



CALIFORNIA
HEALTH BENEFITS REVIEW PROGRAM

**Implementation of Assembly Bill
1996: University of California
Analysis of Legislation Mandating
Health Care Benefits and Services**

A Report to the Governor and Legislature from
The University of California

December 22, 2005

CHBRP 06-01

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Suggested Citation:

California Health Benefits Review Program (CHBRP). (2005). *Implementation of Assembly Bill 1996: University of California Analysis of Legislation Mandating Health Care Benefits and Service*. Report to Governor and Legislature from the University of California. Oakland, CA: CHBRP. 06-01.

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EXECUTIVE SUMMARY

On September 22, 2002 Governor Davis signed Assembly Bill 1996 (Statutes of 2002, Chapter 795) This bill “requested the University of California to assess legislation proposing mandated health care benefits to be provided by health care service plans and health insurers, and to prepare a written analysis in accordance with specified criteria.”

This report is submitted by the University of California in compliance with California Health and Safety Code, Section 127664, which requests the University to submit a report to the Governor and the Legislature no later than January 1, 2006, regarding the implementation of Chapter 7, Part 2 of Division 107 of the Health & Safety Code (AB 1996). This report provides background information regarding the context in which AB 1996 was passed, the objectives and provisions of AB 1996, the establishment of the California Health Benefits Review Program (CHBRP) at the University of California, and the processes, systems, and methods CHBRP has implemented to meet the intent of AB 1996.

Context of AB 1996

- AB 1996 was enacted to provide the California Legislature with an objective analytical tool to evaluate an increasing number of complex bills proposing mandates of specific health-insurance benefits.
- The State requested University of California (UC) to evaluate legislatively-proposed health-insurance mandates because it believed UC would provide impartial, thorough, science-based analysis of these bills. According to the August 6, 2002 Senate Insurance Committee analysis, AB 1996 author Thomson believed that by providing medical, economic and actuarial expertise and current, accurate data and information to the Governor and the Legislature, UC would facilitate more informed policy-making with regard to proposed health-benefit mandates.

AB 1996: Objectives and Provisions

The key provisions of AB 1996 require that:

- UC analyze all legislation proposing a mandated health-insurance benefit or service, and that these analyses be prepared with relevant data on the legislation’s public health, medical, and financial impacts, as defined.
- Analyses be submitted within a specified 60-day timeframe to provide the relevant legislative policy committees with timely information to inform their deliberations.
- Support for UC to conduct these analyses be provided through a non-General Fund source, specifically, fees levied by the Department of Managed Health care and The Department of Insurance on health care service plans and health insurers, respectively, the total annual amount of which would not exceed \$2 million.
- Legislative requests to UC pursuant to AB 1996 be made by the appropriate policy or fiscal committees which the legislative leadership has designated as the Senate Banking, Finance & Insurance Committee and the Assembly Health Committee.
- UC develop and implement conflict-of-interest provisions to prohibit participation in the analyses by a person with a material financial conflict of interest.
- UC use a certified actuary or other person with relevant knowledge and expertise to determine the financial impact of a given bill.
- UC post every analysis on the Internet and make them available to the public on request.

Establishment of CHBRP under UC

The University established the California Health Benefits Review Program (CHBRP) to implement the provisions of AB 1996. Although CHBRP is administered by UC, it functions independently from UC's institutional policy and program interests in responding to the Legislature's requests for analyses. To ensure expertise and objectivity, the implementation process entails:

- identifying appropriate research expertise vis-à-vis a statewide faculty task force, drawing upon faculty from UC's Schools of Medicine and Public Health, as well as from the University of Southern California, Loma Linda University School of Medicine, and Stanford University;
- establishing a National Advisory Council (NAC) of experts from outside the state, including providers, purchasers, consumers, health-policy experts, and health plans;
- recruiting and hiring professional analytic and administrative staff;
- designing a transparent and timely review process;
- developing an appropriate conflict-of-interest policy;
- retaining Milliman to provide independent actuarial services;
- retaining librarians and content experts to support the review of relevant scientific literature;
- developing standardized methods for gathering data necessary to analyze the medical effectiveness, public health, and financial impacts of each proposed mandate;
- developing methods for analyzing the various impacts of each proposed mandate:
 - The Medical Effectiveness Team at UCSF developed a process for conducting literature searches and a hierarchical method of analyzing the literature to report on whether and to what extent a particular mandate will result in changes in relevant patient outcomes.
 - The Cost Team at UCLA, along with actuaries at Milliman, designed methods to determine baseline coverage, utilization, and costs and a model to project impacts of a particular benefit mandate.
 - Using the findings of the Cost and Medical Effectiveness Teams, the Public Health Impact Team at UC Berkeley assesses the overall change in health outcomes in the affected population, using the estimates of changes in utilization resulting from the mandate combined with the rates of effectiveness of intervention derived from the medical-effectiveness literature review. In addition, the Public Health Impact Team estimates the extent to which the proposed benefit or service reduces premature death and the economic loss associated with disease or condition.
- developing a standard report format; and
- creating a user-friendly Web site, <http://www.chbrp.org/index.html>, to disseminate CHBRP reports.

Outcomes and products

- By January 2006, CHBRP issued 22 completed reports analyzing proposed benefit mandates, plus two analyses of amended bills, and four formal follow-up letters to the Legislature clarifying or providing further explanation of completed analysis or amended version of bills.
- All of the 22 analyses requested of CHBRP were completed within the 60-day timeframe or were designated specifically as two-year bills for which an extended submission date was permitted by the Legislature.¹ Table 5 provides a complete list of these analyses. The four follow-up letters and two analyses of amended bills were completed within an abbreviated timeframe in order to

¹ This exception occurred in CHBRP's initial year of operation when the first analyses were requested before staff had been hired and analyses procedures established.

provide useful information to the Legislature in time for hearings on the relevant bills.

- Of the seven mandate bills introduced during 2003 and analyzed by CHBRP, five were reintroduced in the second year of the two-year session. Two were not acted upon by the legislature in the first year of the session.
 - Of the five mandate bills that were reintroduced in the 2004, one was amended to pertain to another subject matter, and one did not pass out of the second house. Of the three that passed out of the legislature, two were vetoed by the Governor and one was enacted into law. One new mandate bill, introduced in 2004, was vetoed by the Governor.
 - Of the ten mandate bills introduced in 2005 and analyzed by CHBRP, seven did not move out of the legislature, either because the bill author decided to amend the bill to pertain to another subject matter, the legislation became a 2-year bill, or it was held in an appropriations suspense file. Of the three passed by the legislature, two were vetoed by the Governor and one was enacted into law.
- CHBRP staff provide oral testimony at policy committee hearings to answer questions regarding their analyses. Prior to the hearings, CHBRP staff provide any necessary assistance and clarifications requested by legislators and legislative staff regarding CHBRP's analyses. CHBRP staff and faculty provide ongoing consultation to legislative and state regulatory agency staff regarding CHBRP's analyses, and to consider the potential implications of various amendments under legislative consideration.
 - CHBRP strives to build and improve its methods, the transparency of its processes, and capacity to respond to the state legislature. This has been done by
 - meeting with stakeholders such as health plans and advocates to allow for input on specific bills and provide information on analytic methods;
 - meeting with legislative and agency staff on how to improve the readability, transparency and usefulness of the reports;
 - conducting public forums where CHBRP faculty and staff provided briefings on CHBRP's methods to the public, legislative and agency personnel, health advocates and stakeholders;
 - obtaining input from CHBRP's National Advisory Council to continuously improve the analyses and reports;
 - updating data sources and methods to reflect the most current available data and analytic approaches that can be feasibly implemented within a 60-day timeframe;
 - conducting an internal review of operations at the administrative and campus level to ensure adequate capacity to respond to the workload and deadline pressure during the first quarter of each calendar year; and
 - implementing quality improvement measures for the reports that were produced in 2005 and those expected to be produced in 2006.
 - Since its inception, the California Health Benefits Review Program has been administered by the University of California at a cost well within the \$2 million maximum annual allocation provided under AB 1996 by (non-General Fund, non-UC budgeted) funds derived from an assessment of health-insurance plans regulated by the Department of Insurance and the Department of Managed Health Care.

INTRODUCTION

On September 22, 2002, Governor Davis signed Assembly Bill 1996 (Statutes of 2002, Chapter 795) This bill “requested the University of California to assess legislation proposing mandated health care benefits to be provided by health care service plans and health insurers, and to prepare a written analysis in accordance with specified criteria.²”

This report is submitted by the University of California in compliance with *California Health and Safety Code*, Section 127664, which requests the University to submit a report to the Governor and the Legislature no later than January 1, 2006, regarding the implementation of Chapter 7, Part 2, of Division 107 of the Health & Safety Code (AB 1996).

The report summarizes the national and state context of AB 1996, the objectives and provisions of AB 1996, important elements of the University’s implementation, analyses requested and provided, refinements of the process, resources and budget issues, challenges for the program, and a discussion about the environment for benefit mandates over the next few years.

The National and State Context of AB 1996

By 2001, state-mandated health-benefit laws were proliferating in states across the nation. In California, more than 40 mandated benefits were enacted into state law by the close of that year, and more than 14 health-benefit mandate bills were introduced in the 2002 legislative session. Policymakers generally viewed mandated benefits as desirable to provide adequate coverage for a maximum number of subscribers, and sought to implement mandated benefits without increasing premiums and thereby potentially reducing coverage rates. However, concerns arose regarding cost containment, increasing opt-outs by small employers, and whether well-intended mandates actually served their intended purposes. In response, 16 states addressed benefits mandate review legislation in 2001–2002.

California’s Legislative Response

Legislative concern in California regarding the impact of health-benefits mandates was manifested in two bills introduced in the 2002 legislative session, both requiring an assessment of the effects of health-benefits legislation: AB 1801 and AB 1996.

AB 1801 (Pacheco) would have created a commission to study and report to the Legislature and the Department of Finance on: (1) the cost impact on the private sector, the Public Employees’ Retirement System, other retirement systems funded by the state or by a local government, Medi-Cal, and the Healthy Families program, resulting from proposed legislation affecting a health care service plan; (2) the impact of proposed legislation on persons in this state without health care coverage; and (3) public policies affecting health care costs and access to health care coverage in California.

² See [Appendix 1](#) for complete text of AB 1996 (2002).

Under AB 1801, this commission was to be composed of five members, three of whom were to be appointed by the Governor. Some viewed an evaluative commission of political appointees as being vulnerable to partisan influence and potential bias. A coalition of employers, for example, opposed the bill based on the political nature of appointments, advocated for a “majority of members with backgrounds that include economics, actuarial, employers benefit specialists, insurers, health-maintenance organizations (HMOs), as well as a consumer and/or labor representative.”³ Other features of the bill ran into opposition as well, such as the lack of a cap on study costs and lack of an automatic termination provision.

After consideration, the Assembly Health Committee decided to use an alternative legislative vehicle, AB 1996 (Thomson), which, on May 2, 2002, was amended to include some of the features of AB 1801, plus a broader scope of analysis that included the social, medical, and financial impacts of proposed mandated health care benefits. This version of the bill sought to create a potentially less-partisan commission. Although a majority of members were still appointed by the Governor, the membership was expanded to include representation from different stakeholder groups. The commission was given the authority to hire analytical staff and levy fees on health care service plans and insurers to provide funding for the enterprise.

Subsequent amendments to the bill located the commission within the Department of Managed Health Care, continued to expand its membership, and specified its role as independent, nonpartisan, and advisory.

In response to concerns regarding partisanship and cost, an amended version of AB 1996 (August 5, 2002) requested the University of California (UC) to administer the proposed program to provide objective analysis. This version of the bill required the UC to adopt conflict-of-interest provisions to prohibit a person from participating in any analysis in which that person has a material financial interest, capped study costs at \$2 million annually, and imposed a “sunset” provision.

According to the August 6, 2002, Senate Insurance Committee analysis, AB 1996 author Thomson believed that UC would be able to establish an independent, nonpartisan mechanism to analyze the clinical efficacy and cost effectiveness of legislative proposals for expanded health care benefits, and that by providing medical, economic, and actuarial expertise and current, accurate data and information to the Governor and the Legislature, UC would facilitate more-informed policy making with regard to legislation proposing mandated health benefits to be provided by health care service plans and health insurers. AB 1996 was chaptered into law on September 22, 2002.

AB 1996: Objectives and Provisions

The preamble to AB 1996 describes the Legislature’s intent and objectives:

The Legislature finds that there is an increasing number of proposals that mandate that certain health benefits be provided by health care service plans and health insurers as components of individual and group contracts. The Legislature further finds that many of these would potentially result in better health outcomes that would be in the public interest. However, the Legislature also recognizes that mandated benefits may

³ Correspondence between Employers Health Care Coalition of Los Angeles and Assembly Appropriations Committee, May 10, 2002.

contribute to the cost and affordability of health-insurance premiums. Therefore, it is the intent of the Legislature that the University of California conduct a systematic review of proposed mandated or mandatorily-offered health-benefit mandates. This review will assist the Legislature in determining whether mandating a particular coverage is in the public interest.

Unlike the majority of other states' mandates programs, the California mandate-review law requires assessing the medical effectiveness and public-health impact *in addition* to the cost impact of a proposed mandate evaluation.⁴ This requirement reflects the Legislature's own review process, which conducts separate policy and fiscal hearings on legislation. In addition, AB 1996 specified a timeframe—60 days—so that the relevant policy committees would have the California Health Benefits Review Program (CHBRP) analysis in time for deliberations. Finally, the Legislature intended the analyses to be unbiased, without conflicts of interest, and based on experts' review of the standards of care and reliable evidence and data sources.

