-Cal Managed Care, age 65 and over (not affected by the mandate).
- \$0.08 (0.0701%) for MRMIB plans.
- \$0.01 (0.0022%) for the CDI-regulated large-group market.
- \$0.01 (0.0043%) for the CDI-regulated small-group market.
- \$0.02 (0.0093%) for the CDI-regulated individual market.

Impacts on the Uninsured and Public Programs As a Result of the Cost Impacts of the Mandate

Changes in the number of uninsured persons as a result of premium increases

CHBRP estimates premium increases of less than 1% for each market segment. CHBRP does not anticipate loss of health insurance, changes in availability of the benefit beyond those subject to the mandate, changes in offer rates of health insurance, changes in employer contribution rates, changes in take-up of health insurance by employees, or purchase of individual market policies, due to the small size of the increase in premiums after the mandate. This premium increase would not have a measurable impact on number of persons who are uninsured.

Impact on public programs as a result of premium increases

Because there would be no increase in premiums that result in a drop in insurance coverage, CHBRP estimates that the mandate would produce no measurable impact on enrollment in publicly funded insurance programs in the publicly funded insurance market.

Table 5. Baseline (Premandate) Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2011

	DMHC-Regulated							CDI-Regulated			Total
	Privately Funded Plans (by market)			CalPERS HMOs (b)	Medi-Cal Managed Care Plans		MRMIB Plans (d)	Privately Funded Policies (by market)			
	Large Group	Small Group	Individual		65 and Over (c)	Under 65		Large Group	Small Group	Individual	
Total enrollees in plans/policies subject to state Mandates (a)	10,526,000	2,241,000	733,000	831,000	285,000	3,539,000	889,000	397,000	1,118,000	1,343,000	21,902,000
Total enrollees in plans/policies subject to AB 652	10,526,000	2,241,000	733,000	831,000	285,000	3,539,000	889,000	397,000	1,118,000	1,343,000	21,902,000
Average portion of premium paid by Employer	\$317.59	\$267.09	\$0.00	\$347.55	\$346.00	\$176.00	\$98.48	\$375.44	\$270.30	\$0.00	\$65,887,370,000
Average portion of premium paid by Employee	\$82.91	\$83.47	\$399.69	\$86.89	\$0.00	\$0.00	\$13.79	\$122.08	\$64.15	\$199.13	\$21,898,323,000
Total Premium	\$400.51	\$350.57	\$399.69	\$434.44	\$346.00	\$176.00	\$112.27	\$497.52	\$334.45	\$199.13	\$87,785,693,000
Enrollee expenses for covered benefits (Deductibles, copays, etc.)	\$21.82	\$32.63	\$84.77	\$22.41	\$0.00	\$0.00	\$4.68	\$63.15	\$123.11	\$58.53	\$7,548,415,000
Enrollee expenses for benefits not covered (e)	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0
Expenses incurred by County (f)	\$0.02	\$0.02	\$0.01	\$0.02	\$0.00	\$0.04	\$0.07	\$0.01	\$0.01	\$0.01	\$5,946,000
Total Expenditures	\$422.34	\$383.22	\$484.48	\$456.86	\$346.00	\$176.04	\$117.02	\$560.68	\$457.57	\$257.68	\$95,334,108,000

Source: California Health Benefits Review Program, 2011.

Notes: (a) This population includes persons insured with private funds (group and individual) and insured with public funds (e.g., CalPERS HMOs, Medi-Cal Managed Care Plans, Healthy Families Program, AIM, MRMIP) enrolled in health plans or policies regulated by the DMHC or CDI. Population includes enrollees aged 0 to 64 years and enrollees 65 years or older covered by employment-sponsored insurance.

(b) Of these CalPERS HMO members, about 58% or 482,000 are state employees or their dependents.

(c) Medi-Cal Managed Care Plan expenditures for members over 65 years of age include those who also have Medicare coverage.

(d) MRMIB Plan expenditures include expenditures for 874,000 enrollees of the Healthy Families Program, 8,000 enrollees of MRMIP, and 7,000 enrollees of the AIM program.

(e) Includes only those expenses that are paid directly by enrollees to providers for services related to the mandated benefit that are not currently covered by insurance. This only includes those expenses that will be newly covered, postmandate. Other components of expenditures in this table include all health care services covered by insurance.

(f) Includes only expenses relating to forensic medical evaluations that are currently paid by the requesting party, typically either a law enforcement agency or Child Welfare Services.

Table 6. Impacts of the Mandate on Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2011

	DMHC-Regulated						CDI-Regulated			Total	
	Privately Funded Plans (by market)			CalPERS HMOs (b)	Medi-Cal Managed Care Plans		MRMIB Plans (d)	Privately Funded Policies (by market)			
	Large Group	Small Group	Individual		65 and Over (c)	Under 65		Large Group	Small Group		Individual
Total enrollees in plans/policies subject to state Mandates (a)	10,526,000	2,241,000	733,000	831,000	285,000	3,539,000	889,000	397,000	1,118,000	1,343,000	21,902,000
Total enrollees in plans/policies subject to AB 652	10,526,000	2,241,000	733,000	831,000	285,000	3,539,000	889,000	397,000	1,118,000	1,343,000	21,902,000
Average portion of premium paid by Employer	\$0.0149	\$0.0156	\$0.0000	\$0.0178	\$0.0000	\$0.0510	\$0.0691	\$0.0083	\$0.0117	\$0.0000	\$5,578,000
Average portion of premium paid by Employee	\$0.0039	\$0.0048	\$0.0187	\$0.0045	\$0.0000	\$0.0000	\$0.0097	\$0.0027	\$0.0027	\$0.0186	\$1,280,000
Total Premium	\$0.0188	\$0.0203	\$0.0187	\$0.0223	\$0.0000	\$0.0510	\$0.0787	\$0.0110	\$0.0144	\$0.0186	\$6,858,000
Enrollee expenses for covered benefits (Deductibles, copays, etc.)	\$0.0000	\$0.0000	\$0.0000	\$0.0000	\$0.0000	\$0.0000	\$0.0000	\$0.0000	\$0.0000	\$0.0000	\$0
Enrollee expenses for benefits not covered (e)	\$0.0000	\$0.0000	\$0.0000	\$0.0000	\$0.0000	\$0.0000	\$0.0000	\$0.0000	\$0.0000	\$0.0000	\$0
Expenses incurred by County (f)	\$0.0000	\$0.0000	\$0.0000	\$0.0000	\$0.0000	\$0.0000	\$0.0000	\$0.0000	\$0.0000	\$0.0000	\$0
Total Expenditures	\$0.0022	\$0.0039	\$0.0037	\$0.0033	\$0.0000	\$0.0061	\$0.0094	\$0.0016	\$0.0029	\$0.0037	\$912,000
Percentage Impact of Mandate											
Insured Premiums	0.0047%	0.0058%	0.0047%	0.0051%	0.0000%	0.0290%	0.0701%	0.0022%	0.0043%	0.0093%	0.0078%
Total Expenditures	0.0005%	0.0010%	0.0008%	0.0007%	0.0000%	0.0035%	0.0081%	0.0003%	0.0006%	0.0014%	0.0010%

Source: California Health Benefits Review Program, 2011.

