



CALIFORNIA
HEALTH BENEFITS REVIEW PROGRAM

Analysis of the Potential Impacts of Senate Bill 365: Out-of-State Carriers

A Report to the 2007-2008 California Legislature
April 19, 2007

CHBRP 07-06



The California Health Benefits Review Program (CHBRP) responds to requests from the State Legislature to provide independent analyses of the medical, financial, and public health impacts of proposed health insurance benefit mandates and proposed repeals of health insurance benefit mandates. CHBRP was established in 2002 to implement the provisions of Assembly Bill 1996 (*California Health and Safety Code*, Section 127660, *et seq.*) and was reauthorized by Senate Bill 1704 in 2006 (Chapter 684, Statutes of 2006). The statute defines a health insurance benefit mandate as a requirement that a health insurer or managed care health plan (1) permit covered individuals to obtain health care treatment or services from a particular type of health care provider; (2) offer or provide coverage for the screening, diagnosis, or treatment of a particular disease or condition; or (3) offer or provide coverage of a particular type of health care treatment or service, or of medical equipment, medical supplies, or drugs used in connection with a health care treatment or service.

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PREFACE

This report provides an analysis of the potential impacts of Senate Bill (SB) 365, a bill that would allow a carrier domiciled in another state to offer, sell, or renew a health care service plan or health insurance policy in California without holding a license or certificate of authority issued by the relevant regulatory agencies. SB 365 could represent a *de facto* repeal of all benefit mandate laws, as well as all other health insurance requirements in California. The implications of this potentially broad *de facto* repeal on the state's health insurance market are described in this report as well as considerations for policymakers to assess the potential financial and public health impacts of SB 365. In response to a request from the California Senate Committee on Health on February 28, 2007, the California Health Benefits Review Program (CHBRP) undertook this analysis pursuant to the provisions of Senate Bill 1704 (Chapter 684, Statutes of 2006) as chaptered in Section 127600, et seq. of the California Health and Safety Code.

Susan Philip, MPP, and Cynthia Robinson, MPP, both of CHBRP staff, and Susan Ettner, PhD, of the University of California, Los Angeles, prepared the Introduction section, the section on the Potential Impacts of SB 365 on the Health Insurance Market, and the section on Other Considerations on the Impacts of SB 365. Susan Ettner, PhD, prepared the cost impact analysis and literature review of the Analysis of Benefit Repeals section. Nicole Bellows, PhD, of the University of California, Berkeley, prepared the public health impact discussion of the Analysis of Benefit Repeals section. Robert Cosway, FSA, MAAA, of Milliman, Inc. provided actuarial analysis. Penny Coppernoll-Blach, MLIS, AHIP, of University of California, San Diego, conducted the literature search. Sarah Ordódy, BA, provided editing services. In addition, a subcommittee of CHBRP's National Advisory Council (see final pages of this report) reviewed the analysis for its accuracy, completeness, clarity, and responsiveness to the Legislature's request. CHBRP also consulted with content experts for input on the relevant literature and analytic approach (see Appendix B).

CHBRP gratefully acknowledges all of these contributions but assumes full responsibility for all of the report and its contents. Please direct any questions concerning this report to:

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Susan Philip
Director

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EXECUTIVE SUMMARY

California Health Benefits Review Program Analysis of the Potential Impacts of Senate Bill 365

Senate Bill 365 would allow a carrier domiciled in another state to offer, sell, or renew a health plan or insurance policy in California without holding a license issued by the California Department of Managed Health Care (DMHC) or without a certificate of authority issued by the Insurance Commissioner. SB 365 could represent a *de facto* repeal of all health insurance requirements in California including benefit mandate laws. The implications of this potentially broad *de facto* repeal on the state's health insurance market are described in this report, as well as considerations for policymakers to assess the potential financial and public health impacts of SB 365.

Currently about two-thirds of privately insured Californians have health insurance through a health plan or insurance policy offered by an entity domiciled in California (“in-state carrier”).¹ About one-third of California insured are covered by a carrier domiciled in another state (“out-of-state carrier”). Four of the seven major carriers are currently domiciled outside California.

There is uncertainty as to how carriers would react in the short and long term if SB 365 were to pass into law. Based on input from content experts and a review of the available literature on how products that are exempt from state regulation would impact the market, SB 365 would affect carriers differently based on where they are domiciled and whether they currently offer California-regulated products.

- In the short-term, in-state carriers (i.e., currently domiciled in California) would not be expected to stop developing, marketing, or selling all Knox-Keene–licensed (DMHC-regulated) plans² or policies regulated by the California Department of Insurance (CDI). In the long term, in-state carriers with DMHC- or CDI-regulated products may move their headquarters to another state if they considered it advantageous to compete with other carriers that develop and sell products not subject to California regulations.
- Out-of-state carriers (i.e., domiciled outside of California) that currently have Knox-Keene licensed plans or CDI-regulated policies would be able to sell their out-of-state policies in the short run, after the passage of SB 365. These carriers would likely choose to sell products in California that would be most competitive in the small employer group market and the individual market. These out-of-state policies would tend to be lower in cost than in-state products because presumably carriers would elect to be domiciled in the state that allows for the development, marketing, and modification of products with minimal insurance requirements, regulatory review, or oversight. Out-of-state carriers that currently have a presence in California (i.e., currently have contracts with providers and already have a share of enrollment) would be well-positioned to develop, market, and sell out-of-state policies under SB 365.

¹ To be “domiciled” in a particular state means that the insurance company must be headquartered in that state.

² Health maintenance organizations in California are licensed under the Knox-Keene Health Care Services Plan Act, which is part of the California Health and Safety Code.

- Out-of-state carriers that do not currently have Knox-Keene–licensed plans or CDI-regulated policies would be permitted to sell out-of-state policies in California under SB 365. However, these out-of-state carriers may not have the same market presence and ability to obtain advantageously priced contracts with providers in the same way carriers that already have a presence in California are able to. But, if these out-of-state carriers are able to sell products that are not subject to the many California-specific insurance requirements (besides benefit mandates), then they would be expected to market less-costly policies that may be attractive—especially to those currently in small group or individual markets or who are uninsured.

This report focuses on the effects, under SB 365, of introducing products, policies, or plans sold by carriers that are currently domiciled in California but obtain domicile elsewhere and those sold by carriers that are currently domiciled out-of-state. (These products that are not regulated under California requirements will henceforth be called “out-of-state policies.”)

Potential Impacts of SB 365 on the Health Insurance Market

CHBRP relied on the input of content experts and the literature on group purchasing arrangements such as Association Health Plans (AHPs), Multiple Employer Welfare Arrangements (MEWAs), and the development of similar products or proposals at the federal level to summarize the potential impacts of exempting out-of-state policies from California-specific requirements and regulatory oversight by the DMHC and the CDI.³ This literature is instructive because these products or proposals are similar to SB 365 in that they allow for (1) the development of health insurance products that can be sold across state lines, and (2) a certain level of exemptions from state-specific regulations. Based on a review of this literature and input from experts, CHBRP identified the following potential impacts of SB 365 on the California health insurance market:

Consumer Protection and Financial Solvency

- California has two regulatory agencies to provide oversight of health insurance products. The California Department of Insurance (CDI) has broad regulatory authority over all insurance products. The DMHC has as its primary focus the oversight of health maintenance organizations (HMOs). California is unique in that it has an agency, the DMHC, that provides regulatory oversight to the managed care market and has one of the most comprehensive standards for managed care products. These standards include access to services, internal grievance review processes, quality assurance and benefit design requirements beyond that afforded by individual mandates. These standards were developed in response to abusive practices by some managed care organizations and because of the high penetration rates (share of the market) of managed care products. SB 365 would exempt out-of-state policies from California consumer protection requirements and enrollees of such plans would have to contact the Insurance Commissioner in the state of domicile to deal with denied claims or other disputes. Depending on the state, resource constraints such as time,

³ Group purchasing arrangements are a type of arrangement that allows more than one employer to band together to provide health coverage by either purchasing health insurance or self-insuring. MEWAs are a type of group purchasing arrangement. AHPs are a type of MEWA that is sponsored by a trade or professional association, where the association either endorses, negotiates, or self-insures health coverage for its members.

number of employees, and budget may prevent regulators from providing assistance to out-of-state consumers and may prevent regulators from enforcing policies. In addition, some states' departments of insurance have taken the position that it is not in their jurisdiction to assist consumers who are out-of-state.

- SB 365 would exempt out-of-state policies from California-specific requirements on financial reporting and solvency. All states require insurance products to maintain adequate reserves to be financially solvent and be able to pay claims. However, these requirements and the capacity to monitor solvency of their carriers vary across states. In addition, funds that are set up to pay for claims if a carrier becomes insolvent may not cover out-of-state consumers or may not be adequate to pay for all eligible consumers (for example, if the carrier is domiciled in a small state with few insurers paying into the insolvency fund).
- SB 365 would exempt out-of-state policies from California-specific requirements establishing specific claims settlement standards for both health plans and their capitated providers that have been delegated claim payment responsibility.
- The effects of SB 365 on the ability of consumers to have claims paid may be minimal, given that there are federal protections in place and given that most states have further protections. On the other hand, if a claim is denied by an out-of-state carrier, the consumer will need to deal with the out-of-state carrier per their arbitration rules, and potentially the out-of-state regulatory agency if there are applicable external grievance processes in place. Historically, less stringent solvency requirements have been associated with insolvency. Between 2001 and 2003, for example, four self-insured MEWAs became insolvent with 66,000 individuals and small businesses losing coverage and about \$48 million of unpaid claims.
- Under SB 365, current California laws that require insurance policies to be licensed in state would no longer apply, thus potentially exposing consumers and groups—especially small groups—to greater risk of purchasing fraudulent policies that claim to be licensed out-of-state. Past experience with MEWAs has shown that lack of clear regulatory oversight or inadequate oversight creates incentives for the rise of such fraudulent insurance products.

Cost and Availability of Insurance

- Researchers projected that federal proposals to introduce group purchasing arrangements (AHP plans that were exempt from various state-level requirements) would increase coverage rates slightly. Nationally, an estimated 330,000 would become newly insured—because 4.6 million individuals would enroll in these new plans while enrollment in state-regulated plans would drop by 4.3 million. When examining the projected impacts of similar federal proposals on the California market, researchers found that there was virtually no increase in insurance coverage resulting from the introduction into the market of plans exempt from state requirements. They projected a less than 1% increase in new coverage or “virtually no net change in insurance coverage resulting from the availability of this alternative insurance product.”
- California-specific and national analyses found that the introduction of AHPs in the market resulted in savings in premiums for those individuals who enrolled in the AHPs and an

increase for those policyholders who stayed in the insured, state-regulated market. According to the California-specific study, the decrease in insurance premiums for AHP policyholders ranged from 13% to 14% and the increase for the policyholders in the insured fully regulated market ranged from 2% to 5%. The savings in premiums for AHP policy holders is attributed to both regulatory relief from state regulations as well as selection of better (low-cost) risk. Conversely, increased premiums in the state-regulated market are due to adverse selection of the worse (high-cost) risk with fewer low-cost enrollees to spread the risk.

- Prior research evaluated a federal proposal that is similar to SB 365. The Health Care Choice Act of 2005 (H.R. 2355) would have allowed individuals buying health insurance in the individual market to do so from an entity licensed in another state. The Congressional Budget Office estimated about 1 million small group enrollees would lose health insurance coverage as a result. However, low-risk individuals who were uninsured would obtain low-cost, out-of-state individual policies, offsetting those who lost insurance. Although the characteristics of the insured population could change, with low-risk individuals gaining insurance coverage and high-risk individuals losing coverage, the net effect with respect to the number of insured would be insubstantial.
- The development of AHPs and other proposals for the development and marketing of products exempt from state-specific requirement is projected to result in out-of-state policies attracting healthy, low-risk employees in the small group and individual market. This selection of low-cost enrollees and risk segmentation could lead to a change in the composition of the market, leaving the high-risk individuals in the state-regulated market or uninsured.
- If SB 365 were to pass, large- and mid-sized employer groups would need to evaluate what products would provide value for the premiums they expend. If fewer California-regulated products are offered in the commercial market, it is expected that over time, more large groups, and perhaps even mid-sized groups, might choose to self-insure rather than purchase an out-of-state policy. This would be likely to occur if the state-regulated products charged higher and higher premiums, due to adverse selection. Out-of-state policies might not be an attractive alternative if they did not have the kind of generous benefit packages that large-groups tend to demand.

Analysis of Benefit Repeals on Cost and Public Health

California has enacted 40 benefit mandates to cover or offer coverage under the California Health and Safety Code and 34 benefit mandates to cover or offer coverage under the Insurance Code. One of the goals of SB 365 is to address the concerns regarding the cost of benefit mandates currently in law. This report addresses this question by (1) presenting an actuarial analysis of the premiums associated with a scaled-down benefit package if, for example, all carriers selling insurance policies in California were to become domiciled in Idaho (the state with the fewest benefit mandates) and drop all benefits mandated in California other than breast cancer treatment, home health care, and services required by Idaho, after the passage of SB 365; (2) summarizing the existing literature on the cost of benefit mandates; and (3) presenting the

potential implications for public health if some out-of-state policies with scaled-down benefits were introduced into the market. These are summarized below.

Cost Estimates

- Under the scenario described above, where all carriers selling policies in California were to become domiciled in Idaho, covered health care expenditures (including both plan and member payments) are estimated to decrease by 10.8% for plans that are currently DMHC-regulated and 4.1% for those that are currently CDI-regulated. Overall, covered health care expenditures would be expected to decline by 10.1%.
- Covered health care expenditures would decline the most for enrollees with large-group coverage (10.8%), who are currently enrolled almost exclusively in DMHC-regulated plans. It would increase the least for individuals with individually purchased insurance (6.4%), more than one-third of whom are currently enrolled in CDI-regulated plans with policies (since CDI-regulated policies are currently subject to fewer benefit mandates than DMHC-regulated plans). Those with small-group coverage fall in between, with a 10.0% projected decline in covered expenditures.
- Assuming that as a percentage of covered expenditures, administrative costs, profits, and cost-sharing would remain the same, the elimination of previously covered services would be expected to decrease premiums by approximately the same percentage as covered expenditures. Risk segmentation could further reduce premiums for limited-benefit out-of-state plans, while increasing premiums for those plans left in the state-regulated insurance market.
- The elimination of insurance coverage for services currently covered under California's benefit mandate laws may lead to a reduction in service use and an increase in out-of-pocket costs to consumers who choose to pay entirely out of pocket for services no longer covered by their health plans. The extent to which SB 365 would increase or decrease the individual's share of insurance premiums plus out-of-pocket health care costs is unknown, but would vary across consumers, depending on factors such as age, health status, gender, occupation, and whether their coverage is obtained through large groups, small groups, or individual purchase.
- CHBRP estimates that an overall 10.1% decline in premiums, among the entire privately insured population of 17,335,000 Californians, would increase the number of insured by at most 192,262. This estimate is likely to overstate the increase in the purchase of insurance coverage because the attractiveness of the limited-benefit plans due to lower premiums would be offset by their lesser desirability in terms of having fewer benefits covered. If competition based on limited-benefit plans occurs primarily in the market where CDI-regulated products are currently sold (where the premium decrease is estimated to be only 4.1%) the increase in the number of insured Californians would be 8,374.

