SENATE THIRD READING
SB 428 (Hurtado)
As Amended September 3, 2021
Majority vote

SUMMARY

Requires a health care service plan (health plan) contract or health insurance policy issued, amended, or renewed on or after January 1, 2022, that provides coverage for coverage for pediatric services and preventive care to additionally include coverage for adverse childhood experiences (ACEs) screenings. Defines ACEs as an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being. Allows the Department of Managed Health Care (DMHC) and California Department of Insurance (CDI) to adopt guidance to implement this bill.

Major Provisions

COMMENTS

Medi-Cal coverage. In 2017, California passed Assembly Bill 340 (Arambula), Chapter 700, Statutes of 2017, and with its enactment, made available screening for childhood trauma to the other Early and Periodic Screening, Diagnostic and Treatment Program (EPSDT) screenings covered by Medi-Cal for those under 21 years of age. AB 340 contemplated trauma screening at least once every five years for children and required the Department of Health Care Services (DHCS) to convene a work group to review tools and protocols for screening children for trauma as defined within EPSDT, a Medi-Cal benefit for individuals under age 21 years. The AB 340 Workgroup recommended to DHCS that Medi-Cal providers be given the following three options for screening pediatric populations (children and youth under the age of 21) for exposure to trauma:

1) Utilize the Bay Area Research Consortium on Toxic Stress and Health screening tool, called PEARLS, alongside the existing state-required Staying Healthy Assessment (SHA), Bright Futures, or another state-approved Individual Health Education Behavior Assessment (IHEBA) to improve screening for trauma in children, and examine formal integration of this tool within the SHA;

2) Use the Whole Child Assessment, an existing State-approved IHEBA that incorporates screening for exposure to trauma along with required elements of the SHA; and,

3) Request approval from DHCS to use an alternative tool to screen for trauma that includes, at a minimum, all of the items contained in the PEARLS tool.

The ACEs Aware is an initiative led by the Office of the California Surgeon General and the DHCS to give Medi-Cal providers training, clinical protocols, and payment for screening children and adults for ACEs. DHCS is responsible for implementing Medi-Cal payments to providers to deliver ACEs screenings for children and adults under age 65 in the Medi-Cal program. The AB 340 Workgroup recommended that DHCS include the PEARLS tool as a complementary screening component along with the existing SHA, Bright Futures, or another approved IHEBA to improve trauma-screening practices immediately. The Workgroup

encouraged the Legislature to explore systems that support trauma screening for adults in the future. Screening for ACEs has become a Medi-Cal covered benefit, effective for dates of service on or after January 1, 2020. Medi-Cal has begun reimbursing for ACEs screenings for both children and adults up to 65 years of age, except for those dually eligible for Medi-Cal and Medicare Part B, with Proposition 56 funds. Individuals under 21 years of age may receive periodic rescreening as determined appropriate and medically necessary, but screenings will not be paid more than once per year, per provider. Screenings for individuals 21 years of age and older will be paid once in their lifetime, per provider. ACEs screenings will be reimbursed at $29 per screening in both the fee-for-service and managed care delivery systems.

4) *ACEs.* According to the California Health Benefits Review Program (CHBRP), ACEs are potentially traumatic events that occur any time before adulthood. There are a large number of events that may qualify as an adverse childhood experience. The original ACE Study Questionnaire examines the impact of originally seven, then expanded to 10 ACEs in the three categories below (abuse, neglect, and household dysfunction) with later modification. The 10 ACEs commonly described are events or patterns of:

   a) Abuse (3: physical, emotional/psychological, and sexual);

   b) Neglect (2: physical and emotional); and,

   c) Household dysfunction (5: parental loss by divorce, abandonment or death; parental incarceration; adult-on-adult violence; adult mental illness; adult substance use disorder) Recent studies have identified additional possible ACEs to include for screening, such as peer victimization, isolation from peers, peer rejection, property victimization, racial discrimination, exposure to community violence, death or serious illness of a close relative, low socioeconomic status and experience with the foster care system while growing up.