Notes: (a) This population includes persons insured with private funds (group and individual) and insured with public funds (e.g., CalPERS HMOs, Medi-Cal Managed Care Plans, Healthy Families Program, AIM, MRMIP) enrolled in health plans or policies regulated by the DMHC or CDI. This population includes enrollees aged 0 to 64 years and enrollees 65 years or older covered by employment-sponsored insurance.

(b) Of these CalPERS members, about 58% or 482,000 are state employees or their dependents.

(c) Medi-Cal Managed Care Plan expenditures for members over 65 years of age include those who also have Medicare coverage.

(d) MRMIB Plan expenditures include expenditures for 874,000 enrollees of the Healthy Families Program, 8,000 enrollees of MRMIP, and 7,000 enrollees of the AIM program.

(e) Includes only those expenses that are paid directly by enrollees to providers for services related to the mandated benefit that are not currently covered by insurance. This only includes those expenses that will be newly covered, postmandate. Other components of expenditures in this table include all health care services covered by insurance.

(f) Includes only expenses relating to forensic medical evaluations that are currently paid by the requesting party, typically either a law enforcement agency or Child Welfare Services.

PUBLIC HEALTH IMPACTS OF THE MANDATE TO COVER FORENSIC MEDICAL EVALUATIONS

Child maltreatment is a serious and widespread public health problem. Maltreatment is often defined by four categories: physical abuse, sexual abuse, emotional abuse, and neglect. According to the Child Health Bureau of the U.S. Health and Human Services Agency, in 2009 approximately 3.3 million child abuse referrals were made to child welfare agencies nationwide, with a total of approximately 702,000 children identified as victims of abuse. The majority (78.3%) were victims of neglect, 17.8% experienced physical abuse, 9.5% were victims of sexual abuse, and 7.6% experienced emotional abuse. Girls were more likely than boys to experience abuse (51% vs. 48%) and 87% of all victims were identified as African American (22.3%), Hispanic (20.7%) or White (44%). Approximately 1,770 children died in the United States in 2009 due to maltreatment (HHS, 2010b).

CHBRP estimates that approximately 12,098 forensic medical evaluations are conducted annually in California. Of these, approximately 9,068 (75%) are conducted for children enrolled in health plans and policies that would be subject to AB 652. Approximately 3,029 (25%) are conducted for children who are uninsured or are in plans or policies that are not subject to state-level mandates.

Public Health Impact Analysis

As presented in the *Medical Effectiveness* section, the primary purpose of the forensic medical evaluation is to gather and document evidence of abuse for the purposes of prosecution or child placement decisions. CHBRP found no evidence in the scientific literature relating to forensic medical evaluations as described in AB 652 and health outcomes. Therefore, the public health impact is unknown. Please note that the absence of evidence is not “evidence of no effect.” It is possible that an impact—positive or negative—could result. However, currently available scientific evidence does not allow CHBRP to project either.

As presented in the *Benefit Coverage, Utilization, and Cost Impacts* section, although AB 652 could impact utilization of forensic medical evaluations, CHBRP is unable to estimate any change in utilization. Therefore, the public health impact is unknown.

Impact on Gender and Racial Disparities

Several competing definitions of “health disparities” exist. CHBRP relies on the following definition: *A health disparity/inequality is a particular type of difference in health or in the most important influences of health that could potentially be shaped by policies; it is a difference in which disadvantaged social groups (such as the poor, racial/ethnic minorities, women or other groups that have persistently experienced social disadvantage or discrimination) systematically experience worse health or great health risks than more advantaged groups* (Braveman, 2006).

CHBRP investigated the effect that AB 652 would have on health disparities by gender, race, and ethnicity. While there are existing gender and racial/ethnic disparities in child abuse in

California, the extent to which AB 652 would have an impact on these disparities is unknown. CHBRP found no evidence to assess whether there are racial and ethnic disparities in the use of forensic medical examinations. Further, CHBRP estimates no change in utilization of forensic medical evaluations based on AB 652, therefore no impact on child abuse disparities is expected.

Long-term Public Health Impacts

As presented in the *Benefit Coverage, Utilization, and Cost Impacts* section, although AB 652 could impact utilization of forensic medical evaluations, CHBRP is unable to estimate any change in utilization or any short- or long-term public health impacts. However, it is important to note that shifting costs of forensic medical evaluations from public entities, such as law enforcement or child welfare agencies, to privately funded insurance, Medi-Cal Managed Care, and the Healthy Families program could have long-term impacts on funding and resources for county-level child welfare services and law enforcement. Local entities might respond to this cost shift by backfilling budget gaps or by increasing staff, providing additional services to children and families, creating new programs, or respond in other ways. Shifting costs to state public insurance programs like Medi-Cal Managed Care or Healthy Families may also have some long-term impacts. It is beyond the scope of CHBRP to determine what these responses might be or what the long-term impact might be of the potential cost shifts.

APPENDICES

Appendix A: Text of Bill Analyzed

On February 17, 2011, the Assembly Committee on Health requested that CHBRP analyze AB 652.

Below is the bill language, as it was introduced on February 16, 2011.

California Legislature—2011–12 Regular Session

ASSEMBLY BILL No. 652

Introduced by Assembly Member Mitchell

February 16, 2011

An act to add Section 1367.17 to the Health and Safety Code, to add Section 12693.625 to the Insurance Code, and to add Section 14132.19 to the Welfare and Institutions Code, relating to child health.

Legislative Counsel's Digest

AB 652, as introduced, Mitchell. Child health.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act), provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law creates the Healthy Families Program, administered by the Managed Risk Medical Insurance Board, to arrange for the provision of health, dental, and vision benefits to eligible children pursuant to a federal program, the State Children's Health Insurance Program. Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions.