Public Health Implications

- Enrollees of out-of-state policies would no longer be guaranteed to have coverage of treatments and services specified by the California benefit mandates. While a review of the medical effectiveness of all of the treatments or services included in California mandates is not feasible for this analysis, it is important to consider the potential health implications of SB 365.
- Several mandates require coverage for health screenings and other preventive care services. Based on the recommendations by the U.S. Preventive Services Task Force (USPSTF), several of the screening and preventive services mandated in California are medically effective. If SB 365 results in a shift of enrollees from DMHC- and CDI regulated plans and policies to out-of-state carrier policies, enrollees would no longer be guaranteed to have coverage for these preventive services, which could result in increased morbidity and mortality.
- DMHC plans are required to cover maternity services; however, CDI-regulated policies can exclude coverage for maternity services. If effective prenatal services are under-utilized due to lack of coverage under out-of-state policies, it is expected to result in increased complications for women and newborns.
- Both DMHC- and CDI regulated health policies are required to cover the treatment for biologically based severe mental disorders at the same level they cover other medical conditions, otherwise known as mental health parity. There are several potential health outcomes associated with treatment for mental disorders and many treatments have been found to be effective.
- Low-costs out-of-state policies (not subject to California benefit mandates) are expected to attract healthier individuals. As a result, there would be a greater share of high-cost enrollees left in state-regulated plans. Because state-regulated plans, especially those in the small group and individual market, are likely to experience premium increases, these high-cost enrollees may face loss of insurance in the privately insured market.
- Racial and ethnic minorities are more likely to be uninsured compared to whites and a higher proportion of Latinos work for small businesses. To the extent that SB 365 reduces the number of uninsured, minorities could experience improvements in their health insurance status. Coverage under out-of-state policies would likely attract low-risk enrollees rather than those uninsured with chronic or high-risk conditions.

INTRODUCTION

Senate Bill 365 would allow a carrier domiciled in another state to offer, sell, or renew a health plan or insurance policy in California without holding a license issued by the California Department of Managed Health Care (DMHC) or without a certificate of authority issued by the Insurance Commissioner.

The carrier's plan or policy would be exempt from all Knox-Keene⁴ licensing requirements and requirements under the California Insurance Code, as long as the plan or policy is lawfully authorized and complies with the domiciliary state's requirements.

The intent of SB 365 is to allow for the development, marketing, and purchasing of health insurance products licensed outside of California, thereby sparking innovation and competition among carriers, driving down the cost of available products, and expanding coverage to those who are currently uninsured—especially for those in the small group or individual markets.

Proponents of similar bills at the federal levels state that allowing for the development of plans exempt from state mandates would encourage the market to develop lower-priced products, giving employers and individuals more health plan choices, and forcing state-regulated plans to compete with lower priced policies. Proponents state that allowing such competition will prevent one or two insurers from controlling a large portion of the market. Supporters of H.R. 2355, for example, (a federal bill allowing those in the individual insurance market to buy policies across state lines) stated that the provisions of the bill would “ensure that individuals are able to purchase affordable health insurance policies by creating a nationwide market” (PRI, 2006). In addition the bill would “broaden and intensify competition among health plans and medical providers” and spark a “serious review” of existing regulations (Moffit, 2006). Proponents also state that the current regulatory framework of charging the younger and healthier more to subsidize the sick raises issues of equity and fairness in payment structures. Benefit mandates, in particular, proponents argue, force those who would not necessarily want or need a benefit to buy it even when they would rather purchase a less-expensive limited benefit plan (Westerfield, 2003).

The bill seeks to meet these various policy objectives by allowing these out-of-state carriers' products to:

- No longer be subject to California health benefit mandates.
- No longer be subject to California premium requirements, patient protection requirements, fiduciary and financial requirements, and provider access mandates.

CHBRP has been asked to analyze SB 365 because it would effectively repeal or relax a set of health benefit mandate requirements in current law. However, because benefit mandates are only one of several sets of state laws that would be affected by SB 365, this report discusses the potential implications of exempting out-of-state carriers from all California licensure requirements.

⁴ Health maintenance organizations in California are licensed under the Knox-Keene Health Care Services Plan Act, which is part of the California Health and Safety Code.

This report varies from previous CHBRP analyses of a specific benefit mandate or repeal, given that SB 365 is broader in scope and would effectively repeal all California-specific health insurance requirements, oversight, and regulatory authority of the DMHC and the California Department of Insurance (CDI). Because the benefit mandate requirements and their impacts on the California health insurance market are highly intermingled and interdependent with the other health insurance requirements, this report would be remiss in not pointing out those relevant issues for policymakers. In addition, given the scope of SB 365 and the highly compressed timeframe for analysis, this report does not address the medical effectiveness, costs, or public health impacts associated with each of the 42 benefit mandates that are currently required under California law.⁵

Background and Discussion on Carriers' Domicile

To be “domiciled” in state means that the insurance company must be headquartered in that state. Currently about two-thirds of privately insured Californians have health insurance through a state-regulated health plans or insurance policies offered by an entity domiciled in California (“in-state carrier”). About one-third of California insured are covered by a carrier domiciled in another state (“out-of-state carrier”). Four of the seven major carriers are currently domiciled outside California. See Table 1 for a summary of where these carriers are currently domiciled and the corresponding share of the California market.

⁵ There are 40 benefit mandates to cover or offer coverage under the California Health and Safety Code. There are 34 benefit mandates to cover or offer coverage under the Insurance Code. There are 42 total unique benefit mandates to cover or offer coverage under the Health and Safety or Insurance Code. Under the Health and Safety Code is an expansive benefit mandate to cover “basic health care services,” which include a wide range of preventive and medically necessary diagnostic and treatment services provided in the inpatient, outpatient, physician offices and post-acute care settings. Note that these counts include benefit mandate only—not mandates on access to providers or eligibility mandates. (See Appendix C for a list of these mandates.)

Table 1. California Market Share by Insurer and State of Domicile

Insurer/CA Affiliate	Domicile (headquarters) of Insurer	States Insurer Operates	Market Share (CDI)	Market Share (DMHC)
Kaiser Permanente/Kaiser Foundation Health Plan	Oakland, CA	Kaiser Foundation Health Plan licensed in 9 states, including California and the District of Columbia	0%	29.6%
Blue Shield of California/Blue Shield of California & Blue Shield of California Life and Health Insurance	San Francisco, CA	Licensed in California	1.8%	12.3%
Wellpoint, Inc./Blue Cross of California & Blue Cross Life and Health Insurance Company	Indianapolis, IN	Blue Cross and Blue Shield licensed in 14 states, including California	21.2%	20.6%
Health Net/Health Net of California & Health Net Life Ins. Co.	Woodland Hills, CA	Licensed in 27 states, including California, and the District of Columbia	5.7%	9.3%
United Health Group/PacifiCare of California & PacifiCare Life and Health Insurance Company & United HealthCare Insurance Company	Minnetonka, MN	Licensed to sell products in all 50 states and the District of Columbia	9.3%	7.5%
Aetna/Aetna Health of California & Aetna Life Insurance Co.	Hartford, CT	Licensed to sell products in 50 states, and the District of Columbia	6.6%	1.3%
CIGNA/Cigna Healthcare of California & Connecticut General Life Insurance Co.	Philadelphia, PA	Licensed to sell products in all 50 states and the District of Columbia	4.5%	1.6%

Source: Hoovers, Inc., California Health Benefits Review Program Analysis of data from Hoovers Inc. available at www.hoovers.com; 2005 Report of Health Care Service Plans' Provider Dispute Resolution Mechanisms, DMHC. February 2006, available at [http://www.dmhc.ca.gov/aboutthedmhc/gen/reports/2005%20DRM%20Annual%20Report%20\(3-1-06\).pdf](http://www.dmhc.ca.gov/aboutthedmhc/gen/reports/2005%20DRM%20Annual%20Report%20(3-1-06).pdf); and 2005 Life and Annuity Market Share Report. CDI, July 2006. available at <http://www.insurance.ca.gov/0400-news/0200-studies-reports/0100-market-share/>

There is uncertainty as to how carriers would react in the short and long term if SB 365 were to pass into law. Based on input from content experts and a review of the available literature on how products that are exempt from state-regulation would impact the market, SB 365 would affect carriers differently based on where they are domiciled and whether they currently offer California-regulated products.

- In-state carriers: Carriers currently domiciled in California would not be expected to stop developing, marketing, or selling all Knox-Keene–licensed (DMHC-regulated) plans or CDI-regulated policies in the short term. These carriers that have Knox-Keene licensed plans would be expected to maintain those licenses and continue to offer managed care

products, especially to large- or mid- sized groups who may demand a state-regulated product that comes with a comprehensive set of benefits and predictable provider network. In-state carriers with DMHC-regulated products may move their headquarters to another state if they considered it advantageous to compete with other carriers that develop and sell products not subject to California regulations. In-state carriers who currently have CDI-regulated products would also maintain certificate of authority in California. CDI-regulated products are subject to less stringent requirements (such as benefit mandates) than DMHC-regulated plans and are already able to develop and sell products with lower premiums than DMHC-regulated products.

These carriers may also consider moving their headquarters out of state if they thought it advantageous to develop out-of-state licensed products to obtain any savings beyond that which might be obtained under CDI-regulated products, and to compete with other carriers. For example, the CDI-regulated market is not subject to certain benefit mandates or to benefit design requirements and have been free to develop high deductible health plans (HDHPs) without coverage for services (such as maternity care) with high co-insurance levels (e.g., above 30%). In-state carriers offering out-of-state products would operate based on the rules of the state in which these products are licensed. Assuming they would elect to sell plans licensed in states with more lax rules than California (as discussed further in this report), they could potentially market these products to healthier individuals and build benefit packages with fewer covered benefits and lower premiums.

- **Out-of-state carriers currently licensed in California:** Carriers that are currently domiciled outside of California but have Knox-Keene–licensed plans or CDI-regulated policies would be able to sell their out-of-state policies in the short run, immediately following the passage of SB 365. Again, these carriers would be likely to sell products in California that would be most competitive in the small employer group market and the individual market. These out-of-state policies would tend to be lower in cost than in-state products because the state of domicile allows for the development, marketing, and modification of products with minimal insurance requirements, regulatory review, or oversight. Out-of-state carriers that currently have a presence in California—meaning they currently have contracts with providers and already have a share of enrollment—would be well-positioned to develop, market, and sell out-of-state policies under SB 365.
- **Out-of-state carriers not currently licensed in California:** Carriers that are currently domiciled out-of-state and do not currently have Knox-Keene licensed plans or CDI-regulated policies would be permitted to sell out-of-state policies in California, under SB 365. These out-of-state carriers may not have the same market presence and ability to obtain advantageously priced contracts with providers in the same way carriers that already have a presence in California are able to, especially for managed care products which tend to offer comprehensive benefits with defined provider networks. An out-of-state carrier’s ability to negotiate discounts for services would depend on factors such as geography, patient mix, and employer demands for certain providers within networks. For example, a hospital system may be unwilling to enter into contract with an out-of-state carrier for services to enrollees in out-of-state licensed products because (1) the hospital system would want to ensure that the carrier is subject to California oversight, and (2) the hospital system would not want to be saddled with uncompensated care

burden that may result from enrollees, or the hospital being liable for uncovered services. But again, if these out-of-state carriers are able to sell products that are not subject to the many California-specific insurance requirements (besides benefit mandates), then they would be expected to market less-costly policies that may be attractive—especially to those currently in small group or individual markets or who are uninsured.

The remainder of this report focuses on the effects, under SB 365, of introducing these products, policies, or plans sold by carriers that are currently domiciled in California but obtain domicile elsewhere and those sold by carriers that are currently domiciled out-of-state. (These products that are not regulated under California requirements will henceforth be called “out-of-state policies.”) This analysis seeks to examine the following questions:

- To what extent would exempting out-of-state policies from California benefit mandates affect the cost of insurance and the public health?
- To what extent would a decrease in the price of insurance increase the purchase of insurance among those who are currently uninsured?
- To what extent would exempting out-of-state policies from other California health plan and insurance policy requirements affect the health insurance market?
- What would be the effect of unregulated competition on coverage and delivery of health insurance benefits in California?

This report is organized into three sections:

- **Potential Impacts of SB 365 on the Health Insurance Market: the Case of Group Purchasing Arrangements and Federal Proposals Exempting State Requirements:** This first section examines the potential impacts of exempting out-of-state policies from the body of state statutes and regulations designed with the goal of ensuring that the market is fair and efficient for providers and consumers. California currently has several laws in place that require insurers and health plans to maintain certain levels of reserves to maintain financial solvency, protect consumers, provide access to certain provider types, maintain availability of coverage, and distribute risk. The intent of SB 365 is to relieve the carrier from those requirements so that they are better able to develop and market more competitive products in California, thereby reducing the cost of health insurance and potentially expanding coverage to individuals who may currently be uninsured. The *Potential Impacts of SB 365 on the Health Insurance Market* section addresses this question by including input from content experts and summarizing the literature on past experiences of group purchasing arrangements such as association health plans (AHPs) and multiple employer welfare arrangements (MEWAs), and the projected impacts of similar proposals at the federal level. The literature on AHPs and MEWAs is relevant because these types of plans have, at one point, been exempt from state requirements, or there have been proposals to exempt them from state requirements.⁶

⁶ Group purchasing arrangements are a type of arrangement that allows more than one employer to band together to provide health coverage by either purchasing health insurance or self-insuring. MEWAs are a type of group purchasing arrangement. AHPs are a type of MEWA that is sponsored by a trade or professional association, where the association either endorses, negotiates, or self-insures health coverage for its members.

- **Analysis of Benefit Repeals:** This second section looks at the potential impact of exempting out-of-state policies from California benefit mandates. California has enacted 40 benefit mandates to cover or offer coverage under the California Health and Safety Code and 34 benefit mandates to cover or offer coverage under the Insurance Code. These mandates range from requiring coverage of a specific item or service, to covering a category of services related to screening, diagnosing and treating a set of conditions. The intent of SB 365 is to address the concerns regarding the cost of benefit mandates currently in law. The *Analysis of Benefit Repeals* section of this report addresses this question by (1) presenting an actuarial analysis of the premiums associated with a scaled-down benefit package if, for example, all carriers selling insurance policies in California were to become domiciled in Idaho (the state with the fewest benefit mandates) and drop all benefits mandated in California other than breast cancer treatment, home health care, and services required by Idaho, after the passage of SB 365; (2) summarizing the existing literature on the cost of benefit mandates; and (3) presenting the potential implications for public health if some out-of-state policies with scaled-down benefits were introduced into the market. Idaho is used as a reference point because with only five benefit mandates in place, it has the fewest benefit mandates of any state in the union. Therefore, the scenario in which carriers domicile in Idaho yields the greatest possible estimate of the savings related to benefit mandates that could be achieved through passage of the bill.
- **Other Considerations Related to the Potential Impacts of SB 365:** In this final section, CHBRP will raise some additional policy considerations if SB 365 were to go into effect; for example, the implications of in-state carriers moving their headquarters out of state.