To meet the intent of the Legislature, the following provisions were specified in AB 1996:

- 1) A “mandated benefit or service” is defined as “a proposed statute that requires a managed health care plan and/or health insurer” to (a) permit a person insured or covered under the policy or contract to obtain health care treatment or services from a particular type of health care provider, (b) offer or provide coverage for the screening, diagnosis, or treatment of a particular disease or condition, or (c) 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.
- 2) All legislation proposing a “mandated benefit or service” is to be analyzed by UC and a written analysis is to be prepared with relevant data on the legislation's public health, medical, and financial impacts, as defined.
- 3) Support for UC to conduct these analyses is to be provided through a non-General Fund source, specifically fees levied by the Department of Managed Health Care and the Department of Insurance on health-service plans and health insurers, respectively, the total annual amount of which shall not exceed \$2 million.
- 4) Legislative requests to UC pursuant to AB 1996 shall be made by an appropriate policy or fiscal committee chairperson or legislative leadership. (This task has been delegated to the Chair of the Senate Banking, Finance and Insurance Committee and the Chair of the Assembly Health Committee.)
- 5) UC is to submit analyses of proposed health-insurance mandate bills to the appropriate policy or fiscal committee not later than 60 days after receiving a request from the Legislature.
- 6) UC is to develop and implement conflict-of-interest provisions to prohibit participation in the analyses by a person with a material financial conflict of interest, including a person who has a consulting or other agreement with an entity that would be affected by the legislation.
- 7) UC is to use a certified actuary or other person with relevant knowledge and expertise to determine the financial impact of a given bill.
- 8) UC is to post all analyses on the Internet and make them available to the public on request.
- 9) UC was to analyze any of 10 specified benefit mandates, if proposed at the start of the 2003 legislative session.

⁴ See *State Mandated Benefit Review Laws* in [Appendix 20](#) for a paper in a forthcoming issue of *Health Services Research* which examines the characteristics of state laws that have established mandate review evaluation programs in the U.S.

- 10) UC is to provide the Governor and Legislature with a report on the implementation of AB 1996 by January 1, 2006. The established “sunset date” for the program is January 1, 2007, unless a later enacted statute extends or repeals that date.

Pursuant to the enactment of AB 1996, UC established the California Health Benefits Review Program (CHBRP). Although CHBRP is administered by UC, it is designed to act as an independent program to respond objectively to the Legislature's requests for analyses. To ensure expertise and objectivity, the implementation process entailed:

- 1) identifying appropriate research expertise vis-à-vis a statewide faculty task force;
- 2) establishing a national advisory council;
- 3) recruiting and hiring professional analytic and administrative staff;
- 4) designing a transparent and timely review process;
- 5) developing an appropriate conflict-of-interest policy;
- 6) retaining an actuary;
- 7) retaining librarians and content experts to support the literature review;
- 8) obtaining data from health plans for the cost-impact analysis;
- 9) obtaining information from consumer groups and other stakeholders;
- 10) developing standardized methods for conducting literature reviews and medical-effectiveness analyses;
- 11) developing standardized methods for coverage, utilization, and cost-impact analyses;
- 12) developing standardized methods for public-health impact analyses;
- 13) creating a user-friendly Web site to disseminate CHBRP reports; and
- 14) evaluating CHBRP's products/processes/policies to ensure CHBRP is continually meeting the provisions of AB 1996.

Identifying Appropriate Research Expertise: Faculty Task Force

UC's Division of Health Affairs solicited the deans of California's public and private medical schools and schools of public health for nominations of state experts to constitute a Faculty Task Force.⁵ From these nominees, researchers were selected from the University of California at San Francisco (UCSF), UC Berkeley, and the University of California at Los Angeles (UCLA) to serve as vice chairs and to coordinate the three statutorily-required components of each insurance-mandate evaluation (medical effectiveness, financial impact, and public-health impact analyses). Researchers from UC campuses at Davis, Irvine, and San Diego and from the University of Southern California, Loma Linda University, and Stanford University were also selected to ensure participation of all accredited medical-school campuses in California. The Faculty Task Force's expertise reflects the evaluation criteria set forth in AB 1996—the inclusion of experts in health-services research and health policy, public health, economics, political science, and clinical medicine. Details on how each vice-chair's research faculty and staff have developed methods and established processes to fulfill the requirement of AB 1996 are described in detail below.

Establishing a National Advisory Council

UC recruited a National Advisory Council (NAC) of experts from outside the state of California who were selected to provide balanced representation among groups with an interest in health-insurance benefit mandates. Recommendations for members of the NAC were suggested by the

⁵ See [Appendix 2](#), CHBRP Faculty Task Force Membership List.

CHBRP Director, Vice President of Health Affairs, and members of the Faculty Task Force and ratified by the Faculty Task Force. The NAC is composed of opinion leaders from key constituencies, including providers, purchasers, consumers, health-policy experts, and health plans.⁶ The NAC reviews CHBRP's draft bill analyses for accuracy, balance, clarity, and responsiveness to the Legislature's request before the reports are transmitted to the Legislature.⁷ The NAC meets annually. In addition to the annual meeting and review of individual draft reports, individual NAC members have provided advice to CHBRP staff on particular issues as they arise. During the 60-day time period, NAC reviews occur within five days of the last two weeks. Since the NAC was first organized, members have completed a total of 97 reviews. The NAC is an advisory body rather than a governance board.

Recruiting and Hiring Professional Analytic and Administrative Staff

UC hired a professional analytic staff to manage the review process to ensure that reports are produced within a 60-day time period, to support the Faculty Task Force and the NAC, and to serve as a liaison with the Legislature. CHBRP staff consists of a director, four analysts, and an administrative assistant.⁸ Administration and management of CHBRP resides in the system-wide University of California Office of the President (UCOP) within the Office of the Vice President for Health Affairs.

Contracting with an Actuarial Firm

UC retained Milliman (formerly Milliman USA) after a competitive bidding process to meet the AB 1996 requirement to include actuarial analysis in the financial-impact analysis on premiums. Milliman's senior actuaries are closely involved in developing the methodological approach for each analysis. In addition, they conduct actuarial analysis on premium impacts, support the Cost Team at UCLA in analyzing coverage, cost, and utilization impacts, and support the Public Health Impact Team at UC Berkeley by providing utilization data analyses for specific populations when available. Milliman's access to proprietary aggregate claims data enables CHBRP to conduct premium impact analysis for the various market segments. (Information on data sources used in cost analyses is available in [Appendix 11](#).)

Retaining Librarians and Content Experts to Support the Literature Review

The UCSF Medical Effectiveness Team and CHBRP staff addressed the need for resource-intense systematic literature review to be completed within the first three weeks of the analysis process. UCSF and CHBRP staff (1) developed a process to retain a content expert—an individual who has specialized clinical expertise pertaining to the benefit or service addressed by the proposed mandate—and (2) developed a process for retaining the services of medical librarians. Content experts were retained to (1) identify key literature, (2) assist the Medical Effectiveness Team in proposing literature search terms to be used by the medical librarian, (3) draw upon their clinical

⁶ See [Appendix 4](#), National Advisory Council Membership List,

⁷ See [Appendix 3](#), NAC Review Criteria and Guidelines

⁸ See [Appendix 5](#), CHBRP staff list

experience and knowledge of current standards of care to provide input on current and expected physician practice patterns, and (4) help identify and review the diagnostic and procedural codes associated with the mandated benefit or services. It is important to note that content experts were screened for conflicts of interest. More than one content expert was retained for an analysis in cases where expertise in more than one specialty or discipline was required (e.g., AB 1185 [2005] Chiropractic Services. See [Appendix 7](#), CHBRP Process and Policy for Selecting Content Experts).

Librarians with Masters in Library and Information Science from the UCSF Library and Center for Knowledge Management (primarily) and the UC San Diego Biological and Medical Center Libraries work with the Medical Effectiveness Team and the content expert within a four- to five-day period to (1) develop search strategies specific to the mandate, (2) conduct the literature search given inclusion/exclusion criteria developed by the Medical Effectiveness Team, (3) forward relevant abstracts of peer-reviewed literature to the Medical Effectiveness Team for researchers' review and selection, and (4) assist with any additional searches if needed and with obtaining interlibrary loans.

Developing a Conflict-of-Interest Policy

UC conducts a review of all CHBRP analytic participants' potential conflicts of interest at the point of affiliation with CHBRP. To systematically review potential conflicts, and to comply with the AB 1996 requirements,⁹UC developed a Conflict-of-Interest reporting form for the NAC and a separate form for use by all others (faculty and staff) who contribute to CHBRP analyses.¹⁰ These forms were modeled closely on a background and conflict-of-interest disclosure form designed by the National Academies of Sciences (NAS) for use with respect to studies relating to government regulation. (The UC and CHBRP are grateful to the NAS for extending its permission to use the NAS form.)

It is essential that the work of the participants in CHBRP activities not be compromised by any material conflict of interest. All who participate in the development of CHBRP's analyses are required to complete and submit a disclosure form and to update it annually or whenever compelled to do so by a change of circumstance, (e.g., a new investment, equity interest, change of employment, or the specific nature of a given item of legislation for review). The completed forms are recorded and reviewed by UC Health Affairs staff, who monitor potential conflicts and, as appropriate, request recusals where actual or perceived conflicts of interest arise in relation to a given bill.

Faculty Task Force members are encouraged to publish their research results in peer-reviewed journals; however, they are expected to avoid legislative testimony or lobbying related to the findings of CHBRP studies while serving on the Task Force.

Recusals are noted in CHBRP's bill analyses. In the last two years, a subset of CHBRP faculty recused themselves from seven separate analyses, due to potential conflicts of interest. In these

⁹ Health and Safety Code section 127663 requires UC to develop and implement conflict-of-interest provisions to prohibit a person from participating in an analysis in which the person knows or has reason to know he or she has a material financial interest, including but not limited to a person who has a consulting or other agreement that would be affected by the mandate benefit proposal

¹⁰ See [Appendix 8](#), CHBRP Conflict-of-Interest Policies, General Disclosure Form and NAC Disclosure Form

cases, other CHBRP researchers, including other faculty from the Task Force, have stepped in to conduct the relevant analysis.

As mentioned, potential content experts are screened for conflicts of interest before they are selected to work on a particular analysis. Examples of questions initially used to screen content experts are:

1. Do you have any financial interest in the proposed mandated benefit? Examples of financial conflicts:
 - Investments in pharmaceutical companies or medical device manufacturers;
 - relations with a drug company with products related to the mandate; or
 - receipt of research funding.

2. Do you have any interest from an insurance perspective in the proposed mandated benefit? Examples:
 - Have you acted as an expert witness? If so, for one or both sides?
 - Are you a member of a task force that has voted on the benefit being mandated?
 - Have you testified or taken a public position on the mandate?

3. Could your existing research create a perception of bias as it pertains to the proposed mandate? Such a perception might arise if a content expert authored research that included recommendations that are substantially similar to or directly oppose the proposed mandate.¹¹

Obtaining Data from Health Plans

CHBRP must obtain accurate coverage data from health plans and insurers to conduct the cost impact analyses according to the provisions of AB 1996. Coverage data enable CHBRP to (1) appropriately reflect existing (baseline) coverage, (2) obtain information on utilization controls (e.g., referrals requirements) if relevant to the mandate, and (3) obtain such information by market segment (e.g., large-group HMO and small-group preferred provider organization [PPO]). CHBRP worked with the California Association of Health Plans and the Association of California Life and Health Insurance Companies to obtain contact information from the largest health plans and insurers in the state (together representing approximately 75% of covered lives in California).¹² CHBRP works with each of these health plan representatives to ensure that bill-specific surveys are completed for CHBRP researchers to use in the cost impact analysis (see below).

Obtaining Information from Consumer Groups and Other Stakeholders

CHBRP developed a process to obtain information from interested parties for bills under analysis. “Interested parties” are defined by CHBRP as any member of the public, including bill sponsors, disease-specific organizations, consumer advocate organizations, or health plans. CHBRP announces a new legislative request on its Web site and via its email listserv. Any interested party may request that he or she be added to the listserv. All interested parties who

¹¹ See [Appendix 7](#) for details on the protocol for content expert identification, screening, and selection.

¹² http://www.cattaneostroud.com/2005HMO_Study/table_3b.pdf accessed on November 17, 2005

believe they have scientific evidence relevant to CHBRP's analysis of proposed health insurance benefit mandates are encouraged to provide that information to CHBRP's staff. In order for CHBRP to meet its statutory 60-day deadline to complete its analyses, CHBRP requests interested parties to submit information within the first 14 days of the review cycle. Information can be submitted via email, fax, or mail. CHBRP has received information through this public notification process on five completed analyses.

Once CHBRP receives the information submitted by the public, it is disseminated to the analytic team at each campus and to the actuary. The respective teams (Medical Effectiveness, Cost, and Public Health Impact) review the information to determine whether the evidence submitted is relevant to the analysis and meets the standard of rigor for inclusion. If the information is relevant and does meet the inclusion criteria, the teams will decide how to incorporate the information into the analyses. All information that has been submitted is listed in an appendix in the relevant analysis.

CHBRP also works cooperatively with the bill authors' staff to obtain any evidence or information submitted by bill sponsors. For example, Assemblymember Koretz's staff sent to CHBRP articles and citations provided by proponents of AB 228, a bill mandating that health plans cover transplantation services for HIV-positive patients. At the request of Assemblymember Koretz's office, CHBRP reviewed medical journal abstracts supplied by the California Chiropractic Association, sponsors of AB 1185, a bill that would mandate coverage of chiropractic services. Assemblymember Liu's staff sent CHBRP information submitted by proponents of AB 213, a bill mandating coverage for the treatment of lymphedema.

Designing a Transparent and Timely Review Process

In order to address the evaluation criteria specified in AB 1996 (see Table 1) in a timely, transparent manner, CHBRP developed a 60-day timeline that details which activities occur on what day.¹³ The 60-day clock is initiated upon receipt of a request from the Senate Committee on Banking, Finance and Insurance or the Assembly Committee on Health.