This bill would provide that an initial health assessment, as defined, and a forensic medical evaluation, as defined, shall be covered benefits under the Healthy Families Program, the Medi-Cal program, and under health care service plans licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1973, as prescribed. Because a willful violation of the bill's provisions relative to health care service plans would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement. This bill would provide that no reimbursement is required by this act

for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes.

State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 1367.17 is added to the Health and Safety Code, to read:

1367.17. (a) For the purposes of this section, the following definitions shall apply:

(1) "Initial health assessment" means a medical or dental examination, or both, performed on a child for whom a case plan must be prepared pursuant to Section 16501.1 of the Welfare and Institutions Code and who has been placed in an out-of-home placement within the last 30 days, and that is designed to determine the child's medical and dental status and further health care needs.

An initial health assessment shall meet, and may exceed, the guidelines established by the Child Health and Disability Prevention Program for well child exams and includes, but is not limited to, diagnostic testing to the extent necessary to provide a complete assessment.

(2) "Forensic medical evaluation" means an examination performed by a qualified medical professional at the request of a local child welfare agency or local law enforcement agency pursuant to Section 324.5 of the Welfare and Institutions Code. A forensic medical examination includes, but is not limited to, diagnostic testing to the extent necessary to provide a complete evaluation.

(b) An individual or group health care service plan contract issued, amended, or renewed on or after January 1, 2012, shall cover an initial health assessment or forensic medical evaluation provided for any child who is an enrollee at the time the assessment or evaluation is performed. Notwithstanding any other provision of law, prior authorization shall not be required for the provision of an initial health assessment or forensic medical evaluation pursuant to this section.

(c) In the event that a local child welfare agency elects to limit the health care providers that are eligible to receive payment pursuant to this section, the obligation to pay providers shall only apply to initial health assessments and forensic medical evaluations performed by providers designated by the local child welfare agency.

(d) Payments made to providers pursuant to this section shall be equal to the reasonable value of the service, which shall in no event be less than the amount the Medi-Cal program would pay for the same service when rendered by the same provider to a Medi-Cal beneficiary on a fee-for-service basis. A contract between

a provider and a plan obligated to make payment pursuant to this section may provide for a different amount as long as the amount is not less than the amount the Medi-Cal program would pay for the same service when rendered by the same provider to a Medi-Cal beneficiary on a fee-for-service basis.

(e) The obligation to pay a provider pursuant to this section exists irrespective of whether the provider has a contract with the plan obligated to make the payment and irrespective of whether the provider is part of the plan's network.

(f) A court, local law enforcement agency, or local child welfare agency may consider or rely on a report by any qualified medical professional regarding the health care status, needs, or findings of a forensic medical evaluation concerning a child examined or evaluated by the qualified medical professional, irrespective of whether the medical professional may receive payment under this section.

SEC. 2. Section 12693.625 is added to the Insurance Code, to read:

12693.625. (a) For the purposes of this section, the following definitions shall apply:

(1) "Initial health assessment" means a medical or dental examination, or both, performed on a child for whom a case plan must be prepared pursuant to Section 16501.1 of the Welfare and Institutions Code and who has been placed in an out-of-home placement within the last 30 days, and that is designed to determine the child's medical and dental status and further health care needs. An initial health assessment shall meet, and may exceed, the guidelines established by the Child Health and Disability Prevention Program for well child exams and includes, but is not limited to, diagnostic testing to the extent necessary to provide a complete assessment.

(2) "Forensic medical evaluation" means an examination performed by a qualified medical professional at the request of a local child welfare agency or local law enforcement agency pursuant to Section 324.5 of the Welfare and Institutions Code. A forensic medical examination includes, but is not limited to, diagnostic testing to the extent necessary to provide a complete evaluation.

(b) Coverage provided to subscribers under this part shall include an initial health assessment or forensic medical evaluation provided for any child who is a subscriber at the time the assessment or evaluation is performed. Notwithstanding any other provision of law, prior authorization shall not be required for the provision of an initial health assessment or forensic medical evaluation pursuant to this section.

(c) In the event that a local child welfare agency elects to limit

the health care providers that are eligible to receive payment pursuant to this section, the obligation to pay providers shall only apply to initial health assessments and forensic medical evaluations performed by providers designated by the local child welfare agency.

(d) Payments made to providers pursuant to this section shall be equal to the reasonable value of the service, which shall in no event be less than the amount the Medi-Cal program would pay for the same service when rendered by the same provider to a Medi-Cal beneficiary on a fee-for-service basis. A contract between a provider and a plan obligated to make payment pursuant to this section may provide for a different amount as long as the amount is not less than the amount the Medi-Cal program would pay for the same service when rendered by the same provider to a Medi-Cal beneficiary on a fee-for-service basis.

(e) The obligation to pay a provider pursuant to this section exists irrespective of whether the provider has a contract with the plan obligated to make the payment and irrespective of whether the provider is part of the plan's network.

(f) A court, local law enforcement agency, or local child welfare agency may consider or rely on a report by any qualified medical professional regarding the health care status, needs, or findings of a forensic medical evaluation concerning a child examined or evaluated by the qualified medical professional, irrespective of whether the medical professional may receive payment under this section.

SEC. 3. Section 14132.19 is added to the Welfare and Institutions Code, to read:

14132.19. (a) For the purposes of this section, the following definitions shall apply:

(1) "Initial health assessment" means a medical or dental examination, or both, performed on a child for whom a case plan must be prepared pursuant to Section 16501.1 and who has been placed in an out-of-home placement within the last 30 days, and that is designed to determine the child's medical and dental status and further health care needs. An initial health assessment shall meet, and may exceed, the guidelines established by the Child Health and Disability Prevention Program for well child exams and includes, but is not limited to, diagnostic testing to the extent necessary to provide a complete assessment.

(2) "Forensic medical evaluation" means an examination performed by a qualified medical professional at the request of a local child welfare agency or local law enforcement agency pursuant to Section 324.5. A forensic medical examination includes, but is not limited to, diagnostic testing to the extent necessary to provide a complete evaluation.

(b) To the extent permitted by federal law, an initial health assessment or forensic medical evaluation provided by a Medi-Cal provider, including a provider under a Medi-Cal managed care plan, as defined in Section 14093.07, shall be a covered benefit under this chapter for any child who is a Medi-Cal beneficiary at the time the assessment or evaluation is performed.

Notwithstanding any other provision of law, prior authorization shall not be required for the provision of an initial health assessment or forensic medical evaluation pursuant to this section.