POTENTIAL IMPACTS OF SB 365 ON THE HEALTH INSURANCE MARKET: THE CASE OF GROUP PURCHASING ARRANGEMENTS AND FEDERAL PROPOSALS EXEMPTING STATE REQUIREMENTS

California has several laws in place that relate to availability of coverage, consumer protections, access to providers, financial solvency, and risk distribution. This section will summarize these requirements and qualitatively discuss the potential impacts of removing or relaxing these requirements, using the literature on group purchasing arrangements such as AHPs, MEWAs, and similar proposals at the federal level. This literature is instructive because these products or proposals are similar to SB 365 in that they allow for (1) the development of health insurance products that can be sold across state lines, and (2) a certain level of exemptions from state-specific regulations. This section will also discuss the potential implications of removing health insurance oversight and enforcement authority from California to outside of the state.

Consumer Protections & Financial Solvency

During initial licensure and ongoing operations, California regulatory agencies monitor and take corrective action to ensure plans and insurers comply with their requirements related to consumer protections and financial solvency. Exempting insurers from requirements to obtain a Knox-Keene license from the DMHC or a certificate of authority from the Insurance Commissioner would limit the authority of the state in oversight of consumer protection and financial solvency.

The majority of California's health plans are regulated by either the DMHC or CDI. The DMHC regulates HMOs and certain preferred provider organizations (PPOs) (i.e., Blue Cross of California or Blue Shield of California) subject to the Knox-Keene Health Care Service Plan Act of 1975, as amended. Health plans apply for and obtain a Knox-Keene license prior to operating in California.

In applying for licensure, a DMHC-regulated health care service plan must submit for review and approval all of the types of plan contracts (policies) it will offer, standard provider contracts and payment methods, proposed advertising and marketing materials, audited financial statements, administrative structure, projections of financial viability, actuarial analyses, and specific proposed service areas.

The CDI regulates point-of-service health plans and certain PPO plans underwritten by disability insurers who sell health insurance products. Disability insurers obtain a certificate of authority from the Insurance Commissioner for the specific line(s) of business they intend to offer prior to conducting insurance business in this state.

The CDI certificate of authority review process involves a detailed operational and financial review. The application process includes review of the company's financial stability, available

capital and assets, competency and integrity of ownership and management, claims payment procedures, actuarial certifications, and financial projections.⁷

Neither the DMHC nor the CDI regulate self-insured employer-sponsored plans. All employer-sponsored health plans fall under the jurisdiction of Employee Retirement Income Security Act (ERISA). ERISA is a federal law that is enforced by the U.S. Department of Labor, Employee Benefits Security Administration (DOL-EBSA). Under ERISA, employer-sponsored plans are subject to minimum standards related to reporting and disclosure, claims processing, and fiduciary duty (Butler and Polzer, 2002). In addition, most states have further consumer protection requirements on employer-sponsored plans that are not self-insured, while self-insured employer-sponsored plans are exempt from most state requirements.⁸

California's Consumer Protection Requirements

California currently has a number of patient and consumer protection requirements. Some of these requirements include disclosures, access to services, internal and external grievance review processes, quality assurance, benefit design requirements, and fair claims handling. Per SB 913 (2002), both regulatory agencies were directed to coordinate their processes to ensure that consumers were not adversely impacted by California's unique split regulatory authority.

- **Consumer disclosure and marketing requirements:** Both the DMHC and the CDI require plans and carriers to disclose information regarding the benefits, services, and terms of the plan contract to provide enrollees with a full and fair disclosure of the provisions of the plan in readily understood language and a clearly organized manner.⁹
- **Access to services:** DMHC monitors and reviews specific guidelines for availability and accessibility of providers (i.e., one primary care physician for every 2,000 enrollees, primary care provider within 30 minutes or 15 miles of residence or work).¹⁰ Plans are required to receive prior approval of networks in each geographic region. The CDI has accessibility regulations for exclusive provider organizations (EPO).¹¹
- **Coverage for categories of enrollees that could be discriminated against:** California has certain laws forbidding health insurers from denying coverage to certain types of enrollees. Plans and insurers cannot deny coverage to persons who are physically or

⁷ Insurance Code § 717. CDI requirements to apply for certification of authority are available at: www.insurance.ca.gov/0250-insurers/0300-insurers/0100-applications/certificate-of-authority/cert-of-authority-instructions/ca-specific-instruc.cfm.

⁸ A self-insured plan is a health plan in which a group—usually a large employer, labor union, or group of employers—assumes financial responsibility for the health care expenses of its enrollees rather than purchasing health insurance through an insurance company. However, such a group may contract with an insurance or other company (as a third-party administrator) for claims processing and other administrative services and may purchase stop-loss to limit its liability for medical claims (sometimes incorrectly called “reinsurance”). The DOL does not regulate self-insured health plans that are sponsored through school districts, other municipalities, and churches. The CDI does not regulate self-insured health plans. Consumers who are a member of this type of plan may seek a legal remedy through a court of law. (CDI's lack of jurisdiction over these products is described at: <http://www.insurance.ca.gov/0100-consumers/0060-information-guides/0050-health/health-insurance.cfm#hippa>).

⁹ Health and Safety Code §1363(a); Insurance Code §§10603 and 10604.

¹⁰ California Code of Regulations, Title 28, Section 1300.51.

¹¹ Health and Safety Code § 1351(k) and 1367(e); Insurance Code § 10133.5. EPOs are similar to HMOs except they are regulated by the CDI. EPOs require use of their network providers for coverage of services.

mentally impaired. Additionally, DMHC-regulated plans cannot deny coverage for individuals who are blind or partially blind.

- **Internal grievance review processes:** DMHC-regulated plans are required to maintain an internal plan grievance system to respond to consumer complaints. The DMHC reviews a plan's internal grievance and complaint-handling procedures, including type, frequency, and resolution of complaints during on-site survey.¹² In addition, the DMHC operates the "HMO Help Center," a toll-free consumer complaint hotline, 24 hours a day, 7 days per week. An after-hours answering service can page DMHC health professionals. The CDI does not require insurers to maintain an internal grievance or complaint system. The CDI operates a consumer complaint line for all lines of insurance (e.g., life or auto) weekdays during business hours.
- **External grievance review processes:** Effective January 2001, both departments were legislatively mandated to administer an Independent Medical Review (IMR) program for external independent medical review of plan coverage decisions.¹³ The IMR program allows enrollees to appeal denied claims and seek expedited review of denials for particular service (e.g., access to specialty care or a procedure). This process occurs after any internal reviews within the plan have been exhausted. This legislation was motivated by people who felt that HMOs might be approving or denying treatment due to concerns about cost to insurers rather than based on medical appropriateness (IMQ, 2002).
- **Quality assurance:** The DMHC reviews internal procedures of plans to review quality of medical care and performance of providers. The DMHC also conducts onsite medical surveys at least once every three years. Both the DMHC and the CDI have standards for utilization review and disclosure requirements.¹⁴
- **Covered benefits and benefit design:** A number of benefits are mandated for DMHC- and CDI-regulated plans, as will be discussed in further detail in *Analysis of Benefit Repeals* section. It is important to note that, under regulations promulgated and enforced by the DMHC, health plans are ultimately required to provide "medically necessary" services. Medical necessity is to be determined according to "the specific medical needs of the enrollee and any of the following: (1) peer-reviewed scientific and medical evidence regarding the effectiveness of the disputed service; (2) nationally recognized professional standards; (3) expert opinion; (4) generally accepted standards of medical practice; and (5) treatments that are likely to provide a benefit to a patient for conditions for which other treatments are not clinically efficacious."¹⁵ The DMHC also reviews proposed cost-sharing arrangements under various product lines and may require changes to ensure contracts are "fair, reasonable and consistent with the objectives of the chapter." Benefits cannot be subject to "exclusion, exception, reduction, deductible, or copayment that renders the benefit illusory."¹⁶ For example, for outpatient prescription drug benefits, the DMHC limits cost sharing to 20%. CDI-regulated plans have no such

¹² Health and Safety Code §§ 1351(I), 1368, 1370.2, 1380(F).

¹³ Health and Safety Code §§ 1374.30; 1370.4; Insurance Code § 10145.3.

¹⁴ Health and Safety Code §§ 1370, 1380, 1380.1; Insurance Code §§ 101339(d) and 10123.1135.

¹⁵ Health and Safety Code §1370.4(c)(3).

¹⁶ § 1367 CCR Title 28 § 1300.67.4.

related requirements except that health insurers must cover benefits mandated under the Insurance Code.

- **Fair claims handling:** The DMHC monitors its plans for prompt payment of provider claims. The DMHC has also developed a definition of unfair payment patterns and a system of responding to them (AB 1455, Statutes of 2000). The Insurance Commissioner has broad authority to enforce the Insurance Code.¹⁷ As part of their market conduct examinations discussed below, CDI regulators can assess and address the market practices of insurers, including claims handling.¹⁸

California's Financial Solvency Requirements

Regulatory agencies take a number of steps to protect consumers and health care providers from disruptions caused by insolvencies. The DMHC requires regular financial filings and conducts on-site financial reviews.¹⁹ To ensure that business is conducted in an honest, open, and fair manner, the CDI conducts onsite review and regulatory examination of claims, financial records, and rating and underwriting practices of all licensed insurers. These are called market conduct examinations.²⁰

To ensure that HMOs have sufficient levels of capital, the DMHC requires that each plan meet tangible net equity requirements. PPOs and point-of-service plans licensed by the DMHC are subject to higher tangible net equity standards due to the increased risk of offering out-of-network services (Butler and Polzer, 2002). CDI-regulated insurers must maintain the greater of either risk-based capital standard or a minimum capital and surplus requirement (Butler and Polzer, 2002). Disability insurers are required to maintain reserve levels at the greater of either (1) a minimum of \$5 million or (2) 200% of the Risk-Based Capital standards developed by the National Association of Insurance Commissioners (Roth and Kelch, 2001).

If a health plan becomes insolvent, the DMHC may allocate its enrollees to other plans in the area with sufficient capacity and financial resources. Plans must provide care for transferred members.²¹ For carriers that present solvency problems, the CDI can take various options, including asking or ordering an insurer to reduce writing new business, reduce operating costs, seek financial support, or consider the use of reinsurance. As a last resort, the CDI will consider taking regulatory control of an insolvent insurer's operations (Butler, 2002). In addition, the Insurance Code requires all life and disability insurers to participate in the Life and Health Insurance Guarantee Association, which will assess members to pay the losses (expenses) of people insured by the insolvent insurer.²²

¹⁷ Insurance Code § 12919-12938.

¹⁸ The range of activities that a commissioner may initiate to assess and address the market practices of insurers include underwriting and rating, marketing and sales, complaint handling operations/management, advertising materials, licensing, policyholder services, claims handling, and policy forms and filing.

¹⁹ Health and Safety Code §§ 1376, 1381, 1382.

²⁰ www.insurance.ca.gov/0500-about-us/0100-cdi-introduction

²¹ Health and Safety Code § 1394.7.

²² Insurance Code § 1067-1067.18.

California has specific requirements prohibiting health plans from engaging in unfair payment practices to providers. Prohibited practices include the failure to process complete and accurate claims, reducing or denying complete and accurate claims, failing to make timely payments for claims, and failing to automatically include interest (AB 1455, SB 1177; 2000).²³ These enacted legislation required health plans to maintain a dispute resolution mechanism for resolving provider claims payment disputes. In 2003, the DMHC promulgated regulations, known as the Claims Settlement Practice and Dispute Resolution Mechanism Regulations, to establish specific standards and safeguards for the timely and accurate payment of claims, and for the establishment of a fast, fair, and cost-effective dispute resolution process (DMHC, 2006).

Potential Impact of Exempting Out-of-State Policies from California's Consumer Protections and Financial Solvency Requirements

SB 365 would exempt out-of-state policies from California consumer protection requirements, and enrollees of such plans would have to contact the domicile state's Insurance Commissioner to deal with denied claims or other disputes. If disputes were to escalate, enrollees would have to seek resolution in an out-of-state court. Depending on the state, resource constraints—such as time, number of employees, and budget—may prevent regulators from providing assistance to out-of-state consumers and may prevent regulators from enforcing policies (Kofman et al., 2006). Given the size and population of California, its regulatory agencies' capacity is far greater than those of other states in terms of personnel, budget, and resources. For example, the Departments of Insurance in South Dakota and Wyoming have budgets of \$1.7 million and \$1.9 million, respectively, compared with the CDI's \$193 million. In addition, the insurance departments in some states have taken the position that it is not in their jurisdiction to assist consumers who are out-of-state. Marketing practices are an example: out-of-state policies, depending on where they are domiciled, may be prohibited from solely marketing to a younger and healthier population, but again, enforcing such activities across state lines would be resource intensive.

SB 365 would exempt out-of-state policies from California-specific requirements regarding financial reporting and solvency. All states require insurance products to maintain adequate reserves to be financially solvent and able to pay claims. However, these requirements and the capacity to monitor solvency of their carriers vary across states. In addition, funds that are set up to pay for claims if a carrier becomes insolvent may not cover out-of-state consumers or may not be adequate to pay for all eligible consumers (for example if the carrier is domiciled in a small state with few insurers paying into the insolvency fund). If a claim is denied by an out-of-state carrier, the consumer will need to work with the out-of-state carrier, per their arbitration rules, and potentially the out-of-state regulatory agency if there are applicable external grievance processes in place.

SB 365 would exempt out-of-state policies from California-specific requirements prohibiting health plans from engaging in unfair payment practices to providers. Again, while all states require insurance products to pay claims in a timely fashion, it is unclear whether other states have similar protections.

²³ Health and Safety Code §§ 1371.36-1371.39.

For products that are self-insured, the DOL is the regulatory agency with oversight authority and, under ERISA, there are no federal solvency rules. However, 28 states, including California under the CDI, also have licensing requirements for self-insured MEWAs. Under these state rules, MEWAs that self-insure are subject to lower levels of solvency requirements than for insured products, and depending on their size and risk pool, are at higher risk of becoming insolvent. In 2001-2003, four self-insured MEWAs became insolvent, with 66,000 individuals and small business losing coverage and about \$48 million of unpaid claims (Kofman et al., 2006).

