



CALIFORNIA
HEALTH BENEFITS REVIEW PROGRAM

EXECUTIVE SUMMARY:
Analysis of Assembly Bill 1962:
Maternity Services

A Report to the 2007–2008 California Legislature
April 4, 2008
Revised April 10, 2008

CHBRP 08-03

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Suggested Citation:

California Health Benefits Review Program (CHBRP). (2008). *Analysis of Assembly Bill 1962: Maternity Services*. Report to California State Legislature. Oakland, CA: CHBRP. CHBRP 08-03.

*This revised version presents coverage, utilization, and cost estimates which include *only the population subject to the mandate* (enrollees in health insurance policies regulated by the California Department of Insurance).

California Health Benefits Review Program Analysis of Assembly Bill 1962: Maternity Services

The California Health Benefits Review Program (CHBRP) undertook the analysis of Assembly Bill (AB) 1962 in response to a request from the California Assembly Committee on Health on February 5, 2008, pursuant to the provisions of Senate Bill 1704 (Chapter 684, Statutes of 2006) as chaptered in Section 127600, et seq. of the California Health and Safety Code. This report provides an analysis of the medical, financial, and public health impacts of AB 1962.

AB 1962, introduced by Assemblymember Hector De La Torre, would require health insurance products regulated under the California Department of Insurance (CDI) to cover maternity services.¹ The bill would apply only to CDI-regulated policies, which mostly includes preferred provider organizations and represents approximately 10.4% of the privately insured market in California. The remaining portion of the privately insured market are health care service plans (including health maintenance organizations, point of service plans and some preferred provider organization) regulated under the Department of Managed Health Care (DMHC). While DMHC-regulated plans make up the majority of the privately insured market, CDI-regulated policies represent a substantial portion of those products sold in the *individual* market—about 38.5%.

Current laws and regulations governing health care service plans regulated by the DMHC require coverage for maternity services under provisions related to “basic health care services.” DMHC-regulated plans are required to cover maternity and pregnancy-related care under laws governing emergency and urgent care.² Regulations defining basic health care services specifically include prenatal care as preventive care that must be covered.³ CDI-regulated plans currently have no such requirements.

The Federal Civil Rights Act requires employers that offer health insurance and have 15 or more employees to cover maternity services benefits at the same level as other health care benefits.⁴ Complications of pregnancy are generally covered regardless of whether the health insurance plan provides coverage for maternity benefits.

In 2005, the birth rate in California was 70.2 births per 1,000 women of childbearing age, or nearly 550,000 births. Approximately 96% of births in California are covered by some form of health insurance. Overall in California, the rate of maternal pregnancy-related mortality is 13.6 deaths per 100,000 live births, or nearly 75 maternal deaths in California each year. The infant mortality rate in California is 5.3 per 1,000 births and it is estimated that nearly 3,000 infants die each year in their first year of life due to birth defects, prematurity and low birth weight, SIDS, respiratory distress syndrome, and maternal complications of pregnancy.

AB 1962 defines “maternity services” to include prenatal care, ambulatory care maternity services, involuntary complications of pregnancy, neonatal care, and inpatient hospital maternity care including labor and delivery and postpartum care. However, the *Medical Effectiveness* and

1 AB 1962 would add Section 10123.865 to the California Insurance Code.

2 Section 1317.1 of the California Health and Safety Code

3 Section 1300.67 of the California Code of Regulations, Title 28

4 The Pregnancy Discrimination Act under Title VII of the Civil Rights Act of 1964

Public Health Impacts sections of this report focus on the outcomes associated with prenatal care services because 1) a majority of births occur in the hospital setting regardless of insurance status, 2) prenatal care services use would be most affected by the potential for out-of-pocket costs and thus most directly impacted by AB 1962, 3) AB 1962 would not affect coverage for infants, and 4) plans and policies that do not cover maternity services cover complications related to a pregnancy.

Because all group policies are required to and, in practice currently cover maternity services, the *Utilization, Cost, and Coverage Impact* analysis will focus on the CDI-regulated individual market. That section specifically examines the impact of adding maternity services to those CDI-regulated individual policies that do not currently cover those services.

Medical Effectiveness

Studies of prenatal care can be divided into two major groups:

- Studies of the impact of variation in the number of prenatal care visits that pregnant women receive; and
- Studies of the effectiveness of specific services provided during prenatal care visits or in conjunction with them (e.g., laboratory tests, medications).