(c) In the event that a local child welfare agency elects to limit health care providers that are eligible to receive reimbursement under this section, the obligation to reimburse providers shall only apply to initial health assessments and forensic medical evaluations performed by providers designated by the local child welfare agency.

(d) Reimbursement paid to providers pursuant to this section shall be equal to the reasonable value of the service, which shall in no event be less than the amount the Medi-Cal program would pay for the same service when rendered by the same provider to a Medi-Cal beneficiary on a fee-for-service basis. A contract between a provider and a plan obligated to reimburse the provider pursuant to this section may provide for a different amount as long as the amount is not less than amount the Medi-Cal program would pay for the same service when rendered by the same provider to a Medi-Cal beneficiary on a fee-for-service basis.

(e) If applicable, the obligation to reimburse a provider pursuant to this section exists irrespective of whether the provider has a contract with the plan obligated to make the payment and irrespective of whether the provider is part of the plan's network.

(f) A court, local law enforcement agency, or local child welfare agency may consider or rely on a report by any qualified medical professional regarding the health care status, needs, or findings of a forensic medical evaluation concerning a child examined or evaluated by the qualified medical professional, irrespective of whether the medical professional may receive payment under this section.

SEC. 4. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

Appendix B: Literature Review Methods& Research Methods

Appendix B describes methods used in the medical effectiveness literature review for AB 652. The appendix also lists expert input used to inform the cost and public health impact analyses.

The search was conducted to retrieve literature on two topics: (1) the effectiveness of services covered in the Initial Health Assessment; (2) the methods for performing a forensic examination.

The literature of the effectiveness of initial health assessment services among general pediatric populations is obtained from U.S. Preventive Services Task Force (USPSTF) recommendations, Centers for Disease Control (CDC) recommendations, National Institutes of Health (NIH) guidelines, and other authoritative sources. The literature on the summary of methods for performing a forensic medical examination derives from the following reports: California Medical Protocol for Examination of Child Physical Abuse and Neglect Victims, and California Medical Protocol for Examination of Sexual Assault and Child Sexual Abuse Victims.

A total of seven studies or reports were included in the medical effectiveness review for AB 652.

In making a “call” for each outcome measure, the team and the content expert consider the number of studies as well the strength of the evidence. To grade the evidence for each outcome measured, the team uses a grading system that has the following categories:

- research design,
- statistical significance,
- direction of effect,
- size of effect, and
- generalizability of findings.

The grading system also contains an overall conclusion that encompasses findings in these five domains. The conclusion is a statement that captures the strength and consistency of the evidence of an intervention’s effect on an outcome. The following terms are used to characterize the body of evidence regarding an outcome:

- clear and convincing evidence,
- preponderance of evidence,
- ambiguous/conflicting evidence, and
- insufficient evidence.

The conclusion states that there is “clear and convincing” evidence that an intervention has a favorable effect on an outcome if most of the studies included in a review have strong research designs and report statistically significant and clinically meaningful findings that favor the intervention.

The conclusion characterizes the evidence as “preponderance of evidence” that an intervention has a favorable effect if most, but not all five, criteria are met. For example, for some interventions, the only evidence available is from nonrandomized studies. If most such studies that assess an outcome have statistically and clinically significant findings that are in a favorable

direction and enroll populations similar to those covered by a mandate, the evidence would be classified as a “preponderance of evidence favoring the intervention.” In some cases, the preponderance of evidence may indicate that an intervention has no effect or an unfavorable effect.

The evidence is presented as “ambiguous/conflicting” if their findings vary widely with regard to the direction, statistical significance, and clinical significance/size of the effect.

The category “insufficient evidence” of an intervention’s effect indicates that available evidence is not sufficient to determine whether or not a health care service is effective. It is used when no research studies have been completed or when only a small number of poorly designed studies are available. It is not the same as “evidence of no effect.” A health care service for which there is insufficient evidence might or might not be found to be effective if more evidence were available.

ME Search Terms for AB 652

abuse
TI abuse
adolescen*
adolescent
TS=adolescen*
adolescents
assessment*
"battered child syndrome"
DE="battered child syndrome"
child
child*
TS=child*
"child abuse"
allintitle:"child abuse"
intitle:"child abuse"
intitle:"child abuse"
DE="child abuse"
"intitle:"child abuse"
Topic=(child abuse)
child* abuse
child* abuse:ti,ab,kw
"Child Health"
child sexual abuse assess*
children
evaluat*
AB evaluat*
evaluation[ti]
evaluations[ti]
TS=evaluation*
evidentiary

AB evidentiary
TS=evidentiary
evidentiary examination*
evidentiary examination*:ti,ab,kw
exam*
AB exam*
KW exam*
SU exam*
TS=examination
exams
"Extended Evaluation"
"Extended Evaluations"
"Extended Forensic Evaluation"
"Extended Forensic Evaluations"
forensic
AB forensic
forensic[ti]
TI=forensic
TS=forensic
"forensic evaluation"
DE="forensic evaluation"
forensic interview*
"forensic interviews"
forensic medical exam*
"forensic medical examination":ti,ab,kw
forensic medical examination*
"forensic medical examination"
"forensic medical examination*"
Topic=(forensic medical examination*)
"forensic medical examinations"
"forensic medical examinations":ti,ab,kw
infant
infants
Journal of child sexual abuse[Jour]
DE="medical diagnosis"
"medical evidentiary evaluation"
medical exam*
medical exam*:ti,ab,kw
"Physical Abuse Exam"
"Physical Abuse Examination"
"Physical Abuse Screening Exam"
"Physical Abuse Screening Examination"
"Physical Abuse"[ti]
physical exam*
"psychiatric evaluation"
DE="psychiatric evaluation"

rape
TS=rape
"sex offenses"
sexual
sexual*
DE="sexual abuse"
TS=sexual abuse
"Sexual Abuse Medical Evaluation"
"Sexual Abuse Medical Evaluations"
"Sexual Abuse Medical Exam":ti,ab,kw
Sexual Abuse Medical Exam*:ti,ab,kw
"Sexual Abuse Medical Examination"
"Sexual Abuse Medical Examination":ti,ab,kw
"Sexual Abuse Medical Examinations"
"Sexual Abuse Medical Examinations":ti,ab,kw
"Sexual Abuse Medical Exams":ti,ab,kw
"Sexual Abuse Screening Examination"
"Sexual Abuse Screening Examinations"
"sexual abuse"
teen*
TS=teen*

Medical subject headings (MeSH) – PubMed, Cochrane Library

The Medical Subject Headings are designated as follows: [Mesh] – PubMed;MeSHdescriptor – Cochrane Library.

