CONCURRENCE IN SENATE AMENDMENTS
AB 85 (Weber)
As Amended September 8, 2023
Majority vote

SUMMARY

Requires a health plan contract or health insurance policy on or after January 1, 2027, as specified, to include coverage for screenings for social determinants of health (SDOH), as defined. Requires a health plan or health insurer to provide primary care providers with adequate access to community health workers (CHW) in counties where the health plan or health insurer has enrollees or insureds, as specified. Makes SDOH a covered benefit for Medi-Cal beneficiaries and requires the Department of Health Care Services (DHCS) to provide reimbursement for those screenings. Requires the Department of Health Care Access and Information (HCAI) to convene a working group, with specified membership, to determine the standardized methods of data documentation to be used in recording social determinants of health screen responses, to create a standardized model and procedures for connecting patients with community resources, to assess the need for a centralized list of accredited community providers, and to determine gaps in research and data to inform policies on system changes to address SDOH. Requires the working group, by July 1, 2026, to submit a report to the Legislature with recommendations on the topics addressed by the working group. Makes provisions of this bill subject upon appropriation by the Legislature.

Senate Amendments
Delay implementation to January 1, 2027. Allow a provider to focus or expand their questions to issues relevant to the patient and ask these questions in the manner the provider believes is most appropriate or more likely to elicit the best response from the patient. Require the provider to use the tools or protocols approved by the established working group.

COMMENTS

1) *California Advancing and Innovating Medi-Cal (CalAIM).* DHCS began implementing provisions of CalAIM in 2022, which is a multi-year program to improve health outcomes and quality of life for Medi-Cal beneficiaries through broad delivery system, program, and payment reform. One of the components of CalAIM is Population Health Management, in which plans identify and manage social risks and needs of Medi-Cal beneficiaries using whole person care approaches to mitigate negative SDOH. Additionally in early 2022, DHCS released an All Plan Letter (APL) to provide guidance for the collection of SDOH data. The letter states that DHCS expects Medi-Cal managed care plans to develop processes to work closely with providers to promote screening and regularly report SDOH data. The APL also emphasizes that clinicians other than a beneficiary's primary care clinician can document and code SDOH. New Medi-Cal managed care contracts require plans to identify and track SDOH and develop partnerships with local agencies to support community needs, including supports like housing and other non-health–related programs. Also as part of CalAIM, in July 2022, Medi-Cal released an updated provider manual that included CHW as a covered benefit. CHWs may include people known by a variety of job titles, including promotores, community health representatives, navigators, and other nonlicensed public health workers.. Medi-Cal covers CHW services as preventive services and on the written recommendation of a physician or other licensed practitioner for a subset of beneficiaries (those with one or more

chronic conditions, exposure to violence and trauma, at risk for a chronic health condition or environmental health exposure, who face barriers to meeting their health or health-related social needs, and/or who would benefit from preventive services). HCAI is working with stakeholders to develop standards for certifying CHWs and training programs. HCAI is also developing plans for the certification process and training new CHWs.

2) *SDOH.* This bill requires coverage for SDOH screenings. According to the California Health Benefits Review Program (CHBRP), SDOH are nonmedical underlying structural factors that influence health status and health outcomes. There are multiple definitions of SDOH, but it is commonly defined as "the conditions in which people are born, grow, work, live, and age" in which a "wider set of forces and systems shape the conditions of daily life" and "affect health, functioning, and quality-of-life outcomes and risks." The Centers for Disease Control and Prevention defines these forces and systems as economic policies and systems, development agendas, social norms, social policies, racism, climate change, and political systems. The determinants themselves are neutral concepts (housing, education, food access) that can positively or negatively influence every person's health status, longevity, and quality of life depending on their access to and the quality of these determinants (e.g., good or bad education; un/reliable transportation; un/safe, un/affordable housing).