Past experience with MEWAs has shown that lack of clear regulatory oversight or inadequate oversight creates incentives for the rise of fraudulent insurance products (GAO, 1992; GAO, 2004; Kofman et al., 2003b). In the mid-1980s the rise of such insurance scams led Congress to amend ERISA to clarify that states had the authority to regulate MEWAs that self-insure or purchase insured products (GAO, 1992). (As mentioned, 28 states have used the authority to establish licensing requirements for self-insured products.) However, as recently as 2003, the Government Accountability Office (then known as the General Accounting Office [GAO]) found that about 144 fraudulent entities, not authorized to sell insurance, were mostly posing as plans exempt from state regulations under ERISA. All together, these entities included coverage for about 15,000 employers and 200,000 policyholders—leaving about \$252 million in unpaid medical claims (GAO, 2004). As of January, 2007, the DOL had 107 civil and 47 criminal cases, related to MEWA enforcement, open for investigation. The DOL states that often these group purchasing arrangements “are nothing more than shams to avoid state insurance regulations” (DOL, 2007). Under SB 365, the current California laws that require insurance policies to be licensed in state would no longer apply, thus potentially exposing consumers and groups—especially small groups—to greater risk of purchasing fraudulent policies that claim to be licensed out-of-state.

Cost and Availability of Health Insurance

SB 365 would allow out-of-state policies to be exempt from California-specific requirements related to the cost and availability of health insurance. These requirements have been designed to allow purchasers of health care to spread the risk of health insurance-related costs to allow access to health insurance for those who might otherwise face high and potentially unaffordable premiums. In the small group market, these requirements were enacted in 1992 (AB 1672, Margolin, Chapter 1128, Statutes of 1992). When AB 1672 was first enacted, one of its goals was to curtail the insurance industry practice of segmenting risk—that is, providing lower rates to consumers and groups perceived as low-risk (low-cost, usually younger and healthier), while not covering, or charging higher rates to groups perceived as high-risk. This legislation changed insurance underwriting rules and encouraged greater price competition and more uniform benefits among insurers selling to groups of three to fifty persons. The strict underwriting and price limits were designed to provide affordable insurance to persons in high-risk occupations and to prevent “exorbitant” premium increases or termination of coverage due to serious illness (Oliver, 1994). The key provisions included (1) outlawing medical underwriting based on occupation, health status, or previous claims experience (allowing only adjustments for age, family size, and geographic area; (2) limiting denial of coverage for preexisting condition to one six-month period; (3) establishing narrow “rate bands” so that an insurer must offer to any group a premium that is within 20% of its average premium for that plan; and (4) requiring insurers to guarantee issuance and renewal of all plans (Oliver, 1994).

Current Coverage and Availability Requirements

In the small group market, requirements with respect to the cost and availability of health insurance include premium setting, guaranteed issue, guaranteed renewal, and limits on coverage based on pre-existing conditions and continuation of coverage (Kelch, 2005). In the individual market, these requirements are related to guaranteed renewal and limiting coverage based on pre-existing conditions (Roth, 2003). Under SB 365, out-of-state policies would remain subject to federal Health Insurance Portability and Accountability Act (HIPAA) requirements (discussed below) or those of their domiciled state if the state set additional requirements beyond federal floors.

- **Premium setting:** Premium setting requirements place limits on how much carriers may vary rates based on the health status of employees or any other risk factors. The intent of these requirements is to prevent carriers from imposing high, and potentially unaffordable, rates on higher-risk groups, thereby pricing them out of the market. Federal requirements under HIPAA prohibit group health plans (coverage sponsored by employers) from charging different premiums to workers and their dependents based on health-status related factors. Employers may have different premiums based on other factors such as location and employment status (i.e., full-time or part-time). These HIPAA standards, however, do not address the premium rates that insurers set for an employer group. Therefore, although employers cannot charge sick employees higher rates than healthy ones, insurers can charge the employer group with sicker workers a higher rate than an employer group with healthy workers. Most states have adopted premium restrictions, limiting the differences in rates that insurers charge small businesses (2 to 50 employees). Few states apply such restrictions in the individual markets.

Generally, there are two types of premium-setting requirements: community/adjusted community rating and rate bands. Community rating means that insurers must set prices for a policy based on the collective claims experience of everyone with such a policy in the state. In other words, regardless of one's age, gender, occupation, health needs (past and current), claims history, or employer group size, everyone pays the same rate. Insurers would not be allowed to vary rates based on the health status or prior claims experience of a business or individual. California does not require community rating. In the small group market, for example, most states, including California, allow for rate bands with limits on how much premiums can range for sicker people compared to healthy ones buying that policy. These restrictions also include renewal rates (BCBSA 2007; Kofman and Pollitz 2006). California's rate bands are "tighter" than in other states, however. This means that the variation among sick and healthy is smaller in California than in states allowing insurers to vary rates based on health factors. In California, an insurer must offer a small group a premium that varies no more than 10% above or below the standard rate (Roth, 2003). In the individual market, there is no similar limit on premium variations. California law, however, requires that rate increases are not discriminatory and prohibits carriers from setting different rates based on race, religion, ancestry, genetic characteristics, or sexual orientation. CDI-regulated carriers are also required to apply rate increases consistently to individuals in a specific "class" of insured people, such as those sharing the same age, family size, geographic region, or health status (Kelch, 2005).

- **Guaranteed issue (and nondiscrimination):** Guaranteed issue is the right to buy coverage (regardless of industry, health status, age of employees, or any other risk factors). Guaranteed issue laws prohibit insurers from denying coverage to applicants based on health status related factors. For example, under guaranteed issue requirements health insurance carriers could not reject small groups applying for coverage because one employee has a costly, chronic medical condition.

Prior to HIPAA, most states required insurers to sell two products on a guaranteed issue basis. HIPAA expanded this to all small group products. HIPAA's non-discrimination protections apply to all size employers. These protections ensure that an employee or dependent is not denied access to the group health plan on the basis of a health status related factor, such as claims or current medical needs. It also ensures that people within an employer group are not charged different rates on the basis of health status related factors. HIPAA also regulates insurers' ability to limit coverage for a condition pre-dating plan enrollment (pre-existing conditions).

For access to the individual market, HIPAA provides limited protections that apply only to people leaving job-based coverage and meeting specific qualifications. For people who do not qualify as HIPAA-eligible, federal law does not provide a right to purchase an individual health insurance policy.

California, like most states, does not have guaranteed issue requirements in the individual market for initial coverage—carriers may deny coverage based on an individual's health condition (past or present), health status, or any other risk factors. However, once a carrier offers to cover a person, that carrier is prohibited from excluding coverage for a pre-existing condition²⁴ for more than 12 months. If the subscriber changes carriers, the new carrier is required to credit the time of that coverage toward any pre-existing condition exclusion (Pollitz et al., 2006).

- **Guaranteed renewal:** Guaranteed renewal is the right to renew coverage (regardless of changes in employee health status or use of services, or any other risk factors). Without such requirements, carriers could drop a group when one or more employees experience a high-cost medical condition. Guarantee renewal laws prohibit insurers from canceling coverage on the basis of medical claims or diagnosis of an illness. HIPAA established rules that require all group and individual health insurance policies to be guaranteed renewable.

California law also requires health insurance plans marketing to individuals that stop selling coverage or stop enrolling new individuals in a particular product to either offer another product with comparable benefits, services, and terms with no additional underwriting or pool the risk for any discontinued products with other, similar products (Kelch, 2005). This requirement aims to protect individuals who cannot switch to other carriers or other products because of their risk profile. Without any legal protection, those enrolled in a "closed block" of business could end up being clustered in old or

²⁴ A pre-existing condition is any illness or health condition for which an insured has received medical advice or treatment during the six months prior to obtaining health insurance (Insurance Code § 10198.7).

discontinued products at more expensive rates (Kelch, 2005; Academy of Actuaries, 2004).²⁵

- **Continuation of coverage laws:** These laws are designed to protect individuals transitioning from group to individual coverage and gaps in coverage when they are changing jobs. Federal requirements under the Consolidated Omnibus Budget Reconciliation Act (COBRA) requires groups with 20 or more employees to continue health insurance for employees and their dependents following death of a spouse, loss of a job, reduction in hours worked, or divorce. Under “Cal-COBRA,” California expanded COBRA to include firms with 2 to 19 employees. California adopted HIPAA requirements for carriers to offer their two most popular products to individuals who are not eligible for COBRA or who have already exhausted their COBRA coverage. Under California law, people who exhaust their COBRA coverage or lose group coverage can purchase “conversion” coverage through the group’s carrier. The group’s carrier cannot refuse to cover these individuals because of health status or subject them to pre-existing condition exclusions. California law also limits the premiums that can be charged for this type coverage (Butler and Polzer, 2002).

Potential Impact of Exemption from California’s Coverage and Availability Requirements

CHBRP reviewed evidence on group purchasing pools to gauge potential impact of SB 365. The literature on group purchasing arrangements such as AHPs and MEWAs is relevant because these type of plans have, at one point, been exempt from state requirements or there have been proposals to exempt them from state requirements.

Group purchasing arrangements are a type of arrangement that allows more than one employer to band together to provide health coverage by either purchasing health insurance or self-insuring. MEWAs are a type of group purchasing arrangement. AHPs are a type of MEWA that is sponsored by a trade or professional association—where the association either endorses or negotiates coverage or provides self-insured health coverage for its members (Kofman, 2006). Analyses of proposals at the federal level that allow for the development of AHPs tend to focus on the small group market. This is because those legislative proposals are intended to lower the cost of health insurance for small groups—who operate on smaller margins relative to large groups—and thereby expand coverage for those employees of small groups who are uninsured.

Impacts on coverage levels

There have been four quantitative models used for projecting the impacts of AHPs: (1) developed by the analysts at the Congressional Budget Office (CBO); (2) developed by researchers at the Urban Institute, called the Health Insurance Reform Simulation Model (HIRSM); (3) developed by actuaries at Mercer Oliver Wyman; and (4) developed by consultants at The Lewin Group, called the Health Benefits Simulation Model.

²⁵ It is a commonly observed practice of the current individual health insurance market that an insurer will periodically “close” a block of business (meaning they will no longer issue new business in that pool of policies). There can be many reasons for closing a block of business. Regardless of the reason, that block will typically experience claim costs rising more rapidly than would a block that was still open. More information on the closed block problem is available at www.actuary.org/pdf/health/rate_may04.pdf.

The CBO model was used to examine the effects of the introduction of AHPs on the insurance market and specifically examined proposals that establish federally certified AHPs and HealthMarts that would not be subject to state insurance regulations (Baumgardner and Hagen, 2001).²⁶ Researchers found that the introduction of AHPs and HealthMarts would lead to a slight increase in health insurance coverage nationally. They estimated that an additional 330,000 would become newly insured as the net result of 4.6 million individuals who would enroll in those new plans partially offset by a decline in the enrollment in state-regulated plans of 4.3 million individuals.

Blumberg and Shen (2004) used the HIRSM model to estimate the impact of various AHP proposals on the California market. Characteristics of AHP provisions, such as those proposed under U.S. House of Representative bill H.R. 660 (2003) or under the U.S. Senate bill S. 545 (2003), were used in the analysis. These AHPs would have been certified by the U.S. Department of Labor (DOL) and, in general, would have been exempt from state benefit mandates or rules on availability of coverage (e.g., guaranteed renewal). Researchers found that there was a less than 1% increase in new coverage or “virtually no net change in insurance coverage resulting from the availability of this alternative insurance product” (Blumberg and Shen, 2004).

The Mercer evaluation of the federal Health Insurance Marketplace Modernization and Affordability Act of 2006 (S. 1955), conducted for the National Small Business Association (NSBA), projected that the introduction of small business health plans (SBHPs) in the market would result in a net increase of 2 million insured in small group market. However, they assumed that specific state requirements and new federal standards would be in place.^{27,28} A previous analysis conducted by Mercer of H.R. 660 and S. 545, also conducted for the NSBA, found that elimination of rate setting requirements under those AHP proposals would actually generate a net increase in the number of uninsured in the small group market, since some groups would have to drop coverage as soon as an employee became sick (and considered high-risk) and their corresponding premiums increased (Fritchen and Bender, 2003).

The Lewin Group’s analysis of S. 1955, conducted for the Coalition to Protect Access to Affordable Health Insurance, specifically analyzed the affects of the bill on states with community rating requirements. Since California does not have community rating requirement, the results are not relevant to this report (Lewin Group, 2006).

²⁶ Other CBO cost estimates on AHP, HealthMarts and related proposals include CBO, 2000; CBO, 2003; and CBO, 2006. Baumgardner and Hagen (2001) article is summarized here because it includes the most detail regarding the CBO model and discussion on cost and coverage impacts.

²⁷ Specifically, Mercer assumed that (1) state regulations would remain in place since SBHPs were assumed to be fully insured plans, (2) all SBHPs would be subject to the same premium setting requirements as proscribed under S. 1955 and (3) state-regulated policies would be able to adopt the same federal premiums setting requirements that would apply to the SBHPs. Thus the Mercer evaluation essentially evaluated the effects of eliminating benefit mandates.

²⁸ Bender K, Fritchen B. Personal communication with Mr. Todd McCracken of the National Small Business Association regarding the Health Insurance Marketplace Modernization and Affordability Act of 2006, dated March 7, 2006.

Impacts on premiums and risk segmentation

The analyses using the CBO and HIRSM models found that the introduction of AHPs in the market resulted in savings in premiums for those individuals who entered the AHPs and an increase for those policyholders who stayed in the insured, fully regulated market. Blumberg and Shen (2004) found a decrease of 14% of insurance premiums for the AHP policyholders and an increase of 5% for the policyholders in the insured fully regulated market. Baumgardner and Hagen (2001) found a 2% increase for those remaining in the insured, fully regulated market, and a 13% difference between the premiums offered to AHP policyholders versus those in the insured market. The savings in premiums for AHP policyholders is attributed to both regulatory relief from state regulations as well as selection of better (low-cost) risk. Conversely, increased premiums in the state-regulated market are due to adverse selection of the worse (high-cost) risk with fewer low-cost enrollees to spread the risk. The Mercer evaluation of H.R. 660 and S. 545 concurred finding that small group AHPs would reap a 10% decrease in premiums but those decreases primarily resulted from risk selection. By contrast, small group plans in the state-regulated market would face a 23% increase in premiums (Fritchen and Bender, 2003).