During the first two weeks, the program is to:

- review any potential conflicts of interest and establish recusals;
- identify the analytic teams from the Task Force, CHBRP staff, and the actuarial firm;
- work with legislative staff (including bill authors and committee staff) to clarify bill language and intent;
- conduct a mandate-specific health plan survey on coverage;
- develop literature search strategies for the medical effectiveness analysis and conduct the literature review;
- identify the appropriate codes for claims and utilization analysis;
- contact other state mandate-review programs to obtain completed analyses or share knowledge; and
- post on the Web site and send out to the listserv an announcement regarding the new request with information on how interested parties can submit information for CHBRP's consideration.

¹³ See [Appendix 9](#), the 60-Day Timeline of the Analytical Process

During the following three weeks the program is to:

- review any information submitted by interested parties;
- complete the medical effectiveness analysis;
- develop an analytic approach to the cost impact analysis;
- review and compile available information on gender, racial, and relevant population impacts;
- review and compile available information on the economic burden of the disease or illness the mandate attempts to address; and
- draft all three sections and compile any additional information that may be warranted (e.g., a special section on implementation or additional background material).

During the following two weeks the program is to:

- complete the first draft of the fully integrated report including appendices, tables, and executive summary;
- ensure internal review by Vice Chairs and designated internal peer reviewers; and
- revise as necessary.

During the final one-and-a-half weeks the program is to:

- ensure that a subcommittee of the NAC conducts a review of the analysis;
- make necessary revisions;
- edit, finalize, and produce the report for electronic publishing; and
- submit the report to the Legislature, email to listserv and post it on the Web site.

TABLE 1: AB 1996 Criteria for Evaluation

- (1) **Public health impacts**, including, but not limited to, all of the following:
- (A) The impact on the health of the community, including the reduction of communicable disease and the benefits of prevention such as those provided by childhood immunizations and prenatal care.
 - (B) The impact on the health of the community, including diseases and conditions where gender and racial disparities in outcomes are established in peer-reviewed scientific and medical literature.
 - (C) The extent to which the proposed service reduces premature death and the economic loss associated with disease.
- (2) **Medical impacts**, including, but not limited to, all of the following:
- (A) The extent to which the benefit or service is generally recognized by the medical community as being effective in the screening, diagnosis, or treatment of a condition or disease, as demonstrated by a review of scientific and peer-reviewed medical literature.
 - (B) The extent to which the benefit or service is generally available and utilized by treating physicians.
 - (C) The contribution of the benefit or service to the health status of the population, including the results of any research demonstrating the efficacy of the benefit or service compared to alternatives, including not providing the benefit or service.
 - (D) The extent to which the proposed services do not diminish or eliminate access to currently available health care services.
- (3) **Financial impacts**, including, but not limited to, all of the following:
- (A) The extent to which the coverage will increase or decrease the benefit or cost of the service.
 - (B) The extent to which the coverage will increase the utilization of the benefit or service, or will be a substitute for, or affect the cost of, alternative services.
 - (C) The extent to which the coverage will increase or decrease the administrative expenses of health care service plans and health insurers, and the premium, and expenses of subscribers, enrollees, and policyholders.
 - (D) The impact of this coverage on the total cost of health care.
 - (E) The potential cost or savings to the private sector, including the impact on small employers as defined in paragraph (1) of subdivision (l) of Section 1357, the Public Employees' Retirement System, other retirement systems funded by the state or by a local government, individuals purchasing individual health insurance, and publicly-funded state health insurance programs, including the Medi-Cal program and the Healthy Families Program.
 - (F) The extent to which costs resulting from lack of coverage are shifted to other payers, including both public and private entities.
 - (G) The extent to which the proposed benefit or service does not diminish or eliminate access to currently available health care services.
 - (H) The extent to which the benefit or service is generally utilized by a significant portion of the population.
 - (I) The extent to which health care coverage for the benefit or service is already generally available.
 - (J) The level of public demand for health care coverage for the benefit or service, including the level of interest of collective-bargaining agents in negotiating privately for inclusion of this coverage in group contracts, and the extent to which the mandated benefit or service is covered by self-funded employer groups.
 - (K) In assessing and preparing a written analysis of the financial impact of a mandated benefit pursuant to this paragraph, the Legislature requests the University of California to use a certified actuary or other person with relevant knowledge and expertise to determine the financial impact.

Developing Standardized Methods for Literature Reviews and Medical Effectiveness Analyses

AB 1996 requires CHBRP to address in its medical impact analysis:

“...the extent to which the benefit or service is generally recognized by the medical community as being effective in the screening, diagnosis, or treatment of a condition or disease, as demonstrated by a review of scientific and peer-reviewed medical literature.”

“The extent to which the benefit or service is generally available and utilized by treating physicians.”

“The contribution of the benefit or service to the health status of the population, including the results of any research demonstrating the efficacy of the benefit or service compared to alternatives, including not providing the benefit or service.”¹⁴

To ensure that the medical impact analysis appropriately synthesizes and analyzes the existing body of scientific evidence as it pertains to the effectiveness of a proposed service or benefit, the Medical Effectiveness Team at UCSF has developed a process for conducting literature searches and a method for analyzing the literature to report on whether and to what extent a particular mandate will result in changes in relevant patient outcomes. This process and method are summarized below, but for further details, please see [Appendix 10](#) for a description of the general approach to the medical effectiveness analysis and for a description of the step-by-step process.

Conducting the literature search

When CHBRP receives a request to analyze bills from the California Legislature, the Medical Effectiveness Team works with the content expert and the librarian to identify appropriate search terms and launch a literature review. This includes ensuring that the scope of the literature is well defined and reflects not only the language/intent of the proposed mandate, but also the agreed-upon scope of the CHBRP analysis. The Medical Effectiveness Team identifies the type of intervention(s) mandated in the bill and the literature needed to address key issues in the bill (i.e., is the intervention a screening, diagnostic, or monitoring test, a procedure, a device, or a treatment?) and the health outcomes of interest for the proposed intervention(s) (i.e., improved limb function, better self-management of a chronic illness, or slowing of disease progression?). Key issues may also include changes in provider management of illness or injury that may result from the intervention being studied.

Screening, diagnostic, monitoring and treatment interventions require different search strategies and analytic approaches. For example, a treatment is typically designed to cure a disease or to improve function. Designing trials to determine how well the treatment works may be relatively straightforward and literature may be available to directly assess effectiveness. On the other hand, a screening test might indicate an increased risk of a disease. This may lead to recommendations for one or more types of preventive interventions. The interventions may vary in their effectiveness, and the disease, which may or may not occur even though a screening test is positive, may be treated in various ways. Extended periods of time would be necessary to assess each of these links. Testing and treatment options are continually changing over time, and studies that directly address the effectiveness questions raised in a bill are not always be available. In such cases, an effectiveness

¹⁴ Health & Safety Code, Section 127660, subdivision (a) (2) (A)-(C).

assessment of an intervention must be built upon information available for various parts of the “evidence chain.” This may influence how the medical effectiveness analysis is undertaken. These considerations are taken into account when determining the scope of the literature search. In addition, because CHBRP is governed by a 60-day time period, the literature search is limited by certain criteria, which are discussed below.

Medical effectiveness analysis methods

In general, Medical Effectiveness Team faculty and staff adhere to the following hierarchy of evidence, both in conducting the literature search and in analyzing the literature. In other words, certain types of articles or studies are given more “weight” because they are more comprehensive and their research designs are more rigorous. The following are listed in order from most rigorous to least:

1. meta-analyses—The Medical Effectiveness Team relies on meta-analyses, particularly those included in the Cochrane Library, as the principal source of evidence for the review. This is because researchers who have undertaken the meta-analyses typically have had the time and opportunity to examine in some detail the methods of the studies and have excluded studies with less rigorous methods. The remainder of the literature review is focused on systematic reviews and primary studies published after the studies included in the meta-analyses;
2. systematic reviews—particularly those performed by authoritative organizations, such as the U.S. Department of Health and Human Services’ Agency for Healthcare Research and Quality, U.S. Preventive Services Task Force, and Evidence-Based Practice Teams or other government agencies (e.g., National Institutes of Health, Centers for Disease Control and Prevention, Center for Medicare & Medicaid Services);
3. evidence-based guidelines;
4. individual randomized controlled trials;
5. observational studies;
6. case-control studies; and
7. clinical/practice guidelines based on consensus or opinion, rather than on evidence.

A summary of the literature is provided in a standard appendix (Appendix B) of each CHBRP report (see Table 2 below for an example).

Table 2: Summary of Published Studies on Effectiveness of Pediatric Asthma Self-Management and Training Interventions

Citation	Type of Trial	Intervention vs. Comparison Group	Population Studied	Location
Huss et al., 2003	OS	Education and computer-based instructional asthma game vs. education alone	Inner-city children	Baltimore, MD
Krishna et al., 2003	RCT	Internet-enabled, interactive multimedia asthma education and conventional education, management (with action plan) vs. conventional education and management (with action plan)	Children who visited a pediatric pulmonary clinic	St. Louis, MO

OS, observational study; RCT, randomized controlled trial.

Once the literature is reviewed and studies ranked for each outcome measure, the Medical Effectiveness Team assesses what the literature shows about the evidence of effectiveness of the proposed service or benefit on the health outcome measured. In making this assessment for each outcome measure, the Medical Effectiveness Team faculty and staff and the content expert consider the number of studies (as well as their sample size, quality, and relevance to the California population) included in any meta-analyses as well as the same issues in regard to other relevant studies. Evidence for each outcome is “graded” as falling into one of the following categories:

1. Favorable (statistically significant effect): Findings are uniformly favorable and many or all are statistically significant.
2. Pattern toward favorable (but not statistically significant): Findings are generally favorable, but there may be none that are statistically significant.
3. Ambiguous/mixed evidence: Some findings are significantly favorable and some findings with sufficient statistical power show no effect.
4. Pattern toward no effect/weak evidence: Studies generally find no effect, but this may be due to a lack of statistical power.
5. No effect: Studies have sufficient statistical power to assess effects and generally find no effect on the outcomes examined.
6. Unfavorable: No findings show a statistically significant benefit and some show significant harms.
7. Insufficient evidence to make a “call”: There are very few relevant findings, making it difficult to discern a pattern. (Note that this is different than #5 in which there is sufficient information to conclude that an intervention has no effect.)

In some cases, the literature is robust enough to provide quantifiable evidence for specific outcomes. For studies with quantifiable outcomes (e.g., decrease in number of school days absent, decrease in hospitalizations or length of hospital stay, or decrease in emergency department visits), the Medical Effectiveness Team creates a table that includes all studies that measure that specific outcome and presents the results of studies (including the Team’s assessment of studies of outcomes based on the weight of the evidence). Table 3 shows the effect of an asthma education self-management program on the mean number of school day absences for children with asthma. In this example, the “grade” for the evidence of effectiveness for this intervention in terms of school absences is “favorable” in the following sample table. The overall effect, based on seven published U.S. trials included in a meta-analysis and one additional trial from 2003, is an estimated 44% reduction in the mean number of school days absent.

Table 3: Summary of Evidence of Effectiveness by Health Outcome School Day Absences (Mean days)—Favorable		
Trial	Results	Categorization of Results (Significance, Direction)
Meta-analysis (16 trials)	SMD -0.14 [-0.23, -0.04]	Sig, fav
Estimated impact from U.S trials (7 trials included in meta-analysis)	44% reduction This reduction is calculated as the weighted average of the relevant studies (7 in the meta-analysis and 1 additional trial in 2003).	Sig, fav

Table 3: Summary of Evidence of Effectiveness by Health Outcome School Day Absences (Mean days)—Favorable		
Trial	Results	Categorization of Results (Significance, Direction)
Krishna et al., 2003	Intervention pre 7.9 → post 1.4, control pre 6.4 → post 5.4	Sig, fav
*Fireman et al., 1981	Mean intervention post 0.5, control post 4.6	Sig, fav
*Christiansen et al., 1997	Mean intervention post 2.39, control post 2.98	NS, fav
*Persaud et al., 1996	Intervention post 6.4, control post 7.6	NS, fav
*Wilson et al., 1996	Sick days in 1 month: intervention pre 1.0 → post 0.8, control pre 0.7 → post 1.4	NS, fav
*Perrin et al., 1992	Number/month: intervention pre 0.73 → post 0.24, control pre 0.14 → post 0.22	NS, fav
*Evans et al., 1987	Absences/year: intervention pre 21.3 → post 19.4, control pre 20.8 → post 19.7	NS, fav
*Rubin, 1986	Intervention pre 13.0 → post 14.1, control pre 17.0 → post 18.6	NS, fav

* Included in meta-analysis.

Key: fav, favorable; NS, not significant; sig, significant; SMD, standardized mean difference.

Developing Standardized Methods for Coverage, Utilization, and Cost Impact Analyses

In AB 1996, California legislators identified two major sets of financial information that they were interested in understanding regarding proposed health benefits mandates: (1) current coverage, utilization and cost, and (2) projected changes in coverage, utilization and costs after the implementation of a mandate.

The specific information regarding current coverage requested by the California Legislature for each mandate includes:

- existing coverage of the service in the current insurance market;
- current utilization and cost of providing a benefit;
- public demand for coverage among self-insured plans; and
- current costs borne by insurers.

The specific information regarding post-mandate effects requested by the Legislature includes:

- changes in utilization;
- changes in the per unit cost of providing the service;
- administrative costs;
- impact on total health care costs;
- costs or savings for different types of insurers; and
- impact on access and availability of services.

Public Demand

Based on criteria specified under AB 1996, CHBRP is to report on the “level of public demand for health care coverage for the benefit or service, including the level of interest of collective bargaining agents in negotiating privately for inclusion of this [mandated benefit] coverage in

group contracts and the extent to which” self-insured plans currently have coverage for the proposed mandate as a method to gauge public demand for that mandate.