3) *CHBRP analysis.* CHBRP's analysis of this bill includes the following:

   a) *Enrollees covered.* This bill allows insurance carriers to determine criteria for coverage of SDOH screening and allows clinicians to be reimbursed for medically necessary screening. CHBRP assumes the voluntary nature of screening for both patients and clinicians would not result in universal screening. Instead, the use of screening by clinicians would vary across patient populations.

   b) *Impact on expenditures.* This bill would increase total net annual expenditures by $9,926,000 or 0.01% for enrollees in state-regulated insurance. For most commercial market segments, this would translate to increasing premiums by 0.01%. However, enrollees with insurance purchased outside of Covered California would experience the largest proportional increase in enrollee premiums (0.03%) due to lower levels of benefit coverage at baseline. Premiums for enrollees in individual plans purchased through Covered California would increase by $0.05 per member per month (0.01%).

      i) *Medi-Cal.* Since all Medi-Cal plans reported providing and paying for SDOH screening at baseline, no increase is estimated due to this bill. Due to the combination of Medi-Cal contracting requirements, the National Committee for Quality Assurance (NCQA) accreditation requirement changes, and the upcoming CalAIM Medicaid Waiver, CHBRP estimates that this bill would not result in new benefit coverage or increased use of SDOH screening in Medi-Cal managed care plans.

      ii) *CalPERS.* For enrollees associated with CalPERS in Department of Managed Health Care (DMHC)-regulated plans, premiums would increase by 0.01% ($0.04 per member per month, $415,000 total increase in expenditures).

      iii) *Number of Uninsured in California.* Since the change in average premiums does not exceed 1% for any market segment, CHBRP estimates this bill would have no measurable impact on the number of uninsured persons.

c) *Medical effectiveness.* According to CHBRP, the medical effectiveness review summarizes findings from 2019 to present on the evidence that multi-domain clinical screening for SDOH leads to referrals to CHWs or other social service navigators, to use of social services, and to changes in social outcomes, health care utilization, or health outcomes. CHBRP also reviewed evidence of harms of SDOH screening in a clinical setting. Studies on screening for SDOH in a clinical setting were limited in number and quality. It is hard to generalize the findings of this research across studies because of the variety of populations included in studies, the various social needs, the variety of SDOH screening tools, and the variety of referral interventions used in the studies. Therefore, taken together, the evidence on the effectiveness of screening for SDOH in a clinical setting, referral to navigators/social services, and downstream outcomes after screening is a mixture of limited, inconclusive, and insufficient. The lack of evidence due to limited research literature is not evidence of lack of effect.

According to the Author
Research shows that an individual's economic and social conditions influences their health status. Identifying these SDOH for individuals and families is a critical step in ensuring health equity and optimal health outcomes for all people in California. Additionally, the author states that a recent study discovered that physicians feel discomfort not being able to address their patient's SDOH needs. This bill will help physicians begin to address patients' needs by referring patients to supportive resources closest to them. The author concludes that this bill will also require the HCAI to, in part, determine gaps in research and data to inform policy improvements to continue to address SDOH for all in California.

Arguments in Support
The California Academy of Family Physicians, the cosponsor of this bill, writes that this bill is critical to improving health outcomes and health equity for vulnerable communities and aids in California's efforts to achieve a whole person care health care system. The CaliforniaHealth+ Advocates state that unaddressed, SDOH adversely impact health equity due to worsening health outcomes, widening disparities, and increased health care costs for vulnerable communities. Health disparities by race, ethnicity, sexual orientation, gender identity, and disability, as well as by economic and community level factors such as geographic location, poverty status, and employment, are only partly explained by disparities in health care. Social and structural factors play a critical role in driving disparate health outcomes.

Arguments in Support if Amended

The California Chapter of the American College of Emergency Physicians writes that this bill would provide greater tools and more incentives to emergency physicians to screen the vulnerable patients that they serve if provisions were amended to clarify that the reimbursement and access to CHW apply in the emergency department.