5) *ACEs and Health Outcomes.* ACEs include potentially traumatic events that could contribute to the development of a toxic stress response. While it is unclear exactly how toxic stress impacts the brain and body, there is evidence that suggests that ACEs make the individual more susceptible to later illness. A number of studies have associated high ACEs scores with a range of outcomes at the population level. ACEs have been described as having a dose-response effect where higher ACEs scores were more strongly associated with poor health outcomes. In adults, having four or more ACEs was associated with increased levels of: depression, post-traumatic stress disorder, smoking, alcohol and drug abuse, chronic obstructive pulmonary disease, asthma, kidney disease, stroke, coronary heart disease, and lower levels of employment. For children, having two or more ACEs has been associated with poor health, sleep disturbance, somatic complaints, reduced cognitive ability, childhood obesity, asthma symptoms and hospitalization, higher likelihood of being bullied, higher probability of affected males perpetrating bullying, reduced levels of school engagement, and being more likely to repeat a grade in school. Children with special health care needs were twice as likely to report experiencing two or more ACEs than children without such needs. Although ACEs are associated with a high number of negative health outcomes at a population level, screening for ACEs has not yet shown an ability to predict risk for negative health outcomes on an individual basis. While health conditions associated with ACEs can precede, coincide with, or follow ACEs occurring; CHBRP notes that none of these studies have identified a direct, causal link between an ACEs and health outcome. Without a causal

link, it is difficult to determine to what degree ACEs alone have an impact on individual health, as opposed to other potential factors such as socioeconomic status, poverty, pre-existing conditions. Additionally, the health consequences of ACEs may not become apparent in an individual until many years after the experience has occurred.

6) *CHBRP analysis.* AB 1996 (Thomson), Chapter 795, Statutes of 2002, requests the University of California to assess legislation proposing a mandated benefit or service and prepare a written analysis with relevant data on the medical, economic, and public health impacts of proposed health plan and health insurance benefit mandate legislation. CHBRP was created in response to AB 1996. SB 125 (Hernandez), Chapter 9, Statutes of 2015, added an impact assessment on essential health benefits, and legislation that impacts health insurance benefit designs, cost sharing, premiums, and other health insurance topics. CHBRP states the following in its analysis of this bill:

   a) *Enrollees covered.* At baseline, CHBRP estimates that currently, 36% of enrollees with health insurance that would be subject to this bill have coverage for ACEs screening — all of these are enrollees in Medi-Cal Managed Care Programs. DHCS provides reimbursement to providers completing ACEs screenings in Medi-Cal Fee-for-Service and Managed Care. Postmandate, 100% of all enrollees with health insurance that would be subject to this bill would have coverage for ACEs screening.

7) *Impact on expenditures.* CHBRP has assumed $29 reimbursement per each ACEs screening for commercial plans/policies. Under this assumption, this bill would increase total net annual expenditures by $36,060,000, or 0.03%, with no projected cost offsets. CHBRP projected an estimated $1,983,000 impact, or 0.03%, for CalPERS HMO employer expenditures.

According to the Author
Recent research has highlighted the link between ACEs and a decline in an individual's long-term health outcomes. A groundbreaking *American Journal of Preventive Medicine* study demonstrated that a child's exposure to traumatic events substantially impacts his or her long-term health. The findings indicate that identifying a child's exposure to abuse, neglect, discrimination, violence and other adverse experiences, and connecting children and families to early intervention services that can help families heal from trauma or slow or reverse the expected negative health outcomes, is a core component of healthcare. This bill allows providers to screen patients for ACEs and provide necessary services early. It requires a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2022, to provide coverage for adverse childhood experiences screenings. The author concludes that many experts have warned that the current COVID-19 pandemic is a traumatic stressor, so expanding ACEs coverage now will enable doctors to mitigate what would otherwise become a compounding trauma in the future.