Randomized controlled trials (RCTs) have consistently found no association between the numbers of prenatal visits pregnant women receive and birth outcomes for either infants or mothers.

However, there is clear and convincing evidence from multiple RCTs that the following prenatal care services are effective:

- Smoking cessation counseling
- Screening and treatment for asymptomatic bacteriuria
- Screening for hepatitis B
- Screening and treatment for human immunodeficiency virus
- Aspirin and calcium supplements for treatment of hypertensive disorders
- Screening and treatment for Rh(D) incompatibility
- Corticosteroids and progestational agents for women at increased risk for preterm delivery
- Ultrasound to determine gestational age and identify fetal abnormalities
- External cephalic version for breech presentation at term
- Membrane sweeping and induction of labor for prevention of postterm pregnancies

In addition, there is a preponderance of evidence from nonrandomized studies and/or a small number of RCTs that the following prenatal care services are effective:

- Screening for domestic violence
- Screening for certain genetic disorders
- Screening and treatment for chlamydia, gonorrhea, and syphilis
- Screening for group B streptococcus

- Screening and treatment for gestational diabetes
- Iron supplements for treatment of iron deficiency anemia
- Blood pressure monitoring for hypertensive disorders
- Screening for atypical red blood cell alloantibodies other than Rh(D) incompatibility
- Ultrasound to diagnose placenta previa

Utilization, Cost, and Coverage Impacts

Current Coverage

- Most Californians enrolled in CDI-regulated health policies (68%) currently have coverage for maternity benefits, including prenatal care and delivery services.
 - CHBRP estimates that all enrollees in CDI-regulated health policies in the *large- and small-group* markets currently have maternity benefits.
 - An estimated 600,800 enrollees in CDI-regulated health policies in the *individual* (non-group) market currently lack maternity benefits (see rows labeled “Number of individuals with coverage for maternity services” in Table 1).
- Currently, the Medi-Cal and Aid to Infants and Mothers (AIM) programs cover maternity services for women who qualify—generally those women who are in households with incomes less than or equal to 300% of the Federal poverty level. AIM requires that women who are covered by insurance must face costs for maternity services greater than \$500 in order to qualify. CHBRP estimates that currently, approximately 2,700 women enrolled in CDI-regulated plans switch to Medi-Cal or AIM following pregnancy. This is because their income eligibility would change following pregnancy (since pregnant women are considered a household of two and presumably their household income would not change).
 - CHBRP estimates that of the approximately 9,200 expected births among women in 2008 who have no maternity benefits when they become pregnant, about 30% may qualify for Medi-Cal or AIM. CHBRP estimates that about 300 of these women may transfer to plans covering maternity that are offered by their existing carrier.
 - Based on data from AIM, there is evidence that there is current cost-shifting to that program. As of 2007, about 6% of their total enrollment (700 women) was enrolled in health insurance policies that did not cover maternity services. In addition, 10% of their total enrollment (about 1,200 women) were enrolled in policies that *did* cover maternity services.
- There is evidence that risk segmentation has already had a substantial impact on the individual (non-group) insurance market since only 26% of an estimated 812,000 individuals currently have maternity benefits. In 2004, CHBRP had estimated, in the analysis of Senate Bill 1555, that approximately 82% of those in the individual market had maternity benefits.