To determine the collective bargaining agents’ level of interest in negotiating privately for inclusion of this mandated benefit coverage in group contracts, CHBRP queries the California Labor Federation and the Service Employees International Union (SEIU), California State Council. Based on conversations with these large collective bargaining agents, unions do not generally include benefit-by-benefit provisions during the negotiations of their health insurance policies. Instead, they tend to negotiate on benefit “packages” with broad parameters (e.g. premium levels, cost-sharing arrangements, and coverage for dependants). In order to determine whether any local unions engage in negotiations for any particular benefit mandate, they would need to be surveyed individually.¹⁵

To determine the “extent to which the mandated benefit or service is covered by self-funded employer groups,” CHBRP queries the largest public self-funded employer group, the California Public Employees’ Retirement System (CalPERS) regarding existing coverage of the proposed mandate. CalPERS benefit coverage is reported in each CHBRP bill analysis.

California Cost and Coverage Model

To respond to AB 1996 cost and coverage evaluation provisions, the UCLA Cost Team and actuaries from Milliman developed the California Cost and Coverage Model. This model addresses each of these baseline and post-mandate financial impacts, with the exception of public demand for expanding coverage, which is addressed through discussion with unions and California Public Employees’ Retirement System (CalPERS) to determine the breadth of support for each proposed mandate, and the impacts of mandates on access and availability, which require assumptions about whether there are serious supply constraints that might affect the cost or availability of a service if demand substantially increased in response to a mandate.

The California Cost and Coverage Model (see [Appendix 11](#)) is primarily an actuarial forecasting model. Such models are particularly appropriate when substantial behavioral changes in response to mandates are likely to be limited in the short run. To the extent that mandates have a small impact on health insurance premiums and overall health care expenditures, behavioral changes do not need to be modeled and an actuarial forecast should produce a reliable approximation of a mandate’s financial impact.

Definition of terms. “Cost” is defined as the aggregate expenditures, or prices paid, for health care services—not as the costs incurred by the providers of health care. The rationale for this definition of “cost” is that legislators are ultimately interested in evaluating the financial impact of mandates on each of the major payers for health care services in the state.

The following elements of cost are included in the model:

- insurance premiums;
- member cost sharing;
- total cost of covered benefits;
- costs paid by patients who have insurance for mandated services not currently covered by insurance; and

¹⁵ Communication with SEIU and California Labor Federation on February 8, 2005

- total expenditures for health insurance and uncovered mandated benefits.

“Utilization” is defined as the frequency or volume of use of a mandated service. Utilization is the product of the number of health plan members who use the mandated service and the average number of mandated services they use per calendar period.

“Coverage” is defined as the extent to which the mandated services are covered by insurance—either through a health care service plan (an HMO) or a health insurance policy.

Data sources. To estimate current levels of coverage, utilization, and expenditures for the mandated benefit(s), CHBRP constructed a baseline Cost and Coverage Model using data from three primary sources: (1) the 2003 California Health Interview Survey (CHIS), (2) the 2004 California Health Care Foundation/Health Research and Education Trust (CHCF/HRET) California Employer Health Benefits Survey, and (3) the Milliman Health Cost Guidelines. Actual enrollment data from state agencies providing coverage to individuals who lack coverage from private sources are used to validate the CHIS estimates of those enrolled in Medi-Cal and Healthy Families programs.

Coverage and demographic data sources.

The 2003 CHIS is used to identify the demographic characteristics and estimate the insurance coverage of the population in the state. The CHIS is a random telephone survey of over 44,000 households conducted in multiple languages by the UCLA Center for Health Policy Research. This survey allows CHBRP to estimate the number of people with individual insurance coverage and the number with employer-sponsored insurance coverage.

To obtain estimates of the percentage of employees by size of firm and type of health plan, CHBRP used the 2004 California Health Care Foundation/Health Research and Educational Trust (CHCF/HRET) survey of California employers. Collected annually since 2000, these data provide estimates of numbers of employees working in such firms and their types of coverage, based on a representative sample of California’s employers. Coverage categories include conventional fee-for-service (FFS), preferred provider organizations (PPOs), point-of-service (POS) plans, and health maintenance organizations (HMOs). Furthermore, the CHCF/HRET survey also provides information on whether each health plan is self-insured or underwritten.

The model includes four plan types (HMO, POS, PPO, and FFS) and three categories of private purchasers (large group, small group, and individual) to represent typical insured plan benefits in California. Specifically, the privately-insured market was divided into large-group (51 or more employees), small-group (two to 50 employees), and individual coverage, because each of these markets is subject to different regulations and market forces. Since POS plans are similar in type and regulatory requirements as HMOs, POS enrollees are combined with HMO enrollees to form the “HMO” category. Since the number of enrollees in FFS plans is small, the FFS enrollees are combined with PPOs to form the “non-HMO” category. The model thus produces estimates for each market segment (HMO and non-HMO plans for large and small employers and for those enrolled in the individual market). In addition, the model captures those covered under CalPERS

(HMO), Medi-Cal (Managed Care), and Healthy Families.¹⁶ The final estimates for California’s population divided by market segments are shown in Table 4.

To determine baseline coverage for a mandated benefit, CHBRP conducts an ad hoc survey of the seven largest California health plans and insurers—Aetna, Blue Cross of California, Blue Shield of California, CIGNA, Health Net, Kaiser Foundation Health Plan, and PacifiCare. Enrollment and coverage estimates from these insurers vary across assessments because some mandates are limited to Knox-Keene licensed plans (HMOs) or to policies regulated under the California Insurance Code. Coverage for CalPERS, Medi-Cal Managed Care, and Healthy Families is usually publicly available through the Department of Health Services (DHS), Managed Risk Medical Insurance Board (MRMIB), and CalPERS Web sites.

Utilization and expenditure data sources.

The utilization and expenditure data for the California Cost and Coverage Model are drawn primarily from the Milliman Health Cost Guidelines (HCGs). The HCGs are a health care pricing tool used by actuaries in many of the major health plans in the United States. The guidelines provide a flexible but consistent basis for estimating health care costs for a wide variety of commercial health insurance plans. The HCGs are used nationwide and by several California HMOs and insurance companies, including at least five of the largest plans. It is likely that these organizations would use the HCGs, among other tools, to determine the initial premium impact of any new mandate. Thus, in addition to producing accurate estimates of the costs of a mandate, the HCG-based values should also be good estimates of the premium impact as estimated by the HMOs and insurance companies.

Most of the data sources underlying the HCGs are claims databases from commercial health insurance plans. In particular, the data come from health insurance companies, “Blues” plans, HMOs, self-funded employers, and from private data vendors. The data are mostly from loosely-managed health care plans, such as traditional indemnity-style plans and PPO plans. The HCGs are also based on data commonly used by health services researchers.

All the baseline analyses performed by Milliman start with PPOs in the large-group market, then make adjustments to the baseline data to account for differences by type of insurance, size of market, and geographic location. The process of applying adjustments to arrive at estimates of baseline utilization and expenditures in each of the market segments, and the process of estimating changes in utilization due to mandates, are both described in the detailed model description, *The California Cost and Coverage Model: An Analytic Tool for Examining the Financial Impacts of Benefit Mandates* (see [Appendix 11](#))¹⁷

¹⁶ MRMIP, Access for Infants and Mothers, and other public programs are included in the “Other Public Programs, non-Medi-Cal, Medicare” category.

¹⁷ In 2005, CHBRP undertook an extensive revision to the Cost Model by updating the population estimates to appropriately model for impacts to the CalPERS, Medi-Cal, and Healthy Families. In addition, CHBRP decided to present two categories of plans (HMO/POS vs PPO/FFS) in 2005. Because *The California Cost and Coverage Model: An Analytic Tool for Examining the Financial Impacts of Benefit Mandates* was written in 2004, it does not reflect these changes. However, it discusses CHBRP’s general approach to modeling the cost impact to the privately-insured market.

Table 4. Insurance Coverage of Californians by Market Segment, 2005

Uninsured Market Segment					
	Ages (years)				Total
	0–17				672,000
	18–64				4,226,000
	65+				21,000
Publicly-Funded Market Segment					
	Ages (years)	HMO¹	Non-HMO²	Total	
Healthy Families	0–17	63,000	114,000	577,000	
Healthy Families	18–64 ³	31,000	3,000	35,000	
Medicare, non-Medi-Cal	18–64	91,000	76,000	167,000	
Medicare	65+	796,000	2,020,000	2,806,000	
CalPERS	0–17	210,000	64,000	274,000	
CalPERS	18–64	585,000	179,000	764,000	
Medi-Cal	All ages			5,877,000	
Other public (non-Medi-Cal/ Medicare)	0–17			133,000	
Other public (non-Medi-Cal/ Medicare)	18–64			382,000	
Other public (non-Medi-Cal/ Medicare)	65+			179,000	
Privately-Insured Market Segment					
	Ages (years)	HMO¹	Non-HMO²	Total	
<i>Individually-purchased</i>					
Individually purchased	0–17	23,000	245,000 ³	468,000	
Individually purchased	18–64	665,000	820,000	1,485,000	
<i>Employment-based</i>					
Small group (non CalPERS) ⁵	0–17	524,000	397,000	921,000	
Small group (non CalPERS) ⁵	18–64	1,575,000	1,152,000	2,727,000	
Self-insured ⁶	0–17	153,000	55,000	209,000	
Self-insured ⁶	18–64	448,000	160,000	609,000	
Underwritten ⁶	0–17	595,000	118,000	713,000	
Underwritten ⁶	18–64	1,778,000	341,000	2,118,000	
Large group (non-CalPERS) ⁵	0–17	2,634,000	1,332,000	3,966,000	
Large group (non-CalPERS) ⁵	18–64	6,001,000	3,406,000	9,407,000	
Self-insured ⁶	0–17	366,000	293,000	658,000	
Self-insured ⁶	18–64	869,000	749,000	1,618,000	
Underwritten ⁶	0–17	3,173,000	134,000	3,307,000	
Underwritten ⁶	18–64	7,447,000	343,000	7,790,000	
California's Total Population				35,086,000	

Sources: 2003 California Health Interview Survey (CHIS), 2004 California Health Care Foundation/Health Research and Education Trust (CHCF/HRET) Survey of California Employers.

¹ "HMO" includes HMO and POS enrollees.

² Non-HMO" includes PPOs and FFS enrollees.

³ Healthy Families 18–64-year-old category only includes those who are aged 18 years and less because those over 18 are not eligible.

⁴ CHIS data only distinguishes individuals with HMO coverage from those with non-HMO coverage.

⁵ Estimates of workers in HMOs, PPOs, POS, and FFS are obtained by multiplying the percentages of workers in each plan type from HRET 2004 data and CHIS population estimate of workers.

⁶ Estimates of workers in HMOs, PPOs, POS, and FFS who are in self-insured plans are obtained by multiplying the percentages of self-insured workers in each plan type from HRET 2004 data and CHIS 2003 population estimate of workers.

Developing Standardized Methods for Public Health Impact Analyses

AB 1996 requires a written analysis of the public health impact of legislation that proposes a mandated benefit or service, including, but not limited to, the following:

The impact on the health of the community, including the reduction of communicable disease and the benefits of prevention such as those provided by childhood immunizations and prenatal care.

The impact on the health of the community, including diseases and conditions where gender and racial disparities in outcomes are established in peer-reviewed scientific and medical literature.

The extent to which the proposed service reduces premature death and the economic loss associated with disease.¹⁸

Researchers from the Public Health Impact Team at UC Berkeley identified data sources and developed the specific methods to evaluate proposed mandates based on the above-specified criteria.

Health outcomes and data sources

Prior to collection of baseline public health data, the CHBRP analysis team meets to determine and define the relevant health outcomes related to the proposed mandate. For each defined health outcome, baseline data on the incidence and prevalence and health services utilization rates of associated conditions are collected. There are four primary datasets that are used to conduct the public health impact analysis: CHIS, the California Behavioral Risk Factor Survey (BRFS), the CDC WONDER database, and the claims database maintained by Milliman.

Data elements and analysis

Four types of data are needed to conduct the public health impact analysis. First, estimates of baseline health status and health care utilization rates of relevant services are collected. Baseline health status data include, but are not limited to, rates of disease, morbidity, mortality, premature death, disability, health behaviors, and other risk factors stratified by age, gender, race, and ethnicity. Measures of relevant baseline health care utilization in the affected population are obtained and may include rates of physician visits, emergency department visits, and inpatient admissions, length of stay, and prescription drug. Utilization measures may also be stratified by age, gender, condition, and type of health insurance. The specific services for which utilization rates are needed vary by benefit mandate.

Second, the change in coverage suggested by the proposed legislation is estimated. This includes estimates of the number of insured Californians who are presently covered for the proposed benefit and the number who would be newly covered if the mandate were enacted. Coverage rates are derived from surveys of employers and health plans regarding current coverage for the specific mandate benefits. The affected population will vary by mandate and may be defined by gender, age, condition, and type of health insurance coverage.

Third, measures of utilization impacts are estimated for insured Californians who are presently covered for the proposed benefit and those who will be newly covered for the benefit, after the mandate. For persons newly covered by the mandate, an assumption is made about their

¹⁸ Health & Safety Code, Section 127660, subdivision (a) (1).

utilization of the new benefit based on current use of those with existing coverage, as well as use of similar kinds of services by the affected population. Expert opinion and a literature review guide the assumptions regarding expected changes in utilization for people who are currently covered.