The Health Care Choice Act of 2005 (H.R. 2355) was a federal proposal similar to SB 365—it would have allowed individuals buying insurance in the individual market to do so from an entity licensed in another state. The out-of-state individual health policy would have been exempt from laws and regulations of the enrollee’s residence state that are related to consumer protections, mandated benefits, and other requirements related to guaranteed issue, renewal, and limits on covering pre-existing conditions.²⁹ CBO estimates showed that the price of individual policies in the resident state would increase as a result of H.R. 2355, since higher-risk individuals would not be offered insurance from out-of-state policies. CBO also projected that small group markets in resident states would have incentives to stop offering coverage since more affordable out-of-state products would be available to their low-risk employees in the individual market and the remaining high-risk employees would be too costly to insure. This dynamic, the CBO estimated, would lead to about 1 million small group enrollees losing health insurance coverage. However, low-risk individuals who were uninsured would obtain low-cost, out-of-state individual policies, offsetting those who lost insurance. Although the characteristics of the insured population could change, with low-risk individuals gaining insurance coverage and high-risk individuals losing coverage, the net effect with respect to the number of insured would be insubstantial (CBO, 2005). Kofman and Pollitz (2006) found that H.R. 2355 could leave carriers in the states with guaranteed issue requirements with only the sick enrollees who would need access to comprehensive coverage. Although California does not have guaranteed issue requirements in the individual market, state-regulated policies that are required to provide comprehensive health coverage under Knox-Keene requirements would face adverse selection, driving up the cost of coverage for those left in those individual policies.

Impacts on market stability

If SB 365 were to pass, large- and mid-sized employer groups would need to evaluate what products would provide them value for the premiums they expend. California is unusual in that a smaller proportion of private sector employer-sponsored health plans choose to self-insure. Instead, most employer-sponsored plans purchase insured plans that are subject to state

²⁹ H.R. 2355 would have required minimal capital and surplus levels to ensure solvency.

requirements (31% of employees in California are in self-insured plans versus 55% of employees nationally [CHCF/HSC, 2006]). Employers choose to do so, in part, because managed care penetration in California had kept the cost of purchasing comprehensive health care coverage relatively low (Butler and Polzer, 2002). If fewer California-regulated products are offered in the commercial market, it is expected that over time, more large groups, and perhaps even mid-sized groups, might choose to self-insure rather than purchase an out-of-state policy. This would be likely to occur if the state-regulated purchased products charged higher and higher premiums, due to adverse selection. Out-of-state policies might not be an attractive alternative if they did not have the kind of generous benefit packages that large-groups tend to demand (Jensen and Morrissey, 1999a). It is likely that large, multi-state employers that already offer a self-insured product to employees of another state would do so for employees in California, rather than purchase an insured out-of-state product for California residents.

As previously discussed, insurance requirements in the small group market were intended to spread risk and ensure availability of coverage for otherwise uninsurable populations. AHP and other proposals for the development and marketing of products exempt from state-specific requirement are likely to result in out-of-state policies attracting healthy, low-risk employers and individuals. This favorable selection and risk segmentation could lead to change in the composition of the market. For example, in the small group market, those with younger and healthier employees may choose more affordable out-of-state products while other small groups may drop coverage altogether (Kofman and Polzer, 2004; Blumberg and Shen, 2004; Kofman and Pollitz, 2006). Small groups may face dramatic variations in premiums when California-specific rate protections do not apply. The California Department of Insurance (CDI) calculated projected premium impacts if S. 1955 were to pass and found that small group employees of the same firm could face premium differentials of 67% (versus 22% in current CA law) based on less stringent rate band requirements (CDI, 2006). Under SB 365, out-of-state policies licensed in the District of Columbia, Virginia, Pennsylvania, or Hawaii would have no rate band requirements. Thus, those premium differentials could be higher than estimated by the CDI. (BCBSA, 2007; Kofman and Pollitz, 2006).

ANALYSIS OF BENEFIT REPEALS: AN EXAMPLE OF IDAHO

California has many benefit mandates in place—40 benefit mandates to cover or offer coverage under the California Health and Safety Code and 34 benefit mandates to cover or offer coverage under the Insurance Code.³⁰ These mandates range from requiring coverage of a specific item or service, to covering a category of services related to screening, diagnosing and treatment of a set of conditions. One of the goals of SB 365 is to address the concerns regarding the cost of benefit mandates currently in law. This section addresses this question by (1) presenting an actuarial analysis of the premiums associated with a scaled-down benefit package if, for example, all carriers selling insurance policies in California were to become domiciled in Idaho (the state with the fewest benefit mandates) and drop all benefits mandated in California other than breast cancer treatment, home health care, and services required by Idaho, after the passage of SB 365; (2) summarizing the existing literature on the cost of benefit mandates; and (3) presenting the potential implications for public health if some out-of-state policies with scaled-down benefits were introduced into the market.

Potential Cost Impacts of Benefit Mandate Repeals

This section illustrates the potential savings in covered health care expenditures that might result from the passage of SB 365 if out-of-state policies reduced benefits packages for California policyholders. The calculations are based on a hypothetical scenario in which all carriers selling insurance in California would become domiciled in Idaho.³¹ Idaho is used as a reference point because it has five benefit mandates in place and thus the fewest benefit mandates of any state in the union. Therefore, the scenario in which carriers domicile in Idaho yields the greatest possible estimated savings related to benefit mandates that could be achieved through passage of the bill. Relaxation of other forms of regulation could lead to additional cost savings for carriers. Although we were unable to model these costs to provide a formal estimate, an actuarial analysis of a federal bill that could have similar effects (the Small Business Health Fairness Act of 2003) suggested that the relaxation of solvency requirements, participation in state guarantee funds and other state regulations would lead to an additional 2.5% savings above and beyond the savings associated with elimination of benefit mandates³² (Fritchen and Bender, 2003).

³⁰ There are 40 benefit mandates to coverage or offer coverage under the California Health and Safety Code. There are 34 benefit mandates to cover or offer coverage under the Insurance Code. There are 42 total unique benefit mandates to cover or offer coverage under the Health and Safety or Insurance Code. Under the Health and Safety Code is an expansive benefit mandate to cover ‘basic health care services’ which include a wide range of preventive, and medically necessary diagnostic and treatment services provided in the inpatient, outpatient, physician offices and post-acute care settings. Note that these counts include benefit mandate only—not mandates on access to providers or eligibility mandates. (See Appendix C for a list of these mandates.)

³¹ Our use of Idaho as an example for obtaining an “upper-bound” estimate of the cost savings from eliminating benefit mandates should not be interpreted to mean that carriers would necessarily choose Idaho as their domiciliary state if SB 365 passed. As described earlier in the report, a number of other regulations (e.g., guaranteed issue and other requirements in the individual market) would be affected by the choice of domiciliary state. Some of these regulations might prove to be more important to the carrier’s decision than the benefit mandates. Carriers would also have an incentive to domicile in a state with regulatory agencies that do not have the budgets to enforce requirements out-of-state.

³² Bender K, Fritchen B. Personal communication with Mr. Todd McCracken of the National Small Business Association regarding the Health Insurance Marketplace Modernization and Affordability Act of 2006, dated March 7, 2006.

The actual effects on covered expenditures and premiums would depend on a variety of factors (see Appendix D), including which of the mandated benefits are actually dropped from coverage. Under the most extreme scenario, carriers could choose to drop all of the benefits mandated in California except those also required by Idaho as a result of either Federal mandates (breast reconstruction, maternity length of stay) or state mandates (mammography screening, emergency services, cleft palate). Alternative scenarios, in which carriers dropped some but not all previously mandated benefits from coverage, are more plausible and would result in commensurately smaller reductions in premiums. For example, carriers might choose to drop coverage of biologically based mental disorders but retain prostate cancer screening benefits.

Impacts on Covered Expenditures and Premiums

For this analysis, CHBRP assumes that with two exceptions, all California-mandated benefits associated with non-trivial costs would be dropped unless they were also required by the federal government or the state of Idaho. The exceptions are breast cancer treatment (which is considered to be a benefit no carriers would choose to drop) and home health care (which carriers are likely to continue covering as an alternative to skilled nursing care³³). Under this hypothetical scenario, CHBRP has estimated that covered health care expenditures (including both health plan and member payments) would decrease by 10.8% for DMHC-regulated plans, 4.1% for CDI-regulated plans, and 10.1% overall. The majority of mandated benefits contributed very little to the savings on an individual basis, with only a few service categories (preventive services, maternity benefits, services for biologically based mental disorders) having a substantial effect on the total. These projections represent upper bounds on the likely effects; for example, the estimated savings for DMHC-regulated plans includes maternity benefits, which in reality carriers are highly unlikely to eliminate.

The savings in covered health care expenditures for large-group, small-group, and individually purchased insurance policies varies for two reasons, apart from possible effects of risk segmentation. First, some of the current mandates do not apply to individually purchased insurance policies. Second, differences exist in the proportion of individual, small group, and large group policyholders who are enrolled in DMHC- vs. CDI-regulated plans. For these reasons, covered health care expenditures would decline the most for individuals with large-group coverage (10.8%), who are enrolled almost exclusively in DMHC-regulated plans, and the least for individuals with individually purchased insurance (6.4%), more than one-third of whom are enrolled in CDI-regulated plans. Those with small-group coverage fall in between, with a 10.0% projected decline in covered expenditures.³⁴

³³ Dropping home health care benefits would lead to an additional one percentage point decline in covered expenditures for CDI-regulated products. However, this benefit is unlikely to be excluded from limited-benefit plans because it provides a cheaper alternative to nursing home care for certain patients. DMHC-regulated plans are not subject to this mandate.

³⁴ These figures were derived by estimating the proportion of covered health care expenditures attributable to each of the service categories currently covered under California benefit mandates, using an actuarial model based on a large national dataset (see Appendix D) and summing across mandates. Expenditures for services covered under more than one benefit mandate were included only once in the total (e.g., the cancer screening test mandate includes cervical and prostate cancer screening, which are covered under separate mandates as well). Mandated offerings are

Impact on Premiums and Utilization

The projections regarding the effects of SB 365 on premiums rely on the assumption that as a proportion of covered health care expenditures, cost-sharing, administrative costs and profits would not change significantly over the range of expenditures considered here (see Appendix D for further discussion of this issue). Based on this assumption, CHBRP estimates that the greatest possible reduction in premiums that could be expected as a result of reducing the benefit mandate requirements would be the same as for covered expenditures, that is, 10.8% in the DMHC-regulated market and 4.1% for CDI-regulated plans. These reductions would be achieved only if carriers chose to eliminate virtually all of the benefits currently mandated in California, as described above.

Small-group and individually purchased policies are of particular interest for the analysis of SB 365, given concerns about the effects of mandates on insurance offer and take-up rates in these markets. For individually purchased policies, the 4.1% estimated decrease in premiums for the CDI-regulated plans is the more relevant of the two numbers for projecting effects on the rates of insurance coverage. Given the difference in average per member per month (PMPM) premiums between DMHC-regulated vs. CDI-regulated plans (\$269 vs. \$149), it seems likely that individuals interested in purchasing limited-benefit plans are already selecting the CDI-regulated products, which generally have greater deductibles and higher cost-sharing. By the same token, uninsured individuals who might be attracted back into the insurance market through lower premiums may focus on the price of the cheaper CDI-regulated plans and be less responsive to premium changes for the DMHC-regulated plans, since even after the premium decrease, those plans would still be more expensive (i.e., \$240 vs. \$143). For small groups, DMHC- and CDI-regulated policies have virtually the same premium (\$344 vs. \$343), so the DMHC-regulated limited-benefit plans would be relatively more competitive in this segment of the market.

It is important to consider the projected reductions in premiums associated with SB 365 in the context of the value of the insurance policy; although insurance would be less expensive, it would cover fewer of the services that individuals might need or want, such as cervical cancer screening, diabetes supplies, contraceptives, hospice care, and other services. In response to the loss of coverage for previously mandated benefits, individuals will generally choose to reduce or eliminate their utilization of those services. For example, based on data from the RAND Health Insurance Experiment (HIE), Newhouse and colleagues (1993) estimate that in going from 25% to 95% cost-sharing, spending would drop by 32% for acute care, 24% for chronic care and 40% for well care in a fee-for-service insurance environment.³⁵ Under SB 365, the changes in cost-sharing would be even greater (from 20% to 100%) but their effects on spending would be moderated by the high degree of care management in the California insurance market, so utilization decreases resulting from higher cost-sharing in limited-benefit plans would likely be smaller than those found in the HIE. To the extent that individuals cut back on unnecessary services in response to greater cost-sharing, cost savings could be achieved with little adverse impact, but to the extent that they cut back on needed services instead, then SB 365 could have a

not included in the total because of the presumption that the premiums charged by insurers for the riders that cover these services fully cover their costs, so that eliminating the riders would not affect the basic cost of coverage.

³⁵ Alternative estimates based on internal Milliman data suggest that the expenditure decreases might be smaller than those suggested by the HIE, e.g., 15-20% rather than 32% for acute care.

detrimental effect on their health, as described further in the Public Health section. Some evidence suggests that both may occur (Shapiro et al., 1986; Wong et al., 2001).

If “cost offsets” exist, then another possible implication of reduced service use could be higher utilization of services in the long run. For example, lower rates of cancer screening exams could increase the time until cancer diagnosis and cancers diagnosed at later stages are likely to be more expensive to treat, so it is conceivable that the savings in the cost of cancer screening exams might be offset by increased treatment costs over the longer term. Similarly, some have argued that treatment of mental and substance use disorders is associated with subsequent reductions in hospitalizations, emergency room use, and other types of care, implying that a reduced rate of treatment might cost more in subsequent utilization than the savings it provides. The empirical evidence on this point is mixed, however (Holder, 1998; Bray and Zarkin, 2006; Donohue and Pincus, 2007). Given the short timeline for developing this report and the diversity of services covered by the current mandates, CHBRP was unable to review the literature to determine the evidence base for possible cost offsets associated with each of the mandates.

A portion of the services no longer covered by insurance will continue to be used by individuals paying the full cost out of pocket, although they might become more judicious purchasers of health care (e.g., by shopping around for cheaper services) as a result of bearing the full cost. For some individuals, the increase in the amount spent out of pocket might more than offset the reduction in the share of insurance premiums they pay. The extent to which the individual’s costs (share of insurance premiums plus out-of-pocket spending) is increased or decreased will depend on a variety of factors, including their age and health status, and whether their policy was obtained through a large group, small group or individual purchase.

On the other hand, conventional economic wisdom (Summers, 1989) and empirical evidence (Miller, 2004) suggest that in the long run, most of the employer’s share of health insurance premiums is passed back to employees in the form of lower wages³⁶. Thus it could be argued that even if some individuals would pay more out of pocket for their health care, all employees would benefit from increased wages. This argument again raises the issue of the incidence of costs and benefits associated with SB 365, i.e., that younger, healthier individuals may become better off under its provisions, while older, sicker individuals are likely to become worse off.

The estimated effects of SB 365 on premiums do not take into account the likelihood that premiums in plans offering limited benefits would be further reduced due to selection of low-cost individuals into these plans, yet increased for high-cost individuals remaining in state-regulated plans, as discussed in the *Potential Impacts of SB 365 on the Health Insurance Market* section. Finally, the CHBRP cost model does not account for any long-term competitive effects in the marketplace. For example, in theory premiums could eventually rise again if carriers selling out-of-state policies with minimal benefits were able to drive out competition in the insurance market by undercutting carriers selling more generous policies, then used their market power to increase prices and profit margins once the competitors had left the market. We consider this scenario to be extremely unlikely, however, since it would require that there be sufficiently strong barriers to

³⁶ One important reason why insurance benefits are not completely offset by wage reductions is the tax subsidy for employer-based insurance (Pauly, 2002).

entry and exit in the health insurance market to maintain market power and prevent competitors from re-entering the market.