Post-mandate Coverage, Cost, and Utilization

- The enactment of AB 1962 would require all those CDI-regulated individual policies that do not cover maternity services to do so, thus expanding maternity services coverage to 600,800 enrollees, including 147,000 women aged 19-44 years. Because individuals choosing plans without maternity services are doing so to save monthly premiums, those who can afford so (and do not drop insurance entirely) would purchase the next “cheapest” option—high-deductible health plans (HDHPs). Thus, it is likely that most individuals currently enrolled in non-maternity CDI-regulated individual plans would purchase HDHPs post-mandate.
- CHBRP estimates that there would not be a direct impact on AIM and Medi-Cal enrollment as a result of AB 1962. Those women who qualify for Medi-Cal after pregnancy would still shift to Medi-Cal due to their income levels. Those women enrolled in AIM who are currently enrolled in plans that do not cover maternity services would be enrolled in a plan that *does* cover maternity services post-mandate. However, since the cost of maternity services in those plans would be likely still be greater than \$500 (adding up deductibles and copayments), those women would still qualify for AIM.
- Total health expenditures by or for all enrollees in CDI-regulated policies are estimated to increase by 0.32%, or \$24.7 million as a result of this mandate (see row labeled “Total Annual Expenditures” in Table 1). Note that the increase in total expenditures is a total of:
 - the increased premium expenditures in the individual market: \$74.6 million (see row labeled “Premium expenditures for individually purchased insurance” in Table 1).
 - the increased out-of-pocket expenditures for copayments and deductibles for maternity benefits: \$17.9 million (see row labeled “Individual out-of-pocket expenditures”).
 - the reduction in out-of-pocket expenditures for maternity benefits not currently covered by insurance: \$67.9 million (see row labeled, “Out-of-pocket expenditures for noncovered services”).
- All of the cost impact of the mandate would be concentrated in the individual CDI-regulated market, where total expenditures are estimated to increase by about 4.75%, or \$74.6 million (see row labeled “Premium expenditures for individually purchased insurance” in Table 1). Per member per month (PMPM) premium expenditures are estimated to increase by an *average* of \$7.65. Most of the increase in total expenditures would be concentrated among those aged 19-44 years, because insurance premiums in the individual market are stratified by age bands.
- Adding maternity services is expected to increase the premiums of CDI-regulated individual policies. The actual premium increase of those policies depends on a number of market factors, including, but not limited to, the changes in actuarial costs. CHBRP estimates that adding maternity services to policies that do not currently cover maternity would increase the actuarial costs of these policies by a range of 1.13% to 13.42% depending on the age of the enrollee. If the premium increases by the same amount as the actuarial costs increases, the premium increase could result in approximately 2,300 newly uninsured. It is likely that these newly uninsured would disproportionately consist of younger individuals (e.g., ages 19-

29) since they are more likely to be uninsured and are more price-sensitive to premium changes than older individuals.

- CHBRP estimates that approximately, 6,200 pregnancies would be newly-covered under CDI insurance policies post-mandate. Utilization impacts as a result of expanded coverage is summarized below:
 - Overall, the mandate is estimated to have no impact on the number of deliveries since the birth rate is not expected to change post-mandate.
 - There may be an increase in utilization of maternity services, specifically prenatal care. The number of women who forgo any prenatal care may be reduced, because they may no longer face large out-of-pocket expenditures for their obstetrician's services early in the pregnancy. However, to the extent non-maternity CDI-regulated plans would be replaced by HDHPs, most women are likely to continue to face large out-of-pocket expenditures for their obstetrician's services regardless of whether their insurance policy includes maternity benefits. This is because prenatal care is usually subject to the deductible for HDHPs.
 - Specific components of prenatal care may change (e.g., specific types of screening). But again, the amount of the increase is difficult to estimate. (Note that increased use of prenatal care would not affect expenditures as prenatal care is almost always paid for as a single lump-sum fee to physicians.)

Public Health Impacts

- The extent to which AB 1962 would result in increased utilization of effective prenatal care services is unknown. If coverage through health insurance plans that reduce out-of-pocket costs for prenatal care is increased, utilization of effective prenatal services could increase, leading to decreases in preterm births, low birth weight babies, and infant and maternal mortality. AB 1962 does not guarantee that pregnant women would not shift into HDHPs, which typically do not exclude prenatal care from the deductible, thus facing similar financial barriers to prenatal care as those without insurance for maternity care.
- Babies born to black women are twice as likely as babies born to mothers of all other races/ethnicities to be born prematurely and to be classified as low birth weight. In addition, infant mortality rates are twice as high for babies born to black women compared to babies born to mothers belonging to other racial/ethnic groups. There is no evidence that AB 1962 would make an impact on prenatal care utilization rates among black women specifically or reduce these disparities in health outcomes.
- Although there is significant infant and maternal mortality that can be reduced through specific effective prenatal care services, the impact of AB 1962 on the utilization of prenatal care is ambiguous. Therefore, although there is a potential for a decrease in mortality and associated lost productivity, the overall effect of AB 1962 on infant and maternal health is unknown.