Finally, based on the findings from the literature review on medical effectiveness, estimates are made on the impact of new utilization of the mandated benefit on specific health outcomes in the affected population (e.g., the effect of asthma self-management training on the reduction of hospitalizations). The literature review may include meta-analyses and randomized controlled trials providing information on the effectiveness of the proposed benefit or service on specific health outcomes. The Public Health Impact Team compiles the results to produce an overall mean estimate that can be used to calculate the predicted health effects of the benefit mandate. This final step in the analysis assesses the overall change in health outcomes in the affected population, using the estimates of changes in utilization resulting from the mandate combined with the rates of effectiveness of intervention derived from the medical effectiveness literature review. For each specific health outcome reviewed in the literature for which baseline health outcomes data are available, the estimated impact on each health outcome is applied to the affected population to determine the overall change in outcomes resulting from the mandate. In addition, the Public Health Impact Team estimates the extent to which the proposed benefit or service reduces premature death and the economic loss associated with disease and includes expected effects by gender and race/ethnicity whenever data are available.¹⁹

Disseminating CHBRP Reports

The CHBRP Web site, <http://www.chbrp.org>, provides full access to all CHBRP reports and the legislation analyzed in the reports, as required by AB 1996. The Web site also announces new requests from the Legislature and provides instructions on how interested parties can provide CHBRP with evidence they believe should be considered in its analyses. Reference documents describing CHBRP's processes and methods are also available. Individuals associated with CHBRP's work are also listed, including CHBRP's staff ([Appendix 5](#)), Task Force members ([Appendix 2](#)), and NAC members ([Appendix 4](#)). Finally, the Web site serves as the forum for making announcements. For example, a public informational session for legislative staff held in Sacramento on January 24, 2005, was announced on the Web site.

CHBRP also maintains a listserv as an additional venue for disseminating information. Any member of the public interested in receiving email notices from CHBRP may join the listserv by means of an online sign-up process. Currently there are approximately 100 individuals who have signed up to receive such notices, including legislative staff, consumer and interest groups, health plan representatives, and state government agency employees from other states.

Evaluating CHBRP's Products to Ensure Compliance with Provisions of AB 1996

UC continually evaluates the products, processes, and policies of CHBRP to ensure that the program is in compliance with the requirements of AB 1996.

¹⁹ For additional details on the public health impact methods for analyses, see [Appendix 12](#).

For example, UC reviews the conflict-of-interest form on an annual basis to ensure that it reflects the most up-to-date standards from a national and scientific perspective. All CHBRP-related personnel update their disclosures on an annual basis using the revised forms. UC also ensures that the CHBRP reports make no recommendations to the Legislature as to the adoption of a particular bill. In addition, CHBRP reports are not to use language that may imply bias for or against the proposed mandate. Every effort is made to ensure that statements that appear to be pure judgments—not grounded in evidence, expertise, or sound methods—are excluded from the final reports.

Discussions with legislative staff during summer/fall of 2004

During the summer and fall of 2004, CHBRP staff met with legislative staff from the Senate Insurance Committee (now Banking, Finance and Insurance), the Assembly Health Committee, the Senate Health Committee, the Senate Republican Caucus, the Assembly Republican Caucus, the Senate Appropriations Committee, and the Assembly Appropriations Committee to obtain feedback on the first round of reports and determine ways CHBRP could improve the transparency of the review process and methods, responsiveness to bill analysis requests, and the completeness and readability of the reports.

Legislative staff stressed the limited period of time they have to digest the “heavy” reports CHBRP provides. They felt that it was important to have key information—including important caveats—in the executive summary. In addition, they expressed some frustration at having to hunt for the cost impact tables at the end of the reports. In response to these comments, CHBRP revamped the executive summary to include the salient bullet points to each analysis and a summary table of coverage, utilization, and cost impacts.

Because mandate bills would generally apply to CalPERS, Medi-Cal, and MRMIB, legislative staff stated that it would be important for CHBRP reports to explicitly state the cost impact to these programs. The Appropriations Committees were most interested in this information since it would be part of the legislative analyses their staff prepare for members during the hearings. In light of this, CHBRP worked with CalPERS to obtain baseline enrollment and premium information for its HMO product lines (self-insured products are exempt from mandates). CHBRP also worked with the DHS to clarify which data sources to use and to obtain baseline, state-wide, payment rate information for Medi-Cal Managed Care. MRMIB also worked with CHBRP to provide baseline enrollment, premium and benefit information for Healthy Families, Access for Infants and Mothers (AIM), and Major Risk Medical Insurance Program (MRMIP). CHBRP has established cooperative, working relationships with each of these organizations and agencies.

Discussions with legislative staff, agencies, Governor’s office in summer/fall of 2005

CHBRP conducted another round of meetings in Sacramento during the summer and fall of 2005. CHBRP staff met with the staff from the Senate Banking, Finance and Insurance Committee, the Assembly Health Committee, the Senate Health Committee, the Senate Republican Caucus, the Assembly Republican Caucus, the Senate Appropriations Committee, the Assembly Appropriations Committee, the Senate President Pro Tem, the Department of Managed Health Care (DMHC), the California Department of Insurance (CDI), DHS (including Medi-Cal staff and DHS leadership), MRMIB, CalPERS, and the Governor’s Office to update knowledge of stakeholders’ experience with CHBRP processes and reports. In addition, CHBRP held discussions with other stakeholders, including individual health plans and insurers, the California Association of Health Plans, and consumer advocates.

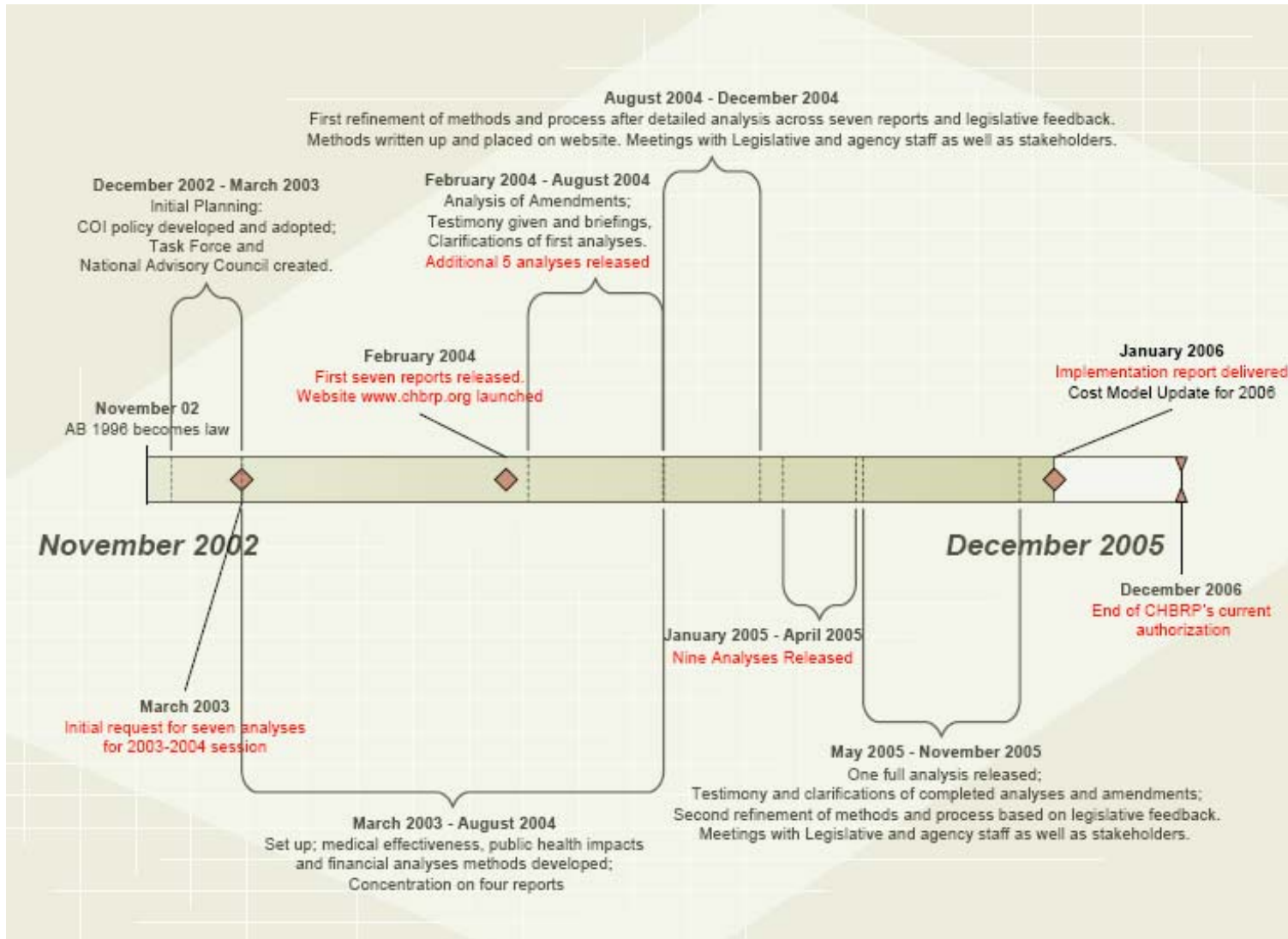
Legislative staff all reported that they utilize the CHBRP analyses, generally find the information they need in the analyses, and find the reports responsive, comprehensive, and useful. Staff also stated that the CHBRP reports provide the essential technical information the Legislature needs to deliberate the complex policy arena of health insurance benefit mandates. In previous years, staff stated that they were completely dependent on information provided to them by advocates, health plans and insurers, and interest groups. Now, as a result of CHBRP reports, they report having an improved perspective of the current status of health care coverage, and the potential impacts of the proposed mandate.

Other key messages relayed by staff:

- Legislative/executive agency staff rely heavily on CHBRP reports to write analyses for hearings or during gubernatorial review of bills that have passed the Legislature.
- The executive summaries of the CHBRP reports are the key sections used in staff analyses.
- CHBRP reports are an important tool to help answer legislators' questions.
- Staff discuss reports with stakeholders, such as the health plans, and the sponsor.
- While staff understood that some analytic questions are outside the scope of AB 1996, they would still like to have a better sense of (1) longer-term impacts of certain bills, especially those that might be preventive in nature, and (2) the impact on the uninsured, even if the impact was negligible.
- Staff stressed the importance of transparency in the analyses, for example, to express in executive summaries how utilization assumptions are derived, since they are the basis of the premium and fiscal impact estimates.
- Generally, CHBRP reports are trusted due to use of neutral language. This helps to avoid the appearance of bias in reporting results.
- It would be helpful if CHBRP consents to continue to deal with amendments on a case-by-case basis. Staff agreed that, in cases in which it was not possible to conduct an analysis of an amendment in time for the next hearing, a letter describing the analytic issues would be useful.

In order to be responsive to legislative needs while maintaining a rigorous analytic process that can feasibly be conducted within a 60-day timeframe, CHBRP is considering various approaches for the upcoming 2006 legislative year (discussed in further detail in the next section).

Figure 1: University of California's Timeline for Implementing the Provisions of AB 1996 2002–2005



FULFILLING THE LEGISLATIVE INTENT: SYSTEMATIC REVIEWS OF PROPOSED BENEFIT MANDATES

By January 2006, CHBRP will have issued 22 completed reports analyzing proposed benefit mandates, two analyses of amended bills, and four formal follow-up letters to the Legislature clarifying or providing further explanation of completed analysis or amended version of bills.

All of the 22 analyses requested of CHBRP were completed within the 60-day timeframe or were designated specifically as two-year bills for which an extended submission date was permitted.¹⁷ Table 5 provides a complete list of these analyses. The four follow-up letters and two analyses of amended bills were completed within the 60-day timeframe in order to provide useful information to legislative staff in time for the relevant hearings.²⁰ In addition, CHBRP also began the analysis of SB 1843 (Karnette, 2004), a bill that would have mandated health plans and insurers cover inpatient care for newborns as specified. The analysis was terminated per the direction of legislative staff since Senator Karnette decided to withdraw the bill from further consideration.

Table 5: CHBRP Completed Analyses, 2004–2005

2005				
Analyzed Legislation	Author	Topic	Completed Analyses	Outcome
SB 576	Ortiz	Tobacco Cessation Services	8/22/05	Vetoed by Governor
AB 1185	Koretz	Chiropractic Services	7/5/05	2 yr. bill
SB 913	Simitian	Medication therapies; Rheumatic Diseases	4/16/05	2 yr. bill: Placed on Appropriations Suspense File
SB 749	Speier	Pervasive Developmental Disorders/Autism	4/16/05	2 yr. bill
SB 572	Perata	Mental Health Benefits	4/16/05	2 yr. bill
SB 415	Alquist	Prescription Drugs: Alzheimer's Disease	4/16/05	Gutted/amended
SB 573	Romero	Elimination of Intoxication Exclusion	4/7/05	Vetoed by Governor
AB 228	Koretz	Transplantation Services: Human Immunodeficiency Virus	4/7/05	Enacted
AB 213	Liu	Lymphedema	4/7/05	2 yr. bill
AB 8	Cohn	Mastectomies and Lymph Node Dissections	3/7/05	Gutted/amended

²⁰ This exception occurred in CHBRP's initial year of operation when the first analyses were requested before staff had been hired and analyses procedures established.