Arguments in Support
Children Now and California Medical Association, cosponsors of this bill, write that the groundbreaking ACEs study demonstrated that a child's exposure to traumatic events substantially impacts their long-term health. The findings make identifying a child's exposure to abuse, neglect, discrimination, violence and other adverse experiences—and connecting children and families to early intervention services that can help families heal from trauma or slow or reverse the expected negative health outcomes—a core component of health care. Screening

children and adults for exposure to adversity can help practitioners identify those at high risk for experiencing toxic stress (frequent and/or prolonged activation of a stress response due to adversity or trauma). Screening in primary care settings can help prevent further exposure to adverse experiences, and—when a strong referral system is in place—can provide appropriate education for parents and caregivers about the relationship between early adversity and negative health outcomes. For example, screening can inform a pediatrician's care plan by identifying children who are at high risk for health problems due to toxic stress, which may be an underlying cause of clinical symptoms. By identifying and intervening, there is an opportunity to reverse the neurological and physical effects of severe adversity that are common when not addressed early. Currently, California provides the trauma screening benefit for Medi-Cal beneficiaries. This approach has the potential to pathologize poverty, as only low-income families are asked about their adverse childhood experiences, a practice that is not supported by research. Without expanding this screening benefit into the commercial market, California will continue to limit the ability for all families at risk for toxic stress to receive targeted interventions that can reduce the risk of chronic disease later in life. The COVID-19 pandemic has been a stressful and traumatic time for most, and is considered a traumatic event for the broader population. However, without universal screening, it is likely the State will under identify those who suffer from toxic stress. The sponsors state that this bill will allow providers to identify individuals' trauma histories, provide necessary services early, and reduce the risk of racial/ethnic and socioeconomic bias. Many experts have warned that the current COVID-19 pandemic is a traumatic stressor and that the long-term mental and physical impacts of the pandemic have yet to be understood. Expanding screening coverage now will enable physicians to mitigate what would otherwise become compounding trauma, ultimately reducing long-term costs in the healthcare system.

Arguments in Opposition
The California Association of Health Plans (CAHP), the Association of California Life and Health Insurance Companies (ACLHIC), and America's Health Insurance Plans (AHIP) write that mandate bills will increase costs, reduce choice and competition, and further incent some employers and individuals to avoid state regulation by seeking alternative coverage options. CAHP, ACLHIC, and AHIP state that benefit mandates stifle the use of innovative, evidence-based medicine and prevent benefits packages from adapting to evolving medical literature and clinical guidelines to provide the most up-to-date and cost-effective products to consumers.

The Department of Finance is opposed to this measure because the identified costs and resources required to implement this bill could potentially create General Fund cost pressures within state health programs.

FISCAL COMMENTS

According to the Assembly Appropriations Committee,

1) DMHC anticipates costs of approximately $22,000 and 0.1 personnel year (PY) in fiscal year (FY) 2021-22, and $114,000 and 0.6 PY in FY 2022-23 for short-term legal work and review of health plan documents, including Evidence of Coverage, for compliance (Managed Care Fund).

2) CDI estimates costs of $22,000 for FY 2021-22 to review health insurance policy forms for compliance with the specific benefit mandate and issue implementing guidance (Insurance Fund).

3) CHBRP analyzed this bill as a health insurance mandate. CHBRP projects an estimated $1,983,000 increase in California Public Employees' Retirement System employer expenditures for annual premiums (General Fund and special funds).

VOTES

SENATE FLOOR: 39-0-1
YES: Allen, Archuleta, Atkins, Bates, Becker, Borgeas, Bradford, Caballero, Cortese, Dahle, Dodd, Durazo, Eggman, Glazer, Gonzalez, Grove, Hertzberg, Hueso, Hurtado, Jones, Kamlager, Laird, Leyva, Limón, McGuire, Min, Newman, Nielsen, Ochoa Bogh, Pan, Portantino, Roth, Rubio, Skinner, Stern, Umberg, Wieckowski, Wiener, Wilk
ABS, ABST OR NV: Melendez

ASM HEALTH: 15-0-0
YES: Wood, Mayes, Aguiar-Curry, Arambula, Bigelow, Calderon, Carrillo, Flora, Maienschein, McCarty, Nazarian, Luz Rivas, Rodriguez, Santiago, Waldron

ASM APPROPRIATIONS: 16-0-0
YES: Lorena Gonzalez, Bigelow, Bryan, Calderon, Carrillo, Chau, Megan Dahle, Davies, Fong, Gabriel, Eduardo Garcia, Levine, Quirk, Robert Rivas, Akilah Weber, Kalra

UPDATED

VERSION: September 3, 2021

CONSULTANT: Kristene Mapile / HEALTH / (916) 319-2097 FN: 0001638