Unless otherwise designated, all MeSH terms include any narrower MeSH terms.

adolescent[MeSH]

child[MeSH]

"Child Abuse"[Mesh]

"Child Abuse/diagnosis"[Mesh]

MeSH descriptor Child Abuse explode all trees with qualifier: DI

"Forensic Psychiatry/methods"[Mesh]

infant[MeSH]

"Interview, Psychological"[Mesh]

"Interviews as Topic"[Mesh]

"Medical History Taking"[Mesh]

"Physical Examination"[Mesh]

"Sex Offenses"[Mesh]

"Sexually Transmitted Diseases/diagnosis"[Mesh]

"Wounds and Injuries/diagnosis"[Mesh]

Designated languages

English

English Only

English[lang]

Language: English

Language=English

Languages= ENGLISH

Designated locations

Location is LO=us

Countries/Territories= USA

County-level experts interviewed to help inform this analysis

CHBRP also relied on the expertise of county child welfare agency leaders to help identify the relevant practices at the county level associated with initial health assessments for foster children, and forensic medical evaluations for children who have suspected victims of abuse. These individuals include:

- Suzie Abdou, DHS, Government Relations & Policy, Los Angeles County
- Deanna Avey-Motikeit, Child Welfare Director, San Bernardino County
- Karen Bernstein, DHS, Director of Special Programs, Los Angeles County
- Laura Coulthard, Deputy Director of Child Protective Services, Sacramento County
- Sylvia Deporto, Assistant Director for Children Services, Riverside County
- Victoria Evers, Los Angeles County Chief Executive Office
- Howard Himes, Child Welfare Director, Fresno County
- Cathi Huerta, Director, Dept. of Social Services, Fresno County
- Jennifer Palmquist, Senior Social Services Supervisor, Orange County
- Gerardo Pinedo, Los Angeles County Department of Health Services (DHS), Director, Government Relations & Policy
- Donna Seitz, Legislative Advocate, Los Angeles County Board of Supervisors
- Cathy Senderling-McDonald, Deputy Executive Director, County Welfare Directors Association.
- Gary Taylor, Child Welfare Director, Orange County
- Cheri Todoroff, Department of Health Services, Planning and Program Oversight, Los Angeles County
- Debra Zanders-Willis, Director, Child Welfare Services, Riverside County

Appendix C: Cost Impact Analysis: Data Sources, Caveats, and Assumptions

This appendix describes data sources, as well as general and mandate-specific caveats and assumptions used in conducting the cost impact analysis. For additional information on the cost model and underlying methodology, please refer to the CHBRP Web site at http://www.chbrp.org/analysis_methodology/cost_impact_analysis.php.

The cost analysis in this report was prepared by the members of cost team, which consists of CHBRP task force members and contributors from the University of California, San Diego, and the University of California, Los Angeles, as well as the contracted actuarial firm, Milliman, Inc. (Milliman). Milliman provides data and analyses per the provisions of CHBRP's authorizing legislation.

Data Sources

In preparing cost estimates, the cost team relies on a variety of data sources as described below.

Health insurance

1. The latest (2009) California Health Interview Survey (CHIS), which is used to estimate health insurance for California's population and distribution by payor (i.e., employment-based, individually purchased, or publicly financed). The biennial CHIS is the largest state health survey conducted in the United States, collecting information from approximately 50,000 households. More information on CHIS is available at <http://www.chis.ucla.edu>.
2. The latest (2010) California Employer Health Benefits Survey is used to estimate:
 - Size of firm,
 - Percentage of firms that are purchased/underwritten (versus self-insured),
 - Premiums for health care service plans regulated by the Department of Managed Health Care (DMHC) (primarily health maintenance organizations [HMOs] and Point of Service Plans [POS]),
 - Premiums for health insurance policies regulated by the California Department of Insurance (CDI) (primarily preferred provider organizations [PPOs] and fee-for-service plans [FFS]), and
 - Premiums for high deductible health plans (HDHPs) for the California population with employment-based health insurance.
 - This annual survey is currently released by the California Health Care Foundation/National Opinion Research Center (CHCF/NORC) and is similar to the national employer survey released annually by the Kaiser Family Foundation and the Health Research and Educational Trust. Information on the CHCF/NORC data is available at: <http://www.chcf.org/publications/2010/12/california-employer-health-benefits-survey>.

3. Milliman data sources are relied on to estimate the premium impact of mandates. Milliman’s projections derive from the Milliman Health Cost Guidelines (HCGs). The HCGs are a health care pricing tool used by many of the major health plans in the United States. See <http://www.milliman.com/expertise/healthcare/products-tools/milliman-care-guidelines/index.php>. Most of the data sources underlying the HCGs are claims databases from commercial health insurance plans. The data are supplied by health insurance companies, Blues plans, HMOs, self-funded employers, and private data vendors. The data are mostly from loosely managed healthcare plans, generally those characterized as preferred provider plans or PPOs. The HCGs currently include claims drawn from plans covering 4.6 million members. In addition to the Milliman HCGs, CHBRP’s utilization and cost estimates draw on other data, including the following:
 - The MarketScan Database, which includes demographic information and claim detail data for approximately 13 million members of self-insured and insured group health plans.
 - An annual survey of HMO and PPO pricing and claim experience. The most recent survey (2010 Group Health Insurance Survey) contains data from seven major California health plans regarding their 2010 experience.
 - Ingenix MDR Charge Payment System, which includes information about professional fees paid for healthcare services, based upon approximately 800 million claims from commercial insurance companies, HMOs, and self-insured health plans.
 - These data are reviewed for applicability by an extended group of experts within Milliman but are not audited externally.
4. An annual survey by CHBRP of the seven largest providers of health insurance in California (Aetna, Anthem Blue Cross of California, Blue Shield of California, CIGNA, Health Net, Kaiser Foundation Health Plan, and PacifiCare) to obtain estimates of baseline enrollment by purchaser (i.e., large and small group and individual), type of plan (i.e., DMHC- or CDI-regulated), cost-sharing arrangements with enrollees, and average premiums. Enrollment in plans or policies offered by these seven firms represents an estimated 93.7% of the persons with health insurance subject to state mandates. This figure represents an estimated 94.4% of enrollees in full service (non-specialty) DMHC-regulated health plans and an estimated 90.1% of enrollees in full service (non-specialty) CDI-regulated policies.²⁹

²⁹CHBRP analysis of the share of enrollees included in CHBRP’s Bill-Specific Coverage Survey of the major carriers in the state is based on “CDI Licenses with HMSR Covered Lives Greater than 100,000” as part of the Accident and Health Covered Lives Data Call, December 31, 2009, by the California Department of Insurance, Statistical Analysis Division, data retrieved from the Department of Managed Health Care’s interactive Web site “Health Plan Financial Summary Report,” July-September 2010, and CHBRP’s Annual Enrollment and Premium Survey.