Table 5: CHBRP Completed Analyses, 2004–2005 (continued)

2004				
Analyzed Legislation	Author	Topic	Completed Analyses	Final Disposition of Legislation
SB 1157	Romero	Elimination of intoxication exclusion	4/27/04	Vetoed by Governor
SB 1158	Scott	Hearing Aids	4/19/04	Vetoed by Governor
AB 1927	Cohn	Vision Services	4/16/04	Gutted/ amended
AB 2185	Frommer	Asthma Management	4/14/04	Enacted
SB 1555	Speier	Maternity Services	4/1/04	Vetoed by Governor
SB 897	Speier	Maternity Services	2/9/04	Reintroduced as SB 1555
SB 174	Scott, Koretz, and Wiggins	Hearing Aids for Children	2/9/04	Reintroduced as SB 1158
SB 101/1192**	Chesbro	Substance Disorder Treatment	2/9/04	SB 101 was reintroduced as SB 1192. SB 1192 failed to be reported out of the Assembly Health Committee
AB 1549	Frommer, Chan, and Laird	Childhood Asthma	2/9/04	Reintroduced as SB 2185
AB 1084	Maddox	Access to Vision Providers	2/9/04	Reintroduced as AB 1927
AB 547	Liu	Ovarian Cancer Screening*	2/9/04	Gutted/amended
AB 438	Lieber	Osteoporosis Screening	2/9/04	Died pursuant to Art. IV, Sec. 10(c) of the Constitution

Impartial Analyses to Help the Legislature and Governor Evaluate Mandate Bills

CHBRP strives to provide the Legislature with a standardized, impartial framework to discuss the complex policy arena of health insurance mandates. CHBRP analyses explicitly report on (1) the medical effectiveness of a proposed mandated benefit or service in terms of clinical outcomes, (2) the projected cost impacts of the mandate in terms of per member per month premiums and total expenditures, (3) the estimated public health impacts in terms of the population and by public health outcomes, and (4) data limitations and caveats. In its first two full years of implementation, CHBRP reports documented the medical, public health, and financial impact of 22 bills (and in some cases, related amendments). In the 22 analyses completed by December 2005, CHBRP documented \$424 million in total costs and \$28 million in potential savings for proposed analyzed mandates. A review of the medical effectiveness analyses indicated a “pattern toward favorable” or “favorable” associated with eleven mandates. A review of the public health impacts analyses indicated favorable impacts (including increased utilization of services associated with favorable outcomes) for eight mandates. CHBRP’s systematic means of evaluating the cost impacts, public health impacts, and medical effectiveness of proposed health benefit mandates is summarized in Table 6 below.

Of these reports, a few proposals pertain to services already widely covered (e.g., transplantation for persons with HIV infection or intoxication exclusion—treatment services for health problems incurred while intoxicated with alcohol or drugs). That a proposed mandated service may already be widely available is an important factor for the Legislature to consider; for example, if a particular benefit is underutilized or not accessed by those who need them, other barriers, besides coverage, may exist in the health care delivery system.

In addition to providing a basic framework for the Legislature and Governor to consider the *impacts* of a particular mandate bill, CHBRP analyses also contribute to the evaluation process by explicitly defining the *scope* of a mandate bill. For example, in order for CHBRP to proceed with an analysis, the researchers must define the clinical terms and explicitly state which services are considered “bundled” into the mandate benefit. If a mandate bill changes the delivery of a certain service by defining standards of care or restricting utilization controls, CHBRP researchers make every effort to indicate whether and how such delivery changes will alter practice patterns or utilization.

TABLE 6: Summary of the Estimated Impact of Mandate Bill Analyzed by CHBRP in 2004 and 2005					
Bills Analyzed	Medical Effectiveness of a Mandated Service or Treatment	Estimated Utilization Impact of Mandate	Estimated Cost Impact in Terms of Total Health care Expenditures ¹	Estimated Cost Impact in Terms of % Premium Changes by Payer ²	Estimated Public Health Impact
2005					
SB 576 (Ortiz) Tobacco Cessation Services	Counseling interventions, brief advice from physicians and clinical staff, and FDA-approved pharmacotherapy are effective treatments for tobacco cessation, as measured by abstinence or quit rates	+10% (from 10%–11%)	\$89.4 million including \$19.5 million in total savings (+15%)	Private: Employers (0.18%) Individuals w/group Insurance (0.18%) Individuals w/individual coverage (0.42%) Public: CalPERS (0.09%) Medi-Cal (0.9%) HFP (0.02%) Members' out-of-pocket expenditures ³ Copayment: (-0.07%) Direct payment: (-100%)	Short-term savings of \$7.9 million from reduced use of ambulatory services; short-term health outcomes: reduction in low-birth-weight deliveries (n = 58) and acute myocardial infarction (n = 146). Long-term outcomes, not quantified, include a reduction in morbidity and mortality, improved health status, decreased work absenteeism, and lower rate of utilization of medical services.

Bills Analyzed	Medical Effectiveness of a Mandated Service or Treatment	Estimated Utilization Impact of Mandate	Estimated Cost Impact in Terms of Total Health care Expenditures ¹	Estimated Cost Impact in Terms of % Premium Changes by Payer ²	Estimated Public Health Impact
AB 1185 (Koretz) Chiropractic Services	Evidence indicates a pattern toward favorable outcomes for chiropractic services with respect to pain relief, objective clinical signs, such as physical exams and adverse events, and functional status, such as decrease in disability and reduction in sick leave. However, state of literature is not sufficient to draw definitive conclusions.	+28%	\$71.6 million (+12%)	Private: Employers (0.15%) Individuals w/group Insurance. (0.19%) Individuals w/individual coverage (0.26%) Public: CalPERS (0.24%) Medi-Cal (0%) HFP (0.23%) Members' out-of-pocket expenditures ³ Copayment: (0.75%) Direct payment (-100%)	Possible increase in health status as suggested by effectiveness literature, possible decrease of economic loss associated with musculoskeletal conditions, such as back pain.
SB 913 (Simitian) Medication Therapies: Rheumatic Diseases	The mandate would prohibit designating a preferred drug among the FDA-approved drug therapies for rheumatic diseases. Biological response modifiers are effective at improving patient outcomes; however, there are no head-to-head trials to provide evidence of comparative effectiveness.	0.0%	\$11.5 million (0.02%)	Private: Employers: (0.02%) Individuals w/group insurance (0.02%) Individuals w/individual coverage (0.03%) Public: CalPERS (0.02%) MediCal (0.03%) HFP (0.01%) Members' out-of-pocket expenditures: (0.02%)	No impact on public health because bill would have no impact on utilization of biological response modifiers.

Bills Analyzed	Medical Effectiveness of a Mandated Service or Treatment	Estimated Utilization Impact of Mandate	Estimated Cost Impact in Terms of Total Health care Expenditures ¹	Estimated Cost Impact in Terms of % Premium Changes by Payer ²	Estimated Public Health Impact
SB 749 (Speier) Diagnostic Protocol for Pervasive Developmental Disorders/Autism	<p>The mandate would require coverage of a specific process for diagnosing autism.</p> <p>There are no data evaluating the effectiveness of the mandated process to diagnose autism. Based on available literature, processes specified by the bill would increase accuracy of diagnosis, lower average age of diagnosis, and decrease time between first referral and diagnosis</p>	10.0%	\$1.3 million (0.002%)	<p>Private: Employers: (0.002%) Individuals w/group Ins. (0.002%) Individuals w/individual coverage (0.003%)</p> <p>Public: CalPERS (0.002%) MediCal (0.008%) HFP (0.0227%)</p> <p>Members' out-of-pocket expenditures:³ (0.002%)</p>	If improved testing results in earlier diagnosis and effective treatment, then intervention would improve functioning of those affected and reduce economic loss associated with reduced productivity. Unable to quantify public health outcomes since no quantifiable evidence was presented in the limited literature.
SB 572 (Perata) Mental Health Benefits	<p>Insufficient evidence to evaluate the effect of health insurance parity on mental health outcomes.</p> <p>The mandate would require coverage for diagnosis and treatment of mental illnesses under the same terms as other medical conditions.</p>	<p>Inpatient days/1,000 members (-2.4%) Outpatient days/1,000 members (+8.5%)</p>	\$118.6 million (0.21%)	<p>Private; Employers: 0.32% Individuals w/group insurance (0.29%) Individuals w/individual (0.42%)</p> <p>Public: CalPERS (0.07%) Medi-Cal (0.0%) HFP (0.10%)</p> <p>Members' out-of-pocket expenditures: (-0.99%)</p>	The scope of potential outcomes includes reduced suicides, reduced inpatient psychiatric care, reduced symptomatic distress, improved quality of life, health improvements for co-morbid conditions, and other social outcomes. Any improvements in outcomes resulting from SB 572 are dependent on changes in access to care, utilization of care, and the appropriateness and effectiveness of that care or treatment.

Bills Analyzed	Medical Effectiveness of a Mandated Service or Treatment	Estimated Utilization Impact of Mandate	Estimated Cost Impact in Terms of Total Health care Expenditures¹	Estimated Cost Impact in Terms of % Premium Changes by Payer²	Estimated Public Health Impact
SB 415 (Alquist) Prescription Drugs: Alzheimer's Disease	All the FDA-approved medications for the treatment of Alzheimer's disease (including cholinesterase inhibitors) have some favorable effect on most of the outcomes analyzed.	No change	No change	No change	No impact: Most major health plans that cover outpatient prescription drugs already cover at least one FDA-approved medication for the treatment of Alzheimer's disease.
SB 573 (Romero) Elimination of Intoxication Exclusion	There is no published data about the medical effects of prohibiting disability insurers from excluding coverage of losses sustained while insured individuals are intoxicated or under the influence of controlled substances.	No change	No change	Insurers in California stated they do not utilize the provision to exclude based on intoxication, therefore no change is projected.	No impact: No evidence insurers are denying medical claims for alcohol- or controlled substance-related injuries.
AB 228 (Koretz) Transplantation Services: HIV	For those who undergo transplant surgery, HIV-positive patients have similar outcomes (e.g. survival rates) as those who are HIV-negative.	No change	No change	No change	No impact: The bill would not increase the number of organ transplants to HIV+ persons due to inherent supply constraints.

Bills Analyzed	Medical Effectiveness of a Mandated Service or Treatment	Estimated Utilization Impact of Mandate	Estimated Cost Impact in Terms of Total Health care Expenditures ¹	Estimated Cost Impact in Terms of % Premium Changes by Payer ²	Estimated Public Health Impact
AB 213 (Liu) Coverage for Lymphedema	There is a lack of consensus on clinical definition of lymphedema, as well as on the standards of care for its treatment. However, based on available evidence, manual lymphatic drainage was found to reduce the volume of lymphedema and pain and discomfort levels. Compression therapy was found to an effective treatment for lymphedema.	1.48% per patient	\$213,855 (0.0003%)	Private: Employers: (0.003%) Individuals w/group insurance (0.0003%) Individuals w/individual coverage (0.0005%) Public: CalPERS (0.003%) MediCal (0.0008%) HFP (0.0006%) Members' out-of-pocket expenditures: ³ (0.0003%)	Favorable public health outcomes for specific treatments but inconclusive on the overall impact of the mandate.
AB 8 (Cohn) Mastectomies and Lymph Node Dissections	There are no published studies that provide evidence of a difference in patient health outcomes for mastectomy or axillary lymph node dissection based on length of hospital stay.	9.5% increase in inpatient admissions for mastectomy and lymph node dissection; -3.0% decrease in outpatient surgery for mastectomy and lymph node dissection; 10% increase in inpatient days for mastectomy and lymph node dissection.	\$960,000 (0.002%)	Less than 0.001%	No impact: There is no evidence that length of stay will have an impact on population's health.

Bills Analyzed	Medical Effectiveness of a Mandated Service or Treatment	Estimated Utilization Impact of Mandate	Estimated Cost Impact in Terms of Total Health care Expenditures ¹	Estimated Cost Impact in Terms of % Premium Changes by Payer ²	Estimated Public Health Impact
2004					
SB 1157 (Romero) Elimination of Intoxication Exclusion	SB 1157 is identical to SB 573 in terms of language relevant to health insurers; the impacts are identical. SB 573 updated this earlier analysis by reviewing the literature of any new studies and soliciting new information from interested parties. The findings are the same.	See SB 573	See SB 573	See SB 573	See SB 573
SB 1158 (Scott) Hearing Aids for Children [coverage once every 36 months]	Evidence shows that the treatment of hearing loss with hearing aids is clinically effective.	4%	\$.8 million (0.02%)	Varies by market segment, 0.03% to 0.06%, with the greatest impact being on the small-group HMO market.	Societal savings in terms of reducing lost productivity and costs to the educational and health care systems.
AB 1927 (Cohn) Vision Care Providers	There is a lack of reliable information regarding the quality-of-care differentials associated with optometrists vs. ophthalmologists and other physicians.	No change	No change	No change	Lack of reliable information on quality-of-care differentials and public demand for access so that public health impacts are inconclusive.
AB 2185 (Frommer) Asthma Management (self-management and training, as well as medical devices)	Self-management and training programs are effective. Effectiveness of medical devices is inconclusive.	See AB 1549	\$180,000 (0.007%) includes offset of 0.002% for reduced ER and hospitalization utilization.	Varies by market segment, ranging from 0.006% in HMO large group and 0.009% in small-group and individual market.	Public health impact includes a reduction in: school absences (166,000 fewer missed days per year); restricted-activity days (6,200 fewer children would report their physical activity is limited due to asthma); ER visits (360 fewer visits); and hospitalizations (115 fewer hospitalizations).

Bills Analyzed	Medical Effectiveness of a Mandated Service or Treatment	Estimated Utilization Impact of Mandate	Estimated Cost Impact in Terms of Total Health care Expenditures ¹	Estimated Cost Impact in Terms of % Premium Changes by Payer ²	Estimated Public Health Impact
SB 1555 (Speier)- Maternity Coverage for CDI-regulated insurance carriers only	Identical to SB 897	No change	\$400,000 (0.01%)	Virtually all the impact would be concentrated in the individual insurance market (10% increase). Total expenditures for privately insured small and large firms would increase by less than 0.01%. Total costs in the group market, for both small and large firms, are estimated to increase by less than 0.01%.	Identical to SB 897
SB 897 (Speier)- Maternity Coverage for DMHC- and CDI- regulated products	There is a lack of data on the effectiveness of the <i>package</i> of maternity services mandated by SB 897. Evidence indicates that individual elements of maternity services, such as screening for specific conditions, are effective in avoiding perinatal complications, mortality, and other poor birth outcomes.	No change	\$440,000 (0.01%)	See SB 1555	This mandate is not likely to impact the health of the community through the benefits of prenatal care, because 97.6% of the insured target population is already covered for prenatal care.
SB 174 (Scott, Koretz, Wiggins) Hearing Aids for Children (coverage once every 12 months)	Evidence shows that the treatment of hearing loss with hearing aids is clinically effective.	4%	\$1 million (0.03%)	Varies by market segment, ranging from 0.05%–0.09%, with greatest impact on small-group HMO market.	Effective early intervention in hearing loss can save society costs in terms of reducing lost productivity and costs to the educational and health care systems.