Impact on the Number of Uninsured

In calculating the increase or decrease in the number of uninsured Californians resulting from changes in insurance premiums, CHBRP uses the estimate that a 10% decrease in premiums will result in a 1.1% increase in the number of insured individuals.³⁷ Assuming that the converse is true as well³⁸, CHBRP estimates that if both the DMHC- and CDI-regulated markets added limited-benefit plans, the projected 10.1% decline in the premiums could increase the number of insured Californians by 192,262 individuals out of a privately insured population of 17,335,000. If competition based on limited-benefit plans occurs primarily in the market for CDI-regulated products, the premium decreases of 4.1% would lead to an increase of 8,374 in the number of insured Californians. To the extent that some of these newly insured individuals previously received services paid for by government programs (e.g., Medi-Cal), there could be beneficial spillover effects in terms of public sector spending. On the other hand, changes in the composition of insured individuals (with insurance rates increasing among younger, healthier individuals and declining among older, sicker individuals) might have the opposite effect, since disabled individuals are more likely to qualify for public programs.

An important caveat is that estimates of the price elasticity of demand for private health insurance reflect the change in demand when the price of the insurance policy varies, holding the characteristics of the policy itself constant. In other words, if the price of a given insurance policy dropped, employees would be more likely to buy that policy. That does not necessarily imply, however, that employees would be more likely to buy a cheaper policy with limited benefits than a more expensive policy with generous benefits (Pauly, 2002; Pauly, 2005). In its analyses of insurance mandates, CHBRP generally assumes that the addition of a single mandate is unlikely to change the desirability of the policy sufficiently to affect the take-up rate, apart from the mandate's impact on the premium. In this case, however, the increase in the number of insured individuals associated with the passage of SB 365 is likely to be overestimated, because individuals may not view an insurance policy with limited benefits (and hence greater exposure to risk) as being worth the price, even if it costs 10% less than a traditional policy would. The counter-argument is if individuals place little or no value on the mandated benefits being given up, then limited-benefit policies with lower premiums will make them better off.

Potentially speaking to the question of whether consumers value more generous insurance policies sufficiently to be willing to pay their higher cost, take-up rates for other forms of limited-benefit and high-deductible policies have been low (Friedenzohn, 2004; Claxton et al., 2006; Fronstin and Collins, 2006). Furthermore, studies of the effects of mandate exemption laws that enable small firms to purchase limited-benefit policies have found at best mixed evidence of any effects on insurance coverage (Sloan and Conover 1998; Jensen and Morrissey, 1999a; Jensen and Morrissey, 1999b; Gruber 1994; Hing and Jensen, 1999). For example, Sloan

³⁷ CHBRP criteria and methods for assessing the impacts of premium increases on the uninsured is available at www.chbrp.org/documents/uninsured_020707.pdf.

³⁸ The assumption that the increase in the number of newly insured resulting from a given premium decrease would be the same as the increase in the number of newly uninsured from an equivalent premium increase may not hold; as one example, entry costs for purchasers would imply less responsiveness of insurance rates to premium reductions.

and Conover (1998) found that while the number of mandates increased the rate of uninsurance, the availability of low-cost insurance policies through partial mandate exemptions had no impact. Conversely, Hing and Jensen (1999) found that while state-mandated benefits were not related to the provision of insurance by small firms, state policies exempting firms newly offering insurance from these mandates were. Jensen and Morrissey (1999b) found strong effects of mandated benefits on the insurance offer decision of firms, while Gruber (1994) found no significant impact. Given the lack of consistency in the literature on this point, it may be overly optimistic to expect that the number of insured individuals would increase by as much as the CHBRP estimates suggest if SB 365 were to be enacted.

As noted earlier in the section, *Potential Impacts of SB 365 on the Health Insurance Market*, if risk segmentation occurs as a result of SB 365, then low-cost individuals may be able to obtain insurance policies at lower premiums than projected above, while high-cost individuals are likely to pay more than before. Although there is insufficient information to predict the effects of risk segmentation on the number of insured individuals, the earlier research on the effects of AHPs and HealthMarts (described under *Potential Impact of Exemption from California's Coverage and Availability Requirements*) provides some indication.

Impact on Self-Insurance

It is possible that SB 365 would motivate firms that would otherwise self-insure to instead purchase insurance products with minimal benefits but lower premiums. However, most self-insured firms are large employers, who tend to offer generous benefits even in the absence of benefit mandates, which may account for the finding that the coverage offered by self-insured firms tends to mirror that offered in purchased insurance products (Acs et al., 1996; Jensen and Morrissey, 1999a). There is also no evidence that mandates are a significant factor in the decision of firms to self-insure (Jensen et al., 1995; Jensen and Morrissey, 1999a); Jensen and Morrissey (1990) found that firms converting to self-insurance actually experienced increases in premiums, suggesting that mandate costs were not driving their decisions. Given the lack of empirical evidence to the contrary, and for all the reasons described in the preceding section of this report, it seems more likely that firms who previously purchased insurance products would have an incentive to switch to self-insurance, rather than the other way around.

Literature Summary on the Cost of Insurance Mandates

This section reviews the existing literature on the cost of insurance mandates in order to put into context CHBRP's findings regarding the possible effects of SB 365 on health care premiums and rates of insurance coverage. Two approaches to examining the cost of mandates have typically been used in the past literature. The first approach, similar to the one used by CHBRP, is to use an actuarial model based on an insurance claims dataset to calculate the cost of paid claims for services covered under the mandate. With this approach, one can either attribute the entire cost of these claims to the mandate, or one can subtract the cost of the services that insurers would cover even in the absence of the mandate, in order to obtain the incremental, or "marginal," cost associated with the mandate.

The second approach to estimating the cost of mandates is to use a “hedonic price” regression to estimate the association between health insurance premiums and mandated benefits or other forms of regulation. The chief advantage of this approach is that, unlike the actuarial models described above, it accounts for the possibility that mandated benefits for one type of service could either increase or decrease the utilization of another service, if the two services are respectively complements or substitutes. A potential disadvantage is unless the sample size is large and the model is able to control for all possible benefit design features, the cost of any particular mandate might end up being overstated if it is positively correlated with unmeasured benefits (the converse, although less likely, would hold as well).

Using the actuarial approach, a Milliman study of the cost of 13 mandates in Texas found that the mandated benefits accounted collectively for 7.6% of the premium for large groups and 7.2% of the premium for small groups (Albee et al., 2000). The only mandates that individually increased premium costs by more than a percentage point were for congenital defects, serious mental illness, and HIV/AIDS. A Mercer study of the cost of 41 mandates in Maryland found that while the full cost of the mandates was about 15.4% of the cost of paid claims, the marginal cost was only 1.9% (Maryland Health Care Commission, 2006). A Mercer evaluation of the federal Health Insurance Marketplace Modernization and Affordability Act of 2006 found that in the small group market, the elimination of benefit mandates that were not in effect in at least 45 states would lead to a premium reduction of 5%.³⁹ A GAO summary of actuarial studies found that the cost of mandated insurance benefits ranged from 5.4% to 22.0% of total claims costs, depending on the state, but noted that the proportion actually attributable to the mandates would depend on which services the insurers would have covered even in the absence of a mandate (GAO, 1996). Overall, the 11.0% expenditure increase estimated by CHBRP for California appears to be consistent with the actuarial estimates from other states, given the large number of mandated benefits but high degree of managed care, which tends to dampen mandate effects on utilization.

Using a hedonic price approach to study eight mandated benefits, Jensen and Morrissey (1990) estimated extremely large premium increases associated with benefits such as psychiatric hospital stays (12.8% increase in premiums), chemical dependency treatment (8.8% increase), psychologist visits (11.8% increase), and dental visits (15% increase). In a later study, however, Jensen and Gabel (1992) found that mandated benefits for the same services were not significantly associated with the probability that small firms offer coverage. This inconsistency suggests that the premium increases attributed to the mandated benefits in Jensen and Morrissey (1990) may have been overstated, perhaps because the model could not control sufficiently for overall generosity of the insurance policy and the particular benefit design features studied were serving as a proxy. The authors note that with a hedonic price approach, the estimated effect is for the benefits included in an “average” policy, which could be more generous than what is mandated. Furthermore, causal effects of benefit generosity on premiums will be overstated if there is adverse selection in the insurance market, such that firms whose employees have greater need for a benefit are more likely to purchase insurance policies that cover it.

³⁹ Bender K, Fritchen B. Personal communication with Mr. Todd McCracken of the National Small Business Association regarding the Health Insurance Marketplace Modernization and Affordability Act of 2006, dated March 7, 2006.

Other studies using a hedonic price approach with a rigorous study design controlling for baseline differences across states and more detailed information regarding benefit mandates and other regulations found very mixed results, with the passage of certain mandates increasing premiums and the passage of other mandates decreasing them (LaPierre et al., 2007; Henderson et al., 2007a; Henderson et al., 2007b). Interestingly, some of the benefits considered to be the most expensive of the mandates (e.g., alcoholism treatment, mental health services) were actually associated with lower premiums in one study (Henderson et al., 2007b), although mental health services were associated with higher premiums in another (Henderson et al., 2007a).

Estimated associations of mandates with the probability that individuals are uninsured are equally inconsistent, with evidence suggesting that some mandates increase the rate of uninsurance (Sloan and Conover, 1998; Henderson et al., 2007b; Seward et al., 2007), others decrease it (Henderson et al., 2007b; Seward et al., 2007), and still others have no significant effect (Gruber, 1994; Henderson et al., 2007b; Seward et al., 2007). Mental health parity was associated with a lower probability of insurance coverage in one study (Henderson et al., 2007b) and a higher probability in another (Seward et al., 2007). As Sloan and Conover (1999) also conclude in their review of the empirical literature on this topic, there is mixed and inconclusive evidence regarding the impact of state health insurance reforms, including mandated benefits and other forms of regulation, on rates of health insurance coverage.

Potential Impact on Public Health of Benefit Mandate Repeals

Benefit mandates are intended to provide protections to enrollees by requiring that health insurance products include coverage for certain treatments, services, pharmaceuticals, or items such as durable medical equipment. Additionally, benefit mandates can dictate how care will be provided (e.g., minimum lengths of stay in a hospital following childbirth).

If the passage of SB 365 resulted in individuals moving from DMHC- and CDI-regulated policies to out-of-state policies, enrollees would no longer be guaranteed to have coverage as specified by the mandates in California as detailed in Appendix C.⁴⁰ While each mandate is unique in its application to the insured population, a majority of the mandates are related to screening and preventive services, treatment related to women's health, and coverage related to pharmaceutical and durable medical equipment benefits. Other mandates require coverage for specific treatments related to chronic health conditions (e.g., diabetes, asthma) and coverage for specific types of services such as hospice care and medical transportation services.

Although there has not been research on the health outcomes associated with most of California's health insurance mandates, one can estimate the public health impact of individual mandates by examining the medical effectiveness of the mandated service or treatment and the

⁴⁰ Out-of-state carrier policies would no longer be subject to the mandated benefits in Appendix C that require coverage for certain groups of individuals, treatments, and services. Enrollees in out-of-state carrier policies may also lose benefits based on the mandated offerings detailed in Appendix C, however, insurers are not required to cover these services but only offer them to purchasers. The mandated offering laws are not discussed in detail in this section.

expected increase in utilization expected due to the passage of the mandate.⁴¹ While a review of the medical effectiveness of all of the treatments or services included in California mandates is not feasible for this analysis, it is important to consider the health implications of SB 365 with regard to health insurance mandates.

As mentioned in the previous section, only a few service categories (preventive services, maternity benefits, services for biologically based mental disorders) have a substantial effect on health insurance premiums. These service categories are associated with important health outcomes.

Preventive Services

Several mandates require coverage for specific health screenings and other preventive care services. Based on the recommendations by the U.S. Preventive Services Task Force (USPSTF), several of the screening and preventive services mandated in California are medically effective. Table 2 details the California-mandated preventive services deemed effective and recommended by the USPSTF for both DMHC- and CDI-regulated plans and policies. If SB 365 results in a shift of enrollees from DMHC- and CDI-regulated plans and policies to out-of-state carrier policies, enrollees would no longer be guaranteed to have coverage for and would therefore likely reduce their utilization of preventive services, resulting in increased morbidity and mortality. The health impacts of shifting to out-of-state carrier policies would be greater for those originally enrolled in DMHC-regulated plans since more preventive services are required to be covered in these plans.

⁴¹ See CHBRP methodology for evaluating the public health impacts associated with health insurance mandates at: <http://www.chbrp.org/pubhealth.html>.

Table 2. California Preventive Services Mandates Recommended by USPSTF*

DMHC-Regulated Plans	CDI-Regulated Policies
<ul style="list-style-type: none"> ● Child immunizations ● Adult immunizations ● Screening for obesity and counseling/interventions ● Mammography ● Cervical cancer screening ● Colorectal cancer screening ● Screening for hypertension and lipid disorders ● Screening for pregnant women (asymptomatic bacteriuria, hepatitis B, neural tube defects, anemia, pre-eclampsia with blood pressure monitoring, Down syndrome, Rh(D) blood typing and antibody testing, and hemoglobinopathies) ● Screening for sexually transmitted diseases (chlamydia, gonorrhea, syphilis, HIV) ● Screening for tuberculosis ● Behavioral counseling to promote a healthy diet ● Newborn screening (congenital hypothyroidism, phenylketonuria) ● Screening for blood lead levels (children) ● Vision screening (children under age 5 years) ● Screening for diabetes 	<ul style="list-style-type: none"> ● Child immunizations ● Mammography ● Cervical cancer screening ● Colorectal cancer screening ● Newborn screening (congenital hypothyroidism, phenylketonuria) ● Screening for blood lead levels (children) ● Vision screening (children under age 5 years)

Source: Compiled from USPSTF, 2005; Compiled from Health and Safety Code Sections 1365, 1367; California Code of Regulations Section 1300.67; Insurance Code Section 10123.

* The preventive services mandates listed in Table 2 are more inclusive than those in Appendix C because Table 2 includes those preventive services that would be required under “Basic Health Care Services” as defined under the Knox-Keene Act and promulgated in regulations by the DMHC.

Maternity Services

DMHC plans are required to cover maternity services; however, CDI-regulated policies can exclude coverage for maternity services. If SB 365 results in shifting women from DMHC plans to out-of-state carrier policies that exclude maternity benefits, there are important health impacts to consider.