Publicly funded insurance subject to state benefit mandates

5. Premiums and enrollment in DMHC-regulated health plans and CDI-regulated policies by self-insured status and firm size are obtained annually from CalPERS for active state and local government public employees and their dependents who receive their benefits through CalPERS. Enrollment information is provided for DMHC-regulated health care service plans covering non-Medicare beneficiaries—about 74% of CalPERS total enrollment. CalPERS self-funded plans—approximately 26% of enrollment—are not subject to state mandates. In addition, CHBRP obtains information on current scope of benefits from evidence of coverage (EOCs) documents publicly available at <http://www.calpers.ca.gov>.
6. Enrollment in Medi-Cal Managed Care (beneficiaries enrolled in Two-Plan Model, Geographic Managed Care, and County Operated Health System plans) is estimated based on CHIS and data maintained by the Department of Health Care Services (DHCS). DHCS supplies CHBRP with the statewide average premiums negotiated for the Two-Plan Model, as well as generic contracts that summarize the current scope of benefits. CHBRP assesses enrollment information online at http://www.dhcs.ca.gov/dataandstats/statistics/Pages/RASS_General_Medi_Cal_Enrollment.aspx.
7. Enrollment data for other public programs—Healthy Families Program (HFP), Access for Infants and Mothers (AIM), and the Major Risk Medical Insurance Program (MRMIP)—are estimated based on CHIS and data maintained by the Managed Risk Medical Insurance Board (MRMIB). The basic minimum scope of benefits offered by participating health plans under these programs must comply with all requirements for DMHC-regulated health plans, and thus these plans are affected by state-level benefit mandates. CHBRP does not include enrollment in the Post-MRMIP Guaranteed-Issue Coverage Products as these persons are already included in the enrollment for individual market health insurance offered by DMHC-regulated plans or CDI-regulated insurers. Enrollment figures for AIM and MRMIP are included with enrollment for Medi-Cal in presentation of premium impacts. Enrollment information is obtained online at <http://www.mrmib.ca.gov/>. Average statewide premium information is provided to CHBRP by MRMIB staff.

General Caveats and Assumptions

The projected cost estimates are estimates of the costs that would result if a certain set of assumptions were exactly realized. Actual costs will differ from these estimates for a wide variety of reasons, including:

- Prevalence of mandated benefits before and after the mandate may be different from CHBRP assumptions.
- Utilization of mandated benefits (and, therefore, the services covered by the benefit) before and after the mandate may be different from CHBRP assumptions.
- Random fluctuations in the utilization and cost of health care services may occur.

Additional assumptions that underlie the cost estimates presented in this report are:

- Cost impacts are shown only for plans and policies subject to state benefit mandate laws.
- Cost impacts are only for the first year after enactment of the proposed mandate.
- Employers and employees will share proportionately (on a percentage basis) in premium rate increases resulting from the mandate. In other words, the distribution of premium paid by the subscriber (or employee) and the employer will be unaffected by the mandate.
- For state-sponsored programs for the uninsured, the state share will continue to be equal to the absolute dollar amount of funds dedicated to the program.
- When cost savings are estimated, they reflect savings realized for one year. Potential long-term cost savings or impacts are estimated if existing data and literature sources are available and provide adequate detail for estimating long-term impacts. For more information on CHBRP's criteria for estimating long-term impacts please see: www.chbrp.org/analysis_methodology/cost_impact_analysis.php.
- Several recent studies have examined the effect of private insurance premium increases on the number of uninsured (Chernew et al., 2005; Glied and Jack, 2003; Hadley, 2006). Chernew et al. (2005) estimate that a 10% increase in private premiums results in a 0.74 to 0.92 percentage point decrease in the number of insured, while Hadley (2006) and Glied and Jack (2003) estimate that a 10% increase in private premiums produces a 0.88 and 0.84 percentage point decrease in the number of insured, respectively. The price elasticity of demand for insurance can be calculated from these studies in the following way. First, take the average percentage point decrease in the number of insured reported in these studies in response to a 1% increase in premiums (about -0.088), divided by the average percentage of insured persons (about 80%), multiplied by 100%, i.e., ($\{-0.088/80\} \times 100 = -0.11$). This elasticity converts the *percentage point* decrease in the number of insured into a *percentage* decrease in the number of insured persons for every 1% increase in premiums. Because each of these studies reported results for the large-group, small-group, and individual insurance markets combined, CHBRP employs the simplifying assumption that the elasticity is the same across different types of markets. For more information on CHBRP's criteria for estimating impacts on the uninsured please see: http://www.chbrp.org/analysis_methodology/cost_impact_analysis.php.

There are other variables that may affect costs, but which CHBRP did not consider in the cost projections presented in this report. Such variables include, but are not limited to:

- Population shifts by type of health insurance: If a mandate increases health insurance costs, some employer groups and individuals may elect to drop their health insurance. Employers may also switch to self-funding to avoid having to comply with the mandate.
- Changes in benefit plans: To help offset the premium increase resulting from a mandate, subscribers/policyholders may elect to increase their overall plan deductibles or copayments. Such changes would have a direct impact on the distribution of costs between the health plan and policies and enrollees, and may also result in utilization reductions (i.e., high levels of patient cost sharing result in lower utilization of health care).

services). CHBRP did not include the effects of such potential benefit changes in its analysis.