Bills Analyzed	Medical Effectiveness of a Mandated Service or Treatment	Estimated Utilization Impact of Mandate	Estimated Cost Impact in Terms of Total Health care Expenditures ¹	Estimated Cost Impact in Terms of % Premium Changes by Payer ²	Estimated Public Health Impact
SB 101/1192 (Chesbro) Parity of Coverage for Substance Abuse Treatment with coverage of medical care	Substance abuse treatment is effective in reducing dependency; however, effectiveness of treatment type and setting varies depending on several factors, such as severity of the patient's addiction.	Increases in utilization for substance abuse treatment will vary based on plan type, with HMOs having smaller increases (2% for outpatient services) than those with loosely-managed arrangements (30% for outpatient services).	\$6.8 million (0.01%–0.3%)	Insurance premiums would be expected to increase by a range of 0.1% to 0.4%, depending on the market segment.	Effective treatment has been shown to reduce medical costs, improve care for individuals with health problems unrelated to their dependence, and reduce the health risks of the general population.
AB 1549 (Frommer, Chan, and Laird) Childhood Asthma Management (OTC drugs, prescription medication, associated pediatric outpatient self-management training & education)	Asthma programs have had favorable effects on a variety of health outcomes for children with symptomatic asthma.	4% for asthmatic children enrolled in HMO and POS plans; 10% increase in asthma self-management training and education; use of OTC drugs for pediatric asthma increase by 10%.	\$420,000 (0.02%). Savings associated with reduced emergency room and hospital utilization is estimated to offset total expenditures by .002%. (approx. 10% of increase is offset by savings)	Mandate will have a small impact on commercial HMO and POS costs.	These estimates represent an upper bound: Public health impacts include a reduction in: school absences (180,000 fewer missed days per year), restricted-activity days (6,800 fewer children would report their physical activity is limited due to asthma) ER visits (400 fewer), and hospitalizations (130 fewer).

Bills Analyzed	Medical Effectiveness of a Mandated Service or Treatment	Estimated Utilization Impact of Mandate	Estimated Cost Impact in Terms of Total Health care Expenditures¹	Estimated Cost Impact in Terms of % Premium Changes by Payer²	Estimated Public Health Impact
AB 1084 (Maddox) Vision Care Providers	There is a lack of reliable information regarding the quality-of-care differentials associated with optometrists vs. ophthalmologists and other physicians.	No change	No change	No change	Lack of reliable information on quality-of-care differentials and public demand for access so that public health impacts are inconclusive.
AB 547 (Liu) Ovarian Cancer Screening	The clinical benefits of screening are currently unknown; there is insufficient evidence to support screening's benefit, and insufficient evidence to support there is no benefit.	Possible increase of 14% for women aged 18 to 64 years; and 24% increase for women aged 50 to 64 years.	\$68 million (0.18%)	The impact of the mandate is estimated to range from 0.11% to 0.23% for different categories of employment-based insurance. Public insurers are exempt from the mandate and thus are not affected.	The current state of medical knowledge is that ovarian cancer screening is associated with uncertain benefits and known harms (e.g., anxiety of false-positive results, costs of screening and evaluations, risks of complications from surgical evaluations).
AB 438 (Lieber) Osteoporosis Screening	Of the studies reviewed, there were none that directly assessed whether osteoporosis screening is effective in reducing fractures.	22% increase for privately-insured women between 50 and 64 years	\$52 million (0.14%)	Total estimated would increase by less than 1% for all privately-insured individuals.	The public health impact of a mandate to provide coverage for osteoporosis screening would be relatively small. The number of women aged 50–64 years needed to screen to prevent one fracture is large, approximately 700.

¹ Total expenditures include total premiums and out-of-pocket spending for co-payments and non-covered benefits.

² Percentages differ from those in published reports due to rounding to second decimal.

³ Members' out-of-pocket expenditures refer to privately-insured members' out-of-pocket expenditures, co-payments and direct payments for services not covered under the benefit.

AB 1996 required nonpartisan and independent analysis of health insurance mandate bills. Thus, CHBRP developed a process to ensure that biases in its findings are minimized or eliminated. These checks include systematically reviewing conflicts of interest of faculty and staff and content experts (as discussed above in Developing a Conflict-of-Interest Policy sections);²¹ uniformly applying transparent, standardized methods for all analyses (e.g., literature review methods, medical effectiveness analysis methods, cost impact analysis methods, and public health impact analysis methods); and creating venues to obtain input from stakeholders and any interested party.

The NAC review enhances this ability of CHBRP to produce balanced, impartial analyses by providing feedback on early draft analyses from different stakeholder groups. For each analysis, CHBRP staff selects a subcommittee—generally five members—of the NAC membership to serve as the reviewers. On a rotating basis, these members are selected to represent a balanced set of perspectives, including consumers, providers, employers/purchasers, health plans, industry, and experts. NAC reviewers provide input when a particular draft explanation, method, or underlying assumption may be perceived as leading to biased results. In addition, the NAC members' input enhances the overall quality of the product by (1) reviewing and providing comments on the methods, assumptions, and data sources used in the analyses, (2) identifying sections that warrant further explanation, clarification, or citation, and (3) noting text that may need to be reworded to be more accessible to a lay audience.

A Resource Outside of California

CHBRP has received attention and has become a resource outside of California. For example, Washington State's Sunrise Review Process has cited CHBRP's analysis of SB 174 (Scott) in its own analysis of a state bill that would mandate the coverage of hearing aids for children.²² In Alberta, Canada, the provincial government is replicating parts of CHBRP's model by establishing a government-academic partnership that will allow officials to assess the medical effectiveness and associated potential cost of a new benefit or technology being considered for coverage by their publicly-funded health program.

CHBRP staff has worked to establish relationships with mandate evaluation programs in other states, and contacts such programs when a new analysis is underway. Other states have piggybacked on the communication channels CHBRP has established (e.g., using a common listserv) to contact one another and share learning and completed mandate reports.

Independent of their work with CHBRP, members of the Faculty Task Force have attended conferences to share with fellow researchers and health policy experts methods they have developed. Faculty are expected to publish related work in a special edition of *Health Services Research* in June, 2006 (see [Appendix 20](#)). Such additional work, independent of CHBRP funding, helps to disseminate sound analytical methods to other states and analytic or academic bodies. In addition, by subjecting the methods to scrutiny by peers in the policy and academic communities, CHBRP stands to benefit over the longer term by constant quality improvement in analytic methods.

²¹ See [Appendix 8](#).

²² From http://www.doh.wa.gov/hsqa/sunrise/2005/Hearing_Aid_Final_Rpt.doc, accessed December 7, 2005

Challenges Inherent to the CHBRP Analytic Process

The overarching challenge is delivering a scientific, rigorous, high-quality analysis within the 60-day timeframe required by statute. This inherent challenge was apparent at the startup of the program and continues to present challenges for (1) identifying mandate bills in time for CHBRP analysis, (2) clarifying bill language and legislative intent to produce responsive, useful analyses for the Legislature, (3) appropriate planning to support the expected workload, (4) obtaining coverage data from health plans, and (5) responding to legislative queries or follow-up analysis requests for amendments.

Start-up

During the initial months following the passage of AB 1996, UCOP considered various structural options for building the program. One was to fully staff the program in-house and contract directly with an actuarial firm. In terms of initial setup and future coordination, that approach would have been the simplest option. However, upon further consideration and discussions with faculty from various campuses, UC decided to implement a hybrid model in which the administration and some analytic work would occur at UCOP, but the bulk of the writing and analysis would fall to the designated campuses. This model was the more desirable approach from UCOP's perspective because (1) faculty, junior faculty, and graduate students could derive benefits in terms of collaborative research opportunities, (2) the quality of the CHBRP reports would be enhanced by an internal peer-review process, and (3) the quality of the CHBRP reports would be enhanced by using faculty who are experts in their field.

CHBRP faculty and staff at the various campuses, librarians, and the contracting actuarial firm have expressed a desire to continue to work on CHBRP analyses and be affiliated with the program. Faculty confirm having derived satisfaction in serving the public interest and contributing their research and knowledge to the policy-making process. As mentioned, the program also provides a way in which junior faculty and graduate students can collaborate with senior faculty and explore various topics within the health policy and health services research discipline.

Identifying mandate bills

During 2003–2004, mandate bills were not necessarily identified by the Legislature early in the session since members were not yet familiar with the CHBRP process and the newly-adopted requirements to have mandate bills go through the analytic process in time for the policy committee hearings. As a result, the mandate bills were not readily referred to CHBRP. As a consequence, some bills were referred to CHBRP with less time to produce a report before the policy hearing deadline.

Since that first session, CHBRP has worked with the Assembly Health and the Senate Banking, Finance and Insurance Committees to improve the bill identification process. The Assembly Health Committee sent a memorandum out to all Assembly members discussing the CHBRP process and the requirement for an analysis. The Senate Banking, Finance and Insurance Committee did the same on the Senate side. In January 2005, CHBRP also conducted a public information workshop in Sacramento targeting legislative staff to educate them about CHBRP methods and process.

UC has worked independently to track legislation to identify potential mandate bills. The second year of each two-year legislative session (upcoming, 2006) presents additional challenges due to an accelerated hearing calendar. Approximately 30 days are allotted from the point of bill introduction to the time it must pass out of the policy committees in the house of origin. To address this issue

and provide the CHBRP the statutory 60-day time period, CHBRP entered discussions in the fall of 2005 with the Senate Banking, Insurance and Finance and the Assembly Health Committees to propose the adoption of a rule waiver. The hoped-for rule waiver would allow policy committees to hear mandate bills within a schedule that would permit the statutory 60-day period to run before the special policy hearing date. CHBRP is open to considering any other options to ensure adequate time for analysis.

Bill language and legislative intent

Legislative language in mandate proposals is sometimes vague and difficult to interpret. It is important for CHBRP to correctly interpret a bill since the interpretation could alter the scope of an analysis or the accuracy of impact estimates. Examples of questions that might not be addressed by bill language include: (1) does the mandate apply to all insurance markets (e.g., small group or individual), (2) does the mandate apply to all populations (adults and children), and (3) does the mandate restrict utilization management or impact physician referral requirements?

CHBRP's general approach has been to interpret the bill language referring only to the bill as written. For example, regulatory staff from the DMHC have told CHBRP that they would only refer to secondary sources for legislative intent if the law was not clear on its face or ambiguous.

As a general practice, CHBRP routinely conducts an interview with the bill author's staff upon receipt of each bill request. While this interview may supplement CHBRP's understanding of the legislative intent of the bill and populations to be covered, the author interview does not necessarily provide sufficient information to model the effect of the mandate's implementation. For example, in AB 1185, a bill proposing coverage for chiropractic services, the question of who would deliver chiropractic services and how they would be delivered was not addressed. CHBRP staff entered into a series of discussions with the author and sponsor, which allowed the analysis to be built on the assumption that services would likely be provided according to the current benefit structure, that is, by chiropractic networks under contract with Knox-Keene licensed plans and health insurers.

One disadvantage of relying exclusively on these informal conversations was that it created the expectation on the part of the bill author and sponsor that assumptions for the analysis could be revised without consequence. In fact, these assumptions drive the analyses from Day 1—from the literature search terms to the development of utilization assumptions to developing the health-plan coverage survey. When language is not clarified from the start, valuable time is lost from the limited analytic period.

As a remedy, CHBRP staff have developed a protocol that allows CHBRP to clarify language so that faculty and staff can proceed with an analysis while keeping lines of communication open with the bill author and committee staff. CHBRP will continue to seek immediate clarification by bill authors of all ambiguous provisions of the bill relevant to the analysis. The new protocol however, formalizes in a written document CHBRP's interpretation of unclear language and will clarify the scope of analysis and questions to be addressed in the analysis. This clarification will be developed, when possible in conjunction with the bill author (and potentially committee staff) and transmitted no later than Day 4 after receipt of the bill request. (See [Appendix 13](#) for details on the *Clarification of Bill Language and Legislative Intent*.) By adopting this protocol in the first stages of CHBRP's analysis, the final report will be more valuable and accurate.

CHBRP will host a second information briefing during the winter of 2006, which will be open to the public, but targeted to legislative staff. This briefing session on CHBRP processes will also provide an opportunity to listen to legislative members' and staff's general concerns regarding ways to confirm that the assumptions used for CHBRP analysis are consistent with the author's intent.

Workload

CHBRP must have sufficient capacity to do multiple (e.g., eight or more) analyses on simultaneous 60-day timelines. CHBRP faculty and staff must produce multiple drafts on multiple bills in a very compressed timeframe. Because the process is protocol-driven, there are no shortcuts to produce an abbreviated analysis.

The number of bills referred to CHBRP is difficult to predict, so underestimating the amount of scalability that will be needed and over-preparing for expansion are both problems that can arise in a development process. In the first years of operation, CHBRP relied on short-term contracts with a variety of individuals and institutions to allow for flexibility in workload until CHBRP amassed enough experience to better estimate its resource needs. In fall 2005, CHBRP developed a plan to build capacity to manage and conduct multiple, simultaneous analyses during the September 2005–June 2006 cycle. Staff needs were anticipated assuming a total of 10–12 analyses and four to six simultaneous analyses.