Arguments in Opposition
The California Association of Health Plans, the Association of California Life and Health Insurance Companies, and America's Health Insurance Plans write that state mandates increase costs of coverage, especially for families who buy coverage without subsidies, small business owners who cannot or do not wish to self-insure, and California taxpayers who foot the bill for the state's share of those mandates. Health plans compete for business based on innovative benefit designs that increase access to care, improve quality, and contain costs. All federal

Patient Protection and Affordable Care Act (ACA)-compliant plans provide a robust package of essential health benefits (EHBs in the large group, small business, and individual markets (both on and off the Exchange). In the individual market, the ACA sought to preserve the balance between comprehensive coverage and affordability by requiring states to bear the cost for new mandates that exceed the EHB package. The Centers for Medicaid and Medicare Services recently affirmed that states are still responsible for defraying the cost of new mandates. The opposition states all of these bills will increase costs and limit flexibility for employers. Faced with higher costs, employers must make difficult decisions about whether to absorb premium increases or seek alternative coverage options. The Department of Finance is opposed to this bill, as it creates costs and pressures not included in the 2023-24 budget plan. These costs could also potentially increase health care premiums. Finance recommends this policy should be pursued through the annual budget process.

FISCAL COMMENTS

According to the Senate Appropriations Committee,

1) One-time General Fund costs, likely millions, for HCAI for activities related to the working group.

2) Unknown General Fund costs, likely hundreds of thousands, due to an increase in CalPERS health plan premiums.

3) Minor and absorbable costs for DMHC for state operations (Managed Care Fund). Costs to the Managed Care Fund could be offset to the extent outside funding sources are appropriated.

4) Unknown one-time costs, likely hundreds of thousands, for the California Department of Insurance for state operations (Insurance Fund). Costs to the Insurance Fund could be offset to the extent outside funding sources are appropriated.

VOTES:

ASM HEALTH: 12-0-3
YES: Wood, Waldron, Aguiar-Curry, Arambula, Boerner, Wendy Carrillo, Maienschein, McCarty, Rodriguez, Santiago, Villapudua, Weber
ABS, ABST OR NV: Flora, Vince Fong, Joe Patterson

ASM APPROPRIATIONS: 11-1-4
YES: Holden, Bryan, Calderon, Wendy Carrillo, Mike Fong, Hart, Lowenthal, Papan, Pellerin, Weber, Ortega
NO: Mathis
ABS, ABST OR NV: Megan Dahle, Dixon, Robert Rivas, Sanchez

ASSEMBLY FLOOR: 61-0-19
YES: Addis, Alvarez, Arambula, Bains, Bauer-Kahan, Bennett, Berman, Boerner, Bonta, Bryan, Calderon, Juan Carrillo, Wendy Carrillo, Cervantes, Connolly, Mike Fong, Friedman, Gabriel, Garcia, Gipson, Grayson, Haney, Hart, Holden, Irwin, Jackson, Jones-Sawyer, Kalra, Lee, Low, Lowenthal, Maienschein, McCarty, McKinnor, Muratsuchi, Stephanie Nguyen, Ortega, Pacheco, Pellerin, Petrie-Norris, Quirk-Silva, Ramos, Reyes, Luz Rivas, Robert Rivas, Rodriguez, Blanca Rubio, Santiago, Schiavo, Soria, Ting, Valencia, Villapudua, Waldron, Ward, Weber, Wicks, Wilson, Wood, Zbur, Rendon
ABS, ABST OR NV: Aguiar-Curry, Alanis, Chen, Megan Dahle, Davies, Dixon, Essayli, Flora, Vince Fong, Gallagher, Hoover, Lackey, Mathis, Papan, Jim Patterson, Joe Patterson, Sanchez, Ta, Wallis

SENATE FLOOR: 30-7-3
YES: Allen, Archuleta, Ashby, Atkins, Becker, Blakespear, Bradford, Cortese, Dodd, Durazo, Eggman, Glazer, Gonzalez, Hurtado, Laird, Limón, McGuire, Menjivar, Min, Newman, Padilla, Portantino, Roth, Rubio, Skinner, Smallwood-Cuevas, Stern, Umberg, Wahab, Wiener
NO: Alvarado-Gil, Dahle, Grove, Jones, Nguyen, Niello, Seyarto
ABS, ABST OR NV: Caballero, Ochoa Bogh, Wilk

UPDATED

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