Table 1. Summary of Coverage, Utilization, and Cost Impacts of AB 1962

	Before Mandate	After Mandate	Increase/Decrease	Change After Mandate
Coverage				
Number of individuals subject to the mandate				
In Large- and Small-Group Plans	1,070,000	1,070,000	0	0%
In Individual Plans	812,000	812,000	0	0%
Total	1,882,000	1,882,000	0	0%
Percentage of individuals with maternity coverage				
In Large- and Small-Group Plans	100%	100%	0%	0%
In Individual Plans	26%	100%	74%	285%
Total	68%	100%	32%	47%
Number of individuals with coverage for maternity services				
In Large- and Small-Group Plans	1,070,000	1,070,000	-	0%
In Individual Plans	211,200	812,000	600,800	285%
Total	1,281,200	1,882,000	600,800	47%
Utilization and cost				
Number of individuals subject to the mandate with uncomplicated pregnancies ^a				
Maternity services covered by insurance	16,600	22,800	6,200	37%
Covered by AIM or Medi-Cal because individuals switched following pregnancy	2,700	2,700	0	0%
Maternity services not covered by insurance	6,200	-	-6,200	-100%
Total	25,500	25,500	-	0%
Average cost per uncomplicated delivery	\$11,100	\$11,100	-	0%

Table 1. Summary of Coverage, Utilization, and Cost Impacts of AB 1962 (cont'd)

	Before Mandate	After Mandate	Increase/ Decrease	Change After Mandate
Expenditures^b				
Premium expenditures by private employers for group insurance	\$3,879,390,000	\$3,879,390,000	\$0	0%
Premium expenditures for individually purchased insurance	\$1,568,322,000	\$1,642,884,000	\$74,562,000	4.75%
Premium expenditures by individuals with group insurance	\$900,898,000	\$900,898,000	\$0	0%
Individual out-of-pocket expenditures (deductibles, copayments, etc.)	\$1,405,027,000	\$1,422,975,000	\$17,948,000	1.28%
Out-of-pocket expenditures for noncovered services	\$67,853,000	\$0	-\$67,853,000	-100%
Total annual expenditures	\$7,821,490,000	\$7,846,147,000	\$24,657,000	0.32%

Source: California Health Benefits Review Program, 2008.

Notes: The population includes employees and dependents covered by employer-sponsored insurance or individually purchased insurance. All population figures include enrollees aged 0-64 years and enrollees 65 years or older covered by employer-sponsored insurance. Premium expenditures by individuals include employee contributions to employer-sponsored health insurance and member contributions to public health insurance.

(a) This section details the number of pregnancies for individual in CDI-regulated policies. The population that does not currently have coverage for maternity services, 30% (2,700) are expected to switch to Medi-Cal or AIM, 67% (6,200) are estimated to currently not be covered by insurance, and about 3% (300) are expected to currently switch to a policy that covers maternity services. (b) Expenditures presented here are for those enrollees in plans subject to the mandate, that is, for those enrolled in CDI-regulated policies.

Key: CalPERS = California Public Employees' Retirement System.

ACKNOWLEDGEMENTS

Edward Yelin, PhD, Janet Coffman, MPP, PhD, and Wade Aubry, MD, all of the University of California, San Francisco, prepared the medical effectiveness analysis section. Min-Lin Fang, MLIS, of the University of California, San Francisco, conducted the literature search. Aaron B. Caughey, MD, PhD, of the University of California, San Francisco, provided technical assistance with the literature review and expert input on the analytic approach. Helen Halpin, ScM, PhD, and Sara McMenamin, MPH, PhD, of the University of California, Berkeley, prepared the public health impact analysis and related portions of the Introduction. Gerald Kominski, PhD, and Meghan Cameron, MPH, of the University of California, Los Angeles, prepared the cost impact analysis. Robert Cosway, FSA, MAAA, of Milliman, provided actuarial analysis. Susan Philip, MPP, of CHBRP staff prepared the background section and synthesized the individual sections into a single report. Sarah Ordódy, BA, provided editing services. A subcommittee of CHBRP's National Advisory Council (see final pages of this report) and a member of the CHBRP Faculty Task Force, Sheldon Greenfield of the University of California, Irvine, 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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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 the CHBRP authorizing legislation, UC contracts with a certified actuary, Milliman Inc. (Milliman), to assist in assessing the financial impact of each benefit mandate bill. 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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