- Adverse selection: Theoretically, individuals or employer groups who had previously foregone health insurance may now elect to enroll in a health plan or policy, postmandate, because they perceive that it is to their economic benefit to do so.
- Medical management: Health plans and insurers may react to the mandate by tightening medical management of the mandated benefit. This would tend to dampen the CHBRP cost estimates. The dampening would be more pronounced on the plan types that previously had the least effective medical management (i.e., PPO plans).
- Geographic and delivery systems variation: Variation in existing utilization and costs, and in the impact of the mandate, by geographic area and delivery system models: Even within the health insurance types CHBRP modeled (HMO—including HMO and point of service [POS] plans—and non-HMO—including PPO and fee for service [FFS] policies), there are likely variations in utilization and costs by type. Utilization also differs within California due to differences in the health status of the local population, provider practice patterns, and the level of managed care available in each community. The average cost per service would also vary due to different underlying cost levels experienced by providers throughout California and the market dynamic in negotiations between providers and health plans or insurers. Both the baseline costs prior to the mandate and the estimated cost impact of the mandate could vary within the state due to geographic and delivery system differences. For purposes of this analysis, however, CHBRP has estimated the impact on a statewide level.
- Compliance with the mandate: For estimating the postmandate coverage levels, CHBRP typically assumes that plans and policies subject to the mandate will be in compliance with the coverage requirements of the bill. Therefore, the typical postmandate coverage rates for populations subject to the mandate are assumed to be 100%.

Potential Effects of the Federal Affordable Care Act

As discussed in the *Introduction*, there are a number of the ACA provisions that have already gone into or will go into effect over the next three years. Some of these provisions affect the baseline or current enrollment, expenditures, and premiums. This subsection discusses adjustments made to the 2011 Cost and Coverage Model to account for the potential impacts of the ACA that have gone into effect by January 2011. It is important to emphasize that CHBRP's analysis of specific mandate bills typically address the marginal effects of the mandate bill—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 the *Benefit Coverage, Utilization, and Cost Impacts* section of this report.

CHBRP reviewed the ACA provisions and determined whether and how these provisions might affect:

1. The number of covered lives in California, and specifically the makeup of the population with health insurance subject to state mandates
2. Baseline premiums and expenditures for health insurance subject to state mandates, and

3. Benefits required to be covered in various health insurance plans subject to state mandates

There are still a number of provisions that have gone into effect for which data are not yet available. Where data allows, CHBRP has made adjustments to the 2011 Cost and Coverage model to reflect changes in enrollment and/or baseline premiums and these are discussed here.

Coverage for adult children

PPACA Section 2714, modified by HR 4872, Section 2301, requires coverage for adult children up to age 26 as dependants to primary subscribers on all individual and group policies, effective September 23, 2010. California's recently enacted law, SB 1088 (2010) implements this provision. This could potentially affect both premiums and enrollment in 2011. According to the California Health Interview Survey (CHIS) approximately 22% of Californians aged 19-25 (1,063,000) were estimated to be uninsured at some point in 2009. As a result of the ACA, many of these young adults will likely gain access to health insurance through a parent. This dynamic may diminish the number of uninsured and may also shift some young adults from the individually purchased health insurance market into the group market. The Departments of Treasury, Labor, and Health and Human Services estimate, for 2011, the number of young adults newly covered by his/her parent's plan would be about 0.78 to 2.12 million (using high and low take-up rate assumptions, respectively). Of these young adults, about 0.2 to 1.64 million would have previously been uninsured. The corresponding incremental cost impact to group insurance policies is estimated to be a premium increase of 0.5% to 1.2%. Based on the responses to the Annual Enrollment and Premium survey, there has been an increase of 1% to 1.5% in enrollment for the 19-25 year olds and the increase varies depending on whether the parents were enrolled in the large-group, small-group, or individual markets. Based on analysis of the estimates from the Departments of Treasury, Labor and Health and Human Services as well as CHIS 2009 data, approximately 25% of the increase in enrollment represents a shift from the individual market and approximately 75% were previously uninsured. CHBRP took these estimates into account and adjusted underlying population data since source data did not reflect the effects of this provision, because shift in populations were expected to be significant, and to account for potential lags in enrollment (e.g., due to awareness).

Minimum Medical Loss Ratio requirement

PPACA Section 2718 requires health plans offering health insurance in group and individual markets to report to the Secretary of Health and Human Services the amount of premium revenue spent on clinical services, activities to improve quality, and other non-claim costs. Beginning in 2011, large group plans that spend less than 85% of premium revenue and small-group/individual market plans that spend less than 80% of premium revenue on clinical services and quality must provide rebates to enrollees. According to the Interim Final Rule (45 CFR Part 158), "Issuers will provide rebates to enrollees when their spending for the benefit of policyholders on reimbursement for clinical services and quality improvement activities, in relation to the premiums charged, is less than the MLR standards established pursuant to the statute."³⁰ The requirement to report medical loss ratio is effective for the 2010 plan year, while

³⁰ Department of Health and Human Services, *Interim Final Rule: Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements Under the Patient Protection and Affordable Care Act*. 45 CFR Part 158. December 1, 2010.

the requirement to provide rebates is effective January 1, 2011. The MLR requirement, along with the rebate payment requirement, will affect premiums for 2011, but the effects are unknown and data are not yet available. There is potential for substantial impact on markets with higher administrative costs, including the small and individual group markets. Responses to CHBRP's Annual Enrollment and Premiums Survey indicate that carriers intend to be in compliance with these requirements. For those that may not be in compliance, the requirement to pay rebates is intended to align the MLR retrospectively. Therefore for modeling purposes, CHBRP has adjusted administrative and profit loads to reflect MLRs that would be in compliance with this provision.

Pre-Existing Condition Insurance Plan (PCIP)

PPACA Section 1101 establishes a temporary high-risk pool for individuals with pre-existing medical conditions, effective 90 days following enactment until January 1, 2014. In 2010, California enacted AB 1887 and SB 227, providing for the establishment of the California Pre-Existing Condition Insurance Plan (PCIP) to be administered by the Managed Risk Medical Insurance Board (MRMIB) and federally funded per Section 1101. MRMIB has projected average enrollment of 23,100 until the end of 2013, when the program will expire. As of December 2010, there were approximately 1,100 subscribers (MRMIB, 2010). The California PCIP is not subject to state benefit mandates,³¹ and therefore this change does not directly affect CHBRP's Cost and Coverage Model. CHBRP has revised its annual update of *Estimates of the Sources of Health Insurance in California*³² to reflect that a slight increase in the number of those who are insured under other public programs that are not subject to state level mandates.

Prohibition of pre-existing condition exclusion for children

PPACA Sections 1201 & 10103(e): Prohibits pre-existing condition exclusions for children. This provision was effective upon enactment). California's recently enacted law, AB 2244 (2010) implements this provision. AB 2244 also prohibits carriers that sell individual plans or policies from refusing to sell or renew policies to children with pre-existing conditions. Carriers that do not offer new plans for children are prohibited from offering for sale new individual plans in California for five years.³³ This provision could have had significant premium effects, especially for the DMHC- and CDI-regulated individual markets. The premium information is included in the responses to CHBRP's Annual Enrollment and Premium Survey. Thus the underlying data used in CHBRP annual model updates captured the effects of this provision.