One preventive service listed in Table 2 is screening for pregnant women, including screening for prenatal genetic disorders and other prenatal screenings that could indicate pregnancy complications. Other components of prenatal care that have been found to be effective include prevention, detection, and treatment of prenatal health conditions such as anemia, pre-eclampsia, and infection (Carroli et al., 2001). If these prenatal services are under-utilized due to lack of

coverage in out-of-state policies, it is expected to result in increased complications for women and newborns.

Mental Health Services

Both DMHC- and CDI-regulated health policies are required to cover the treatment for biologically based severe mental disorders at the same level they cover other medical conditions, otherwise known as mental health parity. The severe mental disorders currently covered under mental health parity include: schizophrenia, schizo-affective disorder, bipolar disorders, major depression, panic disorder, obsessive-compulsive disorder, autism, anorexia nervosa, bulimia nervosa, and serious emotional diseases for children.

While a review of the medical effectiveness of all the available treatments for these mental disorders is outside the scope of this analysis, there are effective treatments for mental disorders (IOM, 2006). The potential outcomes associated with mental health treatment include: reductions in suicides and suicide attempts, reductions in psychiatric emergency room visits, reduction in inpatient hospitalizations, improvements in mental health-related quality of life, reduction in symptomatic distress, and improved health outcomes related to comorbid conditions, such as diabetes. Other mental health treatment outcomes include social measures such as a reduction in crime and family problems and increases in employment and housing.

The extent to which these health outcomes are associated with mental health parity coverage depends on how mental health parity affects utilization of care and the appropriateness and effectiveness of treatment. While the literature indicates that parity is associated with increases in utilization of outpatient mental health services, there is a lack of research on the effects of mental health parity on health outcomes.

Health Impacts of Risk Segmentation of the Health Insurance Market

As mentioned previously in this report, one major health implication of SB 365 is that it would likely result in risk segmentation of the market. Out-of-state policies not subject to California benefit mandates are expected to attract healthier individuals. Additionally, these plans are expected to retain coverage for some of the services currently mandated based on federal and Idaho mandates such as mammography, minimum length of stay for maternity services, and breast reconstruction.

Low-costs out-of-state policies (not subject to California benefit mandates) are expected to attract healthier individuals. As a result, there would be a greater share of high-cost enrollees left in state-regulated plans. Because state-regulated plans, especially those in the small group and individual market, are likely to experience premium increases, these high-cost enrollees may face loss of insurance in the privately insured market.

This would likely further lead to a dependence on the already strained safety net providers to provide care to those who lose their insurance. For example, growing numbers of uninsured contribute to overcrowding of emergency rooms and increased uncompensated care. The burden on emergency rooms has prompted more than 400 to close over the past decade and increased the

time all patients must wait, even for lifesaving care (IOM, 2006). In 2004, uncompensated care was estimated at \$40.7 billion nationally. Most uncompensated care incurred in hospitals where care is most costly. The primary source of funding for uncompensated care is government dollars (KFF, 2004).

Gender, Racial and Ethnic Disparities

SB 365 may have implications for gender, racial, and ethnic disparities in health. For example, if maternity care coverage is eroded due to a shift from DMHC-regulated plans to out-of-state policies, women will suffer increased health risks and substantial increased out-of-pocket costs associated with maternity care.

In California, racial disparities in health insurance coverage are also important where racial and ethnic minorities are more likely to be uninsured compared to whites (CHIS, 2005). Additionally, a higher proportion of Latinos work for small businesses (fewer than 50 employees) compared to whites and other minorities (CHIS, 2005). To the extent that SB 365 reduces the number of uninsured, minorities could face improvements in their health insurance status. Coverage under out-of-state policies would likely attract low-risk enrollees rather than those uninsured with chronic or high-risk conditions.

OTHER CONSIDERATIONS RELATED TO THE POTENTIAL IMPACTS OF SB 365

- **How would SB 365 affect businesses and labor in California?** It is possible that the health care administration functions, such as claims adjudication and processing, would be affected if carriers were to move these functions outside of the state to take advantage of some economies of scale and combine similar functions with other out-of-state product lines. (It should be mentioned that some of these functions have already been moved out of state, however.) Nevertheless, impacts of SB 365 could be minimal if out-of-state carriers were to maintain administrative functions in California.
- **How would SB 365 affect state revenue?** SB 365 may have an impact on the state revenue and operating budgets of regulatory agencies. For example, revenue from assessments on carriers may vary depending on how many enrollees remain in or opt out of the state-regulated market as out-of-state policies are introduced in the California market. The DMHC is supported primarily by an annual assessment of each HMO. In 2005, HMOs were assessed \$35 million to fund the DMHC's operations (DMHC, 2006).
The CDI assesses a premium tax of 2.35% on the premium written by 300+ companies authorized to sell Accident and Health insurance products in California. In 2005, CDI collected about \$25.1 million in revenue. Premium tax revenue is deposited into the General Fund.⁴² The Franchise Tax Board estimates it collected about \$75 million in state corporate income tax from health insurers in California.⁴³
- **How would SB 365 interact with other state and federal laws?** Currently California has laws governing the scope of practice for providers within its Business and Professions Code. There would be an inherent contradiction in requirements, if the state law governing an out-of-state carrier were to permit access for care outside of a provider's scope of practice, per California law.
- **How would SB 365 affect competition in the California health care market?** Changes in the mix of available licensed products and carriers in California could affect the relative bargaining power of carriers, independent physician associations, medical groups, hospital networks and other provider groups.

The impact of this bill depends on a number of factors, including market forces, the complicated interaction between the regulatory bodies, and the actions of the carriers, both currently domiciled in California and elsewhere. There may be other consequences not identified by this report.

⁴² 2005 Life and Annuity Market Share Report. CDI, July 2006. available at <http://www.insurance.ca.gov/0400-news/0200-studies-reports/0100-market-share/>

⁴³ Personal communication with J. Chamberlin, Franchise Tax Board, April 11, 2007.

APPENDICES

Appendix A: Text of Bill Analyzed

BILL NUMBER: SB 365
INTRODUCED: FEBRUARY 20, 2007
INTRODUCED BY: Senator McClintock

An act to add Section 1349.3 to the Health and Safety Code, and to add Section 699.6 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 365, as introduced, McClintock. Out-of-state carriers.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, requires, subject to specified exceptions, that a health care service plan be licensed by the Department of Managed Health Care and provide basic health care services, as defined, unless exempted from that requirement by the director of the department. Existing law also requires, subject to specified exceptions, that an insurer obtain a certificate of authority from the Insurance Commissioner in order to transact business in this state and that the insurer operate in accordance with specified requirements.

This bill would allow a carrier domiciled in another state to offer, sell, or renew a health care service plan or a health insurance policy in this state without holding a license issued by the department or a certificate of authority issued by the commissioner. The bill would exempt the carrier's plan or policy from requirements otherwise applicable to plans and insurers providing health care coverage in this state if the plan or policy complies with the domiciliary state's requirements, and the carrier is lawfully authorized to issue the plan or policy in that state and to transact business there.

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

State-mandated local program: no.

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 1349.3 is added to the Health and Safety Code, to read:

1349.3. (a) Notwithstanding any other provision of law, a carrier domiciled in another state is exempt from Section 1349, if it meets the following criteria:

(1) It offers, sells, or renews a health care service plan in this state that complies with all of the requirements of the domiciliary state applicable to the plan.

(2) It is authorized to issue the plan in the state where it is domiciled and to transact business there.

(b) Notwithstanding any other provision of law, a health care service plan offered, sold, or renewed by in this state a carrier that satisfies the criteria of subdivision (a) is exempt from all other provisions of this chapter.

SEC. 2. Section 699.6 is added to the Insurance Code, to read:

699.6. (a) Notwithstanding any other provision of law, a carrier domiciled in another state is exempt from Section 700, if it meets the following criteria:

(1) It offers, sells, or renews a health insurance policy in this state that complies with all of the requirements of the domiciliary state applicable to the policy.

(2) It is authorized to issue the policy in the state where it is domiciled and to transact business there.

(b) Notwithstanding any other provision of law, the health insurance policy offered, sold, or renewed in this state by a carrier that satisfies the criteria of subdivision (a) is exempt from all other provisions of this code.

Appendix B: Literature Review & Research Methods

This literature review and summary relied on the published literature in peer-reviewed journals as well as reports found in the grey literature.

Grey literature is defined as “That which is produced on all levels of government, academics, business and industry in print and electronic formats, but which is not controlled by commercial publishers.” (The New York Academy of Medicine (<http://www.nyam.org/library/greywhat.shtml>, accessed October 2006) Grey literature is, thus, valuable for its timeliness relative to scholarly publications and for its documentation of technical information.

CHBRP searched the grey literature and published peer reviewed journals using the following search terms:

- Association Health plan
- Association sponsored health plans or association sponsored health insurance (and variations)
- multiple-employer welfare association (MEWAs)
- Pre-emption or exemptions of state mandates or state insurance regulations (and variations)
- S.1955 (2006)
- Cost of mandated benefits (and variations)
- H.R. 2355 (2005)

The specific search engines and data bases and web sites that were systematically used are:

- PubMed
- Library of Congress: www.loc.gov
- USA.gov
- California’s Legislative Analyst’s Office: www.lao.ca.gov
- Congressional Research Service: www.opencrs.com
- General Accountability Office: www.gao.gov
- Congressional Budget Office: www.cbo.gov
- ABI/INFORM: <http://www.umi.com/products/pt-products-ABI.shtml>
- www.econlit.org
- American’s Health Insurance Plans: www.ahip.org
- Urban Institute: www.urbaninstitute.org
- Commonwealth Fund: www.cmwf.org
- RAND Health: www.rand.org/health/
- California Health Care Foundation: www.chcf.org/
- Robert Wood Johnson Foundation: www.rwjfo.org/main.html
- National Bureau of Economic Research: www.nber.org
- Heritage Foundation: www.heritage.org
- Cato Institute: www.cato.org
- Pacific Research Institute: www.pacificresearch.org

CHBRP also relied on the input of health policy experts to help identify the relevant literature, provide input on research approach, and review the draft report. These individuals include:

Paul J. Feldstein, PhD, Professor and Robert Gumbiner Chair in Health Care Management, The Paul Merage School of Business, University of California, Irvine

H. E. Frech, III, PhD, Professor, Economics, University of California, Santa Barbara

Mila Kofman JD, Associate Research Professor, Health Policy Institute, Georgetown University Health Policy Institute

Additionally a subcommittee of the CHBRP's National Advisory Council was selected to review and provide input on the draft report (see final pages of this report).

Appendix C: Existing Benefit Mandates Under the California Health and Safety Code and Insurance Code

Source		Benefit/Description	Population/Products Affected				Nature of Coverage		Detailed Description
Knox Keene (Health & Safety Code) Section	CA Insurance Code	Benefit/Description	Exception Made for Specialized Health Care Plan	Ind	Groups Basis	No Mention	Shall Offer Coverage	Shall Cover	
1345		Basic health care services		X	X			X	<p><i>Note: Description is given for Health and Safety Code (HSC) except where noted otherwise. If the mandates applies to both HSC and the Insurance Code, the language is typically parallel.</i></p> <p>Minimum benefits for all health care service plan contracts under the Knox-Keene Health Care Service Plan Act of 1975.</p> <p>"Basic health care services" means all of the following: (1) Physician services, including consultation and referral; (2) Hospital inpatient services and ambulatory care services; (3) Diagnostic laboratory and diagnostic and therapeutic radiologic services; (4) Home health services; (5) Preventive health services; (6) Emergency health care services, including ambulance and ambulance transport services and out-of-area coverage; (7) Hospice care pursuant to Section 1368.2." (HSC 1345(b))</p>
	10123.10	Home health care			X		X		<p>Every disability insurer transacting business in this state shall, on or after January 1, 1979, make available and offer to include in every group disability policy providing hospital, medical or surgical expense benefits payable on an expense incurred basis, to be delivered or issued for delivery in this state, benefits for home health care as set forth in this section provided by a licensed home health agency subject to the right of the group policyholder to reject the benefits or to select any alternative level of benefits as may be offered by the insurer.</p>
1367.06		Asthma management	Yes			X		X	<p>A health care service plan contract, except a specialized health care service plan contract, that is issued, amended, delivered, or renewed on or after January 1, 2005, that covers outpatient prescription drug benefits shall include coverage for inhaler spacers when medically necessary for the management and treatment of pediatric asthma.</p>

*This document is valid as of 12/2006 and subject to changes to the CA Health and Safety Code, the CA Insurance Code and other laws and regulations which may impact the source codes used in this document.

Source		Benefit/Description	Population/Products Affected				Nature of Coverage		Detailed Description
Knox Keene (Health & Safety Code) Section	CA Insurance Code	Benefit/Description	Exception Made for Specialized Health Care Plan	Ind	Groups Basis	No Mention	Shall Offer Coverage	Shall Cover	
1367.18	10123.7	Orthotic and prosthetic devices and services	Yes		X		X		<p><i>Note: Description is given for Health and Safety Code (HSC) except where noted otherwise. If the mandates applies to both HSC and the Insurance Code, the language is typically parallel.</i></p> <p>(a) Every health care service plan, except a specialized health care service plan, that covers hospital, medical, or surgical expenses on a group basis shall offer coverage for orthotic and prosthetic devices and services under the terms and conditions that may be agreed upon between the group subscriber and the plan.</p> <p>b) Notwithstanding subdivision (a), on and after July 1, 2007, the amount of the benefit for orthotic and prosthetic devices and services shall be no less than the annual and lifetime benefit maximums applicable to the basic health care services required to be provided under Section 1367.</p>
1367.19	10123.141	Special footwear for persons suffering from foot disfigurement	Yes			X	X		<p>On and after January 1, 1991, every health care service plan, except a specialized health care service plan, that covers hospital, medical, or surgical expenses on a group basis shall offer coverage as an option for special footwear needed by persons who suffer from foot disfigurement under such terms and conditions as may be agreed upon between the group contract holder and the plan. As used in this section, foot disfigurement shall include, but not be limited to, disfigurement from cerebral palsy, arthritis, polio, spinabifida, diabetes, and foot disfigurement caused by accident or developmental disability.</p>
1367.2	10123.6	Alcoholism treatment			X		X		<p>On and after January 1, 1990, every health care service plan that covers hospital, medical, or surgical expenses on a group basis shall offer coverage for the treatment of alcoholism under such terms and conditions as may be agreed upon between the group subscriber and the health care service plan.</p>
1367.21	10123.195	Prescription drugs: Off label use				X		X	<p>Mandate to <u>cover</u> "off-label" uses of FDA-approved drugs –uses other than the specific FDA-approved use – in life threatening situations and in cases of chronic and seriously debilitating conditions</p>
1367.22		Prescription drugs: Coverage of previously covered drugs				X		X	<p>A health care service plan contract, issued, amended, or renewed on or after July 1, 1999, that covers prescription drug benefits shall not limit or exclude coverage for a drug for an enrollee if the drug previously had been approved for coverage by the plan for a medical condition of the enrollee and the plan's prescribing provider continues to prescribe the drug for the medical condition, provided that the drug is appropriately prescribed and is considered safe and effective for treating the enrollee's medical condition. Nothing in this section shall preclude the prescribing provider from prescribing another drug covered by the plan that is medically appropriate for the enrollee, nor shall anything in this section be construed to prohibit generic drug substitutions as authorized by Section 4073 of the Business and Professions Code.</p>