CHBRP will rely on additional personnel at the campus level and at UC in order to have resources “at the ready.” For example, the Vice Chairs have each hired additional staff with graduate-level training and experience to work on CHBRP analyses during the first quarter of the year. The actuarial firm has made a commitment for a senior actuary to conduct internal peer review and provide analytic services if needed. The literature search process, conducted almost entirely at the UCSF campus during the first years, will involve libraries at other campuses to distribute the workload and increase capacity. Librarians from Health Science libraries at the UC Davis, UC Irvine, and UC San Diego campuses have been recruited and trained to conduct searches for CHBRP. UCSF Library is also investigating options for obtaining literature search assistance “on demand” to initiate literature searches without waiting for a medical librarian to become available.

When the Legislature is not in session, CHBRP undertakes several projects to improve the quality and transparency of its process and products. In the fall of 2004, for example, CHBRP staff conducted a national survey to identify those states which conduct reviews of benefit mandates and the attributes of those evaluations. As a result of this effort, CHBRP has become a clearinghouse for insurance benefit mandate review organizations nationally.

As discussed, during the summer and fall months of both 2004 and 2005, CHBRP conducted numerous interviews with legislative staff and state agency personnel to obtain feedback on the CHBRP process and products. In addition, recommendations from these discussions were presented to the NAC at their annual meetings. Feedback and advice from the NAC are also taken into account to improve the data sources, substance and presentation of the analyses.

In the fall and winter of 2005, CHBRP staff also implemented and trained faculty on a new software application that will allow multiple parties to review, edit, and share documents. These improvements have helped CHBRP to operate more efficiently and, as a result, enhance our ability to be responsive to legislative requests.

CHBRP updates its Cost and Coverage Model annually, during the fourth quarter of the calendar year. The Cost Team supplies updated CHIS and CHCF/HRET data, as described in the California Cost and Coverage Model section (see Appendix 11). In addition, CHBRP incorporates updates and validates the model based on information collected from health plans and the insured. Specifically, CHBRP staff request each major commercial health plan to complete a questionnaire to obtain baseline enrollment data that would serve as a basis for all analyses. Other improvements included adding a question on high-deductible plans designed to reflect the trend by purchasers toward these products. Lastly, CHBRP validates the CHIS estimates of those enrolled in managed care plans covered under Medi-Cal and MRMIB programs by comparing enrollment figures provided directly by these agencies.

Responsiveness to deliberations of policy committee

CHBRP has received informal requests from committee staff to revisit an analysis after the final report has been issued and the 60-day deadline has passed, based on an amendment the committee or author may seek during or after the report has been heard in the policy committee. CHBRP determines whether to revise an analysis on a case-by-case basis depending on the resources available and scope of the amendment. Although CHBRP attempts to remain responsive to the Legislature, the program has sought to avoid analyzing “hypothetical bills.” As CHBRP gains more experience with the resources required for analysis of amendments, the goal is to develop a clearer understanding with the Legislature as to which circumstances allow for analyzing amended bills, particularly during those times when full 60-day analyses are in progress.

Consistent and accurate data on current coverage

To determine baseline coverage for a mandated benefit, CHBRP conducts ad hoc surveys of the seven health insurers that provide coverage for the majority of Californians who are privately insured: Aetna, Blue Cross of California, Blue Shield of California, CIGNA, Health Net, Kaiser Foundation Health Plan, and PacifiCare. In the first years of implementation, health plans’ responsiveness and reliability of the data they provided data varied. Part of the problem has been the short turnaround time afforded the health plans to respond to the survey.

In order to make the process more efficient, CHBRP solicited baseline data from the health plans in fall 2005. The data request was designed to piggyback on the plans’ reporting requirement to DMHC. This gives plans an opportunity to reconcile the enrollment figures with those reported to regulators, thereby enhancing the reliability of the data and making reporting to CHBRP less onerous to the health plans. Valid baseline enrollment data used across all analyses should make the ad hoc survey process less burdensome on the health plans since summary data will be on file with CHBRP. In response to a request by legislative staff, CHBRP will also identify those plans that do not respond to the survey on individual health mandates. Regulators have agreed to encourage health plans/insurers to complete the surveys on time.

Finally, in response to health plan concerns regarding the use of proprietary data, CHBRP has also instituted a policy to destroy proprietary information submitted by the health plans within 30 days of submitting a completed analysis to the legislature. (See [Appendix 14](#)).

Proposed refinements to the analysis

CHBRP protocols place high standards on the research on which the program is willing to rely, in part because more rigorous, comprehensive literature (e.g., meta-analysis of large randomized controlled trials) are more reliable. Although legislative staff see the value of this, they are often in the position of recommending a decision to members based on limited data or anecdotal evidence. In these cases, legislative staff requested that CHBRP seek ways to present “less rigorous” data that may still meet a threshold for inclusion. One example is to seek ways to report on longer-term (greater than one year) cost and public health impacts. Currently, analyses limit impact assessment to one year because there is greater uncertainty in predicting impacts over a longer time span. Also, almost all employer group coverage and actuarial analyses focus pricing projections on a one-year horizon. Legislative staff felt there was merit to CHBRP making some projections, with qualifications, to guide the discussion of what happens in the “out years.”

Legislative staff also desired to correlate the impact of premium price on the uninsured. Currently, CHBRP refrains from quantifying this impact, if it is less than one percent of an increase in premiums, recognizing the many factors that impact price and participation in the marketplace. Nevertheless, legislative staff felt there was value in providing an estimate (even if it were negligible) since they are often presented with estimates from various sources.

Other issues were raised by the Legislature looking for CHBRP to conduct more decision-support research. For example, the legislative staff requested that CHBRP provide information on scope of practice bills. Specifically, CHBRP was asked to look at mandates that amend the Business and Professions Code to identify whether scope of practice was based on quality differentials by profession or solely as a result of political negotiation. Since these types of bills are currently outside the scope of AB 1996, CHBRP does not have the authority to conduct such evaluations.

Agency staff suggested that future proposed legislation may call for the repeal of existing mandates. Staff stated that a CHBRP analysis would be necessary to determine whether the mandate is considered medically effective, whether there would be any projected savings to the health care market, and what impacts a repeal of a mandate may have on the public health.

Applicability of the medical literature

CHBRP’s Medical Effectiveness Team has encountered three specific challenges in addition to the general challenges described above. First, some mandate bills address topics for which few well-designed studies have been completed, such as transplantation services for persons with HIV (AB 228). In such cases, the Medical Effectiveness Team must rely on studies that do not adequately control for potential confounders (i.e., factors other than the intervention that might explain the results) and which lack statistical power (i.e., do not have sample sizes that are large enough to detect statistically significant differences between the intervention and comparison groups).

Second, some mandate bills include multiple interventions or services. Examples include AB 213 (treatment of lymphedema) and AB 1185 (chiropractic services). Many studies focus on a single intervention or service, and their findings are not applicable to all of the interventions or services proposed in a bill. Studies that examine multiple services often do not compare the same bundle of interventions or services, which limits the Medical Effectiveness Team’s ability to generalize findings across studies. The interventions or services studied also may not perfectly match the interventions or services proposed in a bill. In addition, some studies compare the delivery of different services by different types of health professionals (e.g., chiropractors and physical therapists). When reviewing

these studies, the Medical Effectiveness Team cannot ascertain whether findings are due to the service provided or the type of health professional who provided it.

Third, some bills address parity in coverage for treatment of a disease or condition rather than coverage of specific services. The mental health parity bill (SB 572) is a good example of this type of bill. Such bills are difficult to analyze because they implicitly assume that parity in coverage will improve access to services which will, in turn, increase use of appropriate and effective services and thus improve health outcomes. The available medical literature often does not enable the Medical Effectiveness Team to make these causal links. In the case of the mental health parity bill (SB 572), studies of the effects of implementation of parity coverage at the state and federal level are currently being conducted, but few studies had been published at the time the bill was introduced.

In each of these cases, CHBRP reports on both what the literature is able to convey and its limitations. To the extent possible, CHBRP also provides supplemental explanatory sections when the traditional medical effectiveness analytic framework does not lend itself to the particular bill. For example, CHBRP's analysis of SB 572 provided a section on the effects of implementation and what studies were being conducted on the effects of California's previously enacted mental health parity law.

FUTURE DIRECTIONS IN THE NATIONAL AND STATE CONTEXT

CHBRP will continue to respond to requests that fall within the scope of its authority and will continue to work to provide policy-relevant analysis. The analyses CHBRP may conduct in the future depend on the extent to which the Legislature will continue to use mandates as policy tools to address both perceived and actual access problems, and whether the Legislature expands or contracts the scope and nature of legislation subject to CHBRP analysis.

Other States' Mandated Benefit Review Laws and Programs

As previously mentioned, other states have mandate evaluation programs. As of 2004, 29 states have established a formal health benefits review process or have enacted a law requiring evaluations of benefits mandates.²³ ([See Appendix 15.](#))

AB 1996 is the only legislation that places the evaluation requirements squarely on a university. More than half of the mandated benefit review laws place the responsibility on a government entity such as the state's insurance commissioner or the legislative analyst office. Eight have required existing or newly formed commissions or task forces to take up the responsibility. Six place responsibility, solely or in part, on the sponsor or proponent of the particular mandate legislation.

Most states' review processes focus on a review of the financial impact of legislative proposals. This includes the fiscal impacts to publicly-funded programs and the financial impact to the health insurance market in terms of health care premiums. Of those that conduct financial impact analysis on the privately-insured market all use an actuarial analysis—either contracting with a firm or using in-house actuaries to conduct the premium analysis.

The mandate benefit review laws of 12 states include “medical efficacy” as a criteria for evaluation. Discussions with these states reveal that the method of conducting medical efficacy literature reviews varies from state to state—while some conduct their own literature review and analysis (or directly contract the work out), others primarily rely on information submitted to them through a public submission process. Based on the information provided to CHBRP by these states as of 2004, none have developed an explicit “hierarchical” method of analyzing the literature for drawing conclusions on medical effectiveness.

While virtually all states' mandate reviews include “social impacts” (e.g., impacts on utilization, coverage, and access), only six include public health impacts as an explicit criterion for evaluation. As of 2004, based on the information provided to CHBRP by these states, none attempt to link the medical outcomes with the coverage and utilization rate estimates to arrive at quantifiable public health impacts—for example the reduction in the number of school days missed as a result of coverage for pediatric asthma treatment. This type of evaluation is a difficult undertaking, and CHBRP analyses can only provide these estimates when the medical outcomes literature provides quantifiable estimates and when population-based data sources are available.

²³ These include states that have a formal mandate evaluation process in place. As of 2004, about 27 of these have a process in place as a result of legislation. Information for this section is derived from results of a telephone survey of all states, conducted during the summer and fall of 2004 by CHBRP staff (See [Appendix 15](#)). It also reflects evaluations of mandated benefit review laws conducted by researchers at UC Berkeley as of September 2004 (See *State Mandated Benefit Review Laws* in [Appendix 20](#)).

Potential Future Mandates

AB 1996 defines a “mandate” in the following terms:

...a “mandated benefit or service” means a proposed statute that requires a health care service plan or a health insurer, or both, to do any of the following:

- (1) Permit a person insured or covered under the policy or contract 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.*
- (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.*

To date, CHBRP has not received any requests to analyze a bill that mandates *offering* of a particular service or benefit. Virtually all of the mandate bills have mandated *coverage* of a benefit or service. Three bills have focused on preventative services—screenings for osteoporosis and for ovarian cancer, and tobacco cessation treatment. Two bills that CHBRP has analyzed mandated health plans to allow access to specific provider types for services permitted within their scope of practice—optometrists and chiropractors.

Prescription drugs

Sometimes a mandate bill may not fit neatly into what is typically considered a “mandate.” Prescription drug mandates are an example of mandates that are highly specific. These mandates attempt to carve out specific drugs that may already be required under the broader umbrella of “medical necessity” as defined under the Knox-Keene Act and the regulations currently being promulgated by the DMHC.²⁴ It is possible that the Legislature may be interested in bringing forth such legislative proposals in future years, because prescription drugs are the fastest-growing component of health care costs and because many drug manufacturers use direct-to-consumer advertising to stimulate demand for new and more expensive drug products. In response to rising costs, health plans have developed formularies or contracted out to pharmacy benefit management companies for formulary management. In the same way that state mandate benefits were in part a reaction to managed care, there may be an analogous increase in drug-specific mandate bills in reaction to increased pharmacy management.

In the 2005–2006 Legislative Session, CHBRP received two drug bills (SB 415 and SB 913) that mandated access to specific drugs. Discussions during the committee hearing revealed some uncertainty around the current benefit structure with respect to the gatekeeper functions of health plans: the role of prior authorization, step therapy, formulary design, and contractual arrangements with drug manufacturers, which overlay the determination of medical necessity by a primary care physician. For future drug bills, CHBRP will need to provide a context for prescription drug benefit bills that reveals the layering of health care decisions and that provides legislators with sufficient information to determine whether their bills’ language actually targets the issue they intended to address.

“Consumer-driven” plans

CHBRP recognizes the trend toward product development with greater cost-sharing by the enrollee or subscriber. High-deductible policies have become more common. In addition, there is an array of

²⁴ <http://wps.dmhc.ca.gov/regulations/docs/regs/6/1105641312767.pdf> accessed on December 14, 2005

alternatives for individuals and employers that aim to increase cost sharing by individuals: health savings accounts, health reimbursement arrangements, and association health plans. Anticipating mandate bills in response to this trend, CHBRP has modified its carrier survey of the health plans with the highest enrollment in California to obtain baseline information on the number of individuals covered through these insurance vehicles. This will allow CHBRP to more accurately assess who bears the cost of proposed benefit mandates, and help anticipate evaluation of any mandate bills that attempt to “level the playing field” among insurance products.

APPENDICES

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