Prohibition of lifetime limits and annual benefit limit changes

PPACA Section 2711 prohibits individual and group health plans from placing lifetime limits on the dollar value of coverage, effective September 23, 2010. Plans may only impose annual limits on coverage and these annual limits may be no less than \$750,000 for "essential health benefits." The minimum annual limit will increase to \$1.25 million on Sept. 23, 2011, and to \$2 million Sept. 23, 2012. Earlier in 2010, CHBRP conducted an analysis of SB 890, which sought to prohibit lifetime and annual limits for "basic health care services" covered by CDI-regulated policies. CHBRP's analysis indicated that DMHC-regulated plans were generally prohibited

³¹ Correspondence with John Symkowitz, Legislative Coordinator, MRMIB, October 19, 2010.

³² See: http://www.chbrp.org/other_publications/index.php

³³ See enacted language at: http://www.leginfo.ca.gov/pub/09-10/bill/asm/ab_2201-2250/ab_2244_bill_20100930_chaptered.pdf

from having annual or lifetime limits. The analysis also indicated that less than 1% of CDI-regulated policies in the state had annual benefit limits and of those, the average annual benefit limit was approximately \$70,000 for the group market and \$100,000 for the individual market. Almost all CDI-regulated policies had lifetime limits in place and the average lifetime limits was \$5 million. After the effective date of the PPACA Section 2711, removal of these limits may have had an effect on premiums. As mentioned, premium information is included in the responses to CHBRP's Annual Enrollment and Premium Survey. Thus the underlying data used in CHBRP annual model updates captured the effects of this provision to remove lifetime limits and to increase annual limits for those limited number of policies that had annual limits that fell below \$750,000.

Medi-Cal Managed Care Enrollment: Seniors and Persons with Disabilities

While the PPACA allows states the option to expand coverage to those not currently eligible for Medicaid (Medi-Cal in California), large scale expansions are not expected to be seen during 2011. However, as a result of the 2010-2011 California Budget Agreement, there are expected to be shifts in coverage for seniors and persons with disabilities. Specifically, "Seniors and persons with disabilities who reside in certain counties which have managed care plans, and who are not also eligible to enroll in Medicare, will be required to enroll in a managed care plan under a phased-in process" (LAO, 2010). The Medi-Cal Managed Care enrollment in CHBRP's 2011 Cost and Coverage Model has been adjusted to reflect this change. Baseline premium rates have also been adjusted to reflect an increase in the number of seniors and persons with disabilities in Medi-Cal Managed Care. Information from DHCS indicates these changes will go into effect July 1, 2011, and would affect approximately 427,000 Medi-Cal beneficiaries.³⁴ CHBRP used data from DHCS to adjust enrollment in Medi-Cal Managed Care, and to adjust premiums to account for the change in acuity in the underlying populations (Mercer, 2010).

Bill Analysis-Specific Caveats and Assumptions

Calculation of Per Unit Cost

CHBRP spoke with seven California counties representing 17.8 million (60.7%) of the state's population to obtain data on the current cost of forensic medical evaluations for physical and sexual abuse. Two counties were able to provide a detailed break-down of costs by type of abuse and evaluation components (i.e., forensic photos, after-hours exams, translator costs, etc.), while the remaining five counties were able to provide a cost for sexual abuse evaluations alone or an average cost for both physical and sexual abuse evaluations. Based on the detailed cost information from two of the counties, CHBRP calculated the cost of sexual abuse forensic medical evaluations to be 2.6 times the cost of physical abuse evaluations. CHBRP estimated a ratio of 3:1 for the number of sexual abuse to physical abuse evaluations performed, also based on county specific information. These ratios were applied to counties that provided incomplete data in order to estimate separate, county specific costs for physical and sexual abuse exams. Discarding the highest and lowest cost figures, which were deemed to be outliers, CHBRP estimated an average overall cost per forensic medical exam of \$735.

³⁴ Data from the Department of Health Care Services, Medi-Cal Managed Care Division. Received January 14, 2011.

CHBRP recognizes that variation in the costs of forensic medical evaluations exist among counties. The cost of forensic medical evaluations may vary depending on several factors, including the services included in the evaluation, the underlying cost of each of those services, and the negotiation and rate setting practices in each of the counties.

Calculation of number of forensic medical evaluations

There are currently no statewide databases tracking the number of physical and sexual forensic medical evaluations performed each year in California. Therefore, in order to estimate the pre- and postmandate utilization of forensic medical evaluations, CHBRP spoke with representatives from seven California counties. Four counties were able to provide data on the annual number of physical and sexual forensic medical evaluations among children in 2009. The number of physical and sexual abuse allegations by county in 2009 was determined using the Center for Social Services Research Child Welfare Dynamic Report System at UC Berkeley (Needell et al., 2011). Using these two sources of data, CHBRP estimated that 4% of physical abuse allegations and 20% of sexual abuse allegations (9.1% overall) result in a forensic medical evaluation on a statewide basis. Applying this number to the total California child population aged 0 to 17 years enrolled in health plans and policies affected by AB 652, CHBRP estimated the current utilization of forensic medical evaluations to be about 9,068 per year.

Appendix D: Information Submitted by Outside Parties

In accordance with CHBRP policy to analyze information submitted by outside parties during the first two weeks of the CHBRP review, the following parties chose to submit information.

The following information was submitted by the Department of Health Services Los Angeles County, March 2011.

Reimbursement to Counties for Conducting Additional Medical and Forensic Examinations for Children in the Child Welfare System. Fact Sheet Submitted to Calif. Legislature. January 6, 2011.

The following information was submitted by L.A. Care Health Plan, March 2011.

Summary Proposal for L.A. Care Plan Partners: Reimburse Los Angeles County Medical Hubs for Forensic Evaluation.

County of Los Angeles, Chief Executive Office. *Report on Progress in Obtaining Reimbursement for Department of Health Services Medical Hub Forensic Examinations*. Los Angeles, CA: County of Los Angeles, Chief Executive Office; 2009.

County of Los Angeles, Department of Health Sciences. *HubCosts Fiscal Year 2008-2009*.

Submitted information is available upon request.

For information on the processes for submitting information to CHBRP for review and consideration please visit: http://www.chbrp.org/recent_requests/index.php.

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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 and three private universities in California. 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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