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Source		Benefit/Description	Population/Products Affected				Nature of Coverage		Detailed Description
Knox Keene (Health & Safety Code) Section	CA Insurance Code	Benefit/Description	Exception Made for Specialized Health Care Plan	Ind	Groups Basis	No Mention	Shall Offer Coverage	Shall Cover	<i>Note: Description is given for Health and Safety Code (HSC) except where noted otherwise. If the mandates applies to both HSC and the Insurance Code, the language is typically parallel.</i>
1367.3	10123.55	Providing comprehensive preventive care of children 17 or 18 years old			X		X		On and after January 1, 1993, every health care service plan that covers hospital, medical, or surgical expenses on a group basis shall offer benefits for the comprehensive preventive care of children. This section shall apply to children 17 and 18 years of age, except as provided in paragraph (4) of subdivision (b).
1367.35	10123.5	Providing comprehensive preventive care of children 16 years or under			X			X	On and after January 1, 1993, every health care service plan that covers hospital, medical, or surgical expenses on a group basis shall provide benefits for the comprehensive preventive care of children 16 years of age or younger under terms and conditions agreed upon between the group subscriber and the plan.
1367.45	10145.2 22853.1	AIDS vaccine coverage		X	X			X	Every individual or group health care service plan contract that is issued, amended, or renewed on or after January 1, 2002, that covers hospital, medical, or surgery expenses shall provide coverage for a vaccine for acquired immune deficiency syndrome (AIDS) that is approved for marketing by the federal Food and Drug Administration and that is recommended by the United States Public Health Service.
1367.51	10176.61	Diabetes benefits	Yes			X		X	Every health care service plan contract, except a specialized health care service plan contract, that is issued, amended, delivered, or renewed on or after January 1, 2000, and that covers hospital, medical, or surgical expenses shall include coverage for the following equipment and supplies for the management and treatment of insulin-using diabetes, non-insulin-using diabetes, and gestational diabetes as medically necessary, even if the items are available without a prescription.

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Source		Benefit/Description	Population/Products Affected				Nature of Coverage		Detailed Description
Knox Keene (Health & Safety Code) Section	CA Insurance Code	Benefit/Description	Exception Made for Specialized Health Care Plan	Ind	Groups Basis	No Mention	Shall Offer Coverage	Shall Cover	
1367.54	10123.184	Maternity benefits (expanded alpha feto protein)		X	X			X	<i>Note: Description is given for Health and Safety Code (HSC) except where noted otherwise. If the mandates applies to both HSC and the Insurance Code, the language is typically parallel.</i> Every group health care service plan contract that provides maternity benefits, except for a specialized health care service plan contract, that is issued, amended, renewed, or delivered on or after January 1, 1999, and every individual health care service plan contract of a type and form first offered for sale on or after January 1, 1999, that provides maternity benefits, except a specialized health care service plan contract, shall provide coverage for participation in the Expanded Alpha Feto Protein (AFP) program, which is a statewide prenatal testing program administered by the State Department of Health Services.
1367.6	10123.8	Breast cancer benefits	Yes			X		X	Every health care service plan contract, except a specialized health care service plan contract, that is issued, amended, delivered, or renewed on or after January 1, 2000, shall provide coverage for screening for, diagnosis of, and treatment for, breast cancer.
1367.61	10123.82	Prosthetic device benefits for laryngectomy				X		X	Every health care service plan contract which provides for the surgical procedure known as a laryngectomy and which is issued, amended, delivered, or renewed in this state on or after January 1, 1993, shall include coverage for prosthetic devices to restore a method of speaking for the patient incident to the laryngectomy.
1367.62	10123.87	Maternity benefits: restrictions		X	X			X	No health care service plan contract that is issued, amended, renewed, or delivered on or after the effective date of the act adding this section, that provides maternity coverage, shall do any of the following: (1) Restrict benefits for inpatient hospital care to a time period less than 48 hours following a normal vaginal delivery and less than 96 hours following a delivery by caesarean section.
1367.63	10123.88	Reconstructive surgery	Yes	X	X			X	Every health care service plan contract, except a specialized health care service plan contract, that is issued, amended, renewed, or delivered in this state on or after July 1, 1999, shall cover reconstructive surgery, as defined in subdivision (c), that is necessary to achieve the purposes specified in paragraphs (1) or (2) of subdivision (c).

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Source		Benefit/Description	Population/Products Affected				Nature of Coverage		Detailed Description
Knox Keene (Health & Safety Code) Section	CA Insurance Code	Benefit/Description	Exception Made for Specialized Health Care Plan	Ind	Groups Basis	No Mention	Shall Offer Coverage	Shall Cover	
1367.635	10123.86	Mastectomies and lymph nodes dissections contract provisions		X	X			X	<i>Note: Description is given for Health and Safety Code (HSC) except where noted otherwise. If the mandates applies to both HSC and the Insurance Code, the language is typically parallel.</i> Allow the length of a hospital stay associated with those procedures to be determined by the attending physician and surgeon in consultation with the patient, consistent with sound clinical principles and processes. No health care service plan shall require a treating physician and surgeon to receive prior approval from the plan in determining the length of hospital stay following those procedures.
1367.64	10123.83	Prostate cancer screening and diagnosis		X	X			X	Every individual or group health care service plan contract, except for a specialized health care service plan contract, that is issued, amended, or renewed on or after January 1, 1999, shall be deemed to provide coverage for the screening and diagnosis of prostate cancer, including, but not limited to, prostate-specific antigen testing and digital rectal examinations, when medically necessary and consistent with good professional practice.
1367.65	10123.81	Mammography coverage	Yes			X		X	On or after January 1, 2000, every health care service plan contract, except a specialized health care service plan contract, that is issued, amended, delivered, or renewed shall be deemed to provide coverage for mammography for screening or diagnostic purposes upon referral by a participating nurse practitioner, participating certified nurse midwife, or participating physician, providing care to the patient and operating within the scope of practice provided under existing law.
1367.66	10123.18	Cervical cancer screening coverage	Yes	X	X			X	The coverage for an annual cervical cancer screening test provided pursuant to this section shall include the conventional Pap test, a human papillomavirus screening test that is approved by the federal Food and Drug Administration, and the option of any cervical cancer screening test approved by the federal Food and Drug Administration, upon the referral of the patient's health care provider.
1367.665	10123.2	Cancer screening test	Yes	X	X			X	Every individual or group health care service plan contract, except for a specialized health care service plan contract, that is issued, amended, delivered, or renewed on or after July 1, 2000, shall be deemed to provide coverage for all generally medically accepted cancer screening tests, subject to all terms and conditions that would otherwise apply.

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Source		Benefit/Description	Population/Products Affected				Nature of Coverage		Detailed Description
Knox Keene (Health & Safety Code) Section	CA Insurance Code	Benefit/Description	Exception Made for Specialized Health Care Plan	Ind	Groups Basis	No Mention	Shall Offer Coverage	Shall Cover	
1367.67	10123.185	Osteoporosis coverage				X		X	<i>Note: Description is given for Health and Safety Code (HSC) except where noted otherwise. If the mandates applies to both HSC and the Insurance Code, the language is typically parallel.</i> Every health care service plan contract that provides hospital, medical, or surgical coverage, that is issued, amended, delivered, or renewed in this state on or after January 1, 1994, shall be deemed to include coverage for services related to diagnosis, treatment, and appropriate management of osteoporosis. The services may include, but need not be limited to, all Food and Drug Administration approved technologies, including bone mass measurement technologies as deemed medically appropriate.
1367.68	10123.21	Jawbone or bone joints coverage	Yes			X		X	Any provision in a health care service plan contract entered into, amended, or renewed in this state on or after July 1, 1995, that excludes coverage for any surgical procedure for any condition directly affecting the upper or lower jawbone, or associated bone joints, shall have no force or effect as to any enrollee if that provision results in any failure to provide medically-necessary basic health care services to the enrollee pursuant to the plan's definition of medical necessity. (b) For purposes of this section, "plan contract" means every plan contract, except a specialized health care service plan contract, that covers hospital, medical, or surgical expenses.
1367.7	10123.9	Prenatal diagnosis of genetic disorders			X		X		On and after January 1, 1980, every health care service plan contract that covers hospital, medical, or surgical expenses on a group basis, and which offers maternity coverage in such groups, shall also offer coverage for prenatal diagnosis of genetic disorders of the fetus by means of diagnostic procedures in cases of high-risk pregnancy. Every health care service plan shall communicate the availability of such coverage to all group contract holders and to all groups with whom they are negotiating.
1367.71	10119.9	General anesthesia for dental procedures	Yes			X		X	Every health care service plan contract, other than a specialized health care service plan contract, that is issued, amended, renewed, or delivered on or after January 1, 2000, shall be deemed to cover general anesthesia and associated facility charges for dental procedures rendered in a hospital or surgery center setting, when the clinical status or underlying medical condition of the patient requires dental procedures that ordinarily would not require general anesthesia to be rendered in a hospital or surgery center setting.

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Source		Benefit/Description	Population/Products Affected				Nature of Coverage		Detailed Description
Knox Keene (Health & Safety Code) Section	CA Insurance Code	Benefit/Description	Exception Made for Specialized Health Care Plan	Ind	Groups Basis	No Mention	Shall Offer Coverage	Shall Cover	
1368.2		Hospice care			X			X	<i>Note: Description is given for Health and Safety Code (HSC) except where noted otherwise. If the mandates applies to both HSC and the Insurance Code, the language is typically parallel.</i> On and after January 1, 2002, every group health care service plan contract, except a specialized health care service plan contract, which is issued, amended, or renewed, shall include a provision for hospice care. (b) The hospice care shall at a minimum be equivalent to hospice care provided by the federal Medicare program pursuant to Title XVIII of the Social Security Act.
1367.9	10119.7	Diethylstilbestrol				X		X	No health care service plan contract which covers hospital, medical, or surgical expenses shall be issued, amended, delivered, or renewed in this state on or after January 1, 1981, if it contains any exclusion, reduction, or other limitations, as to coverage, deductibles, or coinsurance or copayment provisions applicable solely to conditions attributable to diethylstilbestrol or exposure to diethylstilbestrol.
1367.11	10126.6	Medical transportation services				X		X	Every health care service plan issued, amended, or renewed on or after January 1, 1987, that offers coverage for medical transportation services, shall contain a provision providing for direct reimbursement to any provider of covered medical transportation services if the provider has not received payment for those services from any other source.
1367.215	10123.15	Pain management medication for terminally ill				X		X	Every health care service plan contract that covers prescription drug benefits shall provide coverage for appropriately prescribed pain management medications for terminally ill patients when medically necessary. The plan shall approve or deny the request by the provider for authorization of coverage for an enrollee who has been determined to be terminally ill in a timely fashion, appropriate for the nature of the enrollee's condition, not to exceed 72 hours of the plan's receipt of the information requested by the plan to make the decision.
1367.22		Prescription drug benefits; medically appropriate alternatives.				X		X	A health care service plan contract, issued, amended, or renewed on or after July 1, 1999, that covers prescription drug benefits shall not limit or exclude coverage for a drug for an enrollee if the drug previously had been approved for coverage by the plan for a medical condition of the enrollee and the plan's prescribing provider continues to prescribe the drug for the medical condition, provided that the drug is appropriately prescribed and is considered safe and effective for treating the enrollee's medical condition.
1367.24		Authorization for nonformulary prescription drugs				X		X	If the drug is not on the plan formulary, the participating subscriber's request shall be considered pursuant to the process required by Section 1367.24.

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Source		Benefit/Description	Population/Products Affected				Nature of Coverage		Detailed Description
Knox Keene (Health & Safety Code) Section	CA Insurance Code	Benefit/Description	Exception Made for Specialized Health Care Plan	Ind	Groups Basis	No Mention	Shall Offer Coverage	Shall Cover	
1370.6		Coverage for services related to clinical trials	X			X		X	<i>Note: Description is given for Health and Safety Code (HSC) except where noted otherwise. If the mandates applies to both HSC and the Insurance Code, the language is typically parallel.</i> For an enrollee diagnosed with cancer and accepted into a phase I, phase II, phase III, or phase IV clinical trial for cancer, every health care service plan contract, except a specialized health care service plan contract, that is issued, amended, delivered, or renewed in this state, shall provide coverage for all routine patient care costs related to the clinical trial if the enrollee's treating physician, who is providing covered health care services to the enrollee under the enrollee's health benefit plan contract, recommends participation in the clinical trial after determining that participation in the clinical trial has a meaningful potential to benefit the enrollee.
	10127.3	Reimbursement for acupuncture services	Yes		X		X		On and after January 1, 1985, every insurer issuing group disability insurance which covers hospital, medical, or surgical expenses shall offer coverage for expenses incurred as a result of treatment by holders of certificates under Section 4938 of the Business and Professions Code, under such terms and conditions as may be agreed upon between the group policyholder and the insurer; [Section 4938 of B&P: The board shall issue a license to practice acupuncture to any person who makes an application and meets the following requirements...]
1373.4		Maternity Coverage				X		X	No health care service plan contract that is issued, amended, renewed, or delivered on or after July 1, 2003, that provides maternity coverage shall do either of the following: (1) Contain a copayment or deductible for inpatient hospital maternity services that exceeds the most common amount of the copayment or deductible contained in the contract for inpatient services provided for other covered medical conditions.
1374.56	10123.89	Phenylketonuria; testing and treatment	Yes			X		X	On and after July 1, 2000, every health care service plan contract, except a specialized health care service plan contract, issued, amended, delivered, or renewed in this state that provides coverage for hospital, medical, or surgical expenses shall provide coverage for the testing and treatment of phenylketonuria (PKU) under the terms and conditions of the plan contract.

*This document is valid as of 12/2006 and subject to changes to the CA Health and Safety Code, the CA Insurance Code and other laws and regulations which may impact the source codes used in this document.

Source		Benefit/Description	Population/Products Affected				Nature of Coverage		Detailed Description
Knox Keene (Health & Safety Code) Section	CA Insurance Code	Benefit/Description	Exception Made for Specialized Health Care Plan	Ind	Groups Basis	No Mention	Shall Offer Coverage	Shall Cover	
1374.55	10119.6	Infertility treatments			X		X		<i>Note: Description is given for Health and Safety Code (HSC) except where noted otherwise. If the mandates applies to both HSC and the Insurance Code, the language is typically parallel.</i> On and after January 1, 1990, every health care service plan contract which is issued, amended, or renewed that covers hospital, medical, or surgical expenses on a group basis, where the plan is not a health maintenance organization as defined in Section 1373.10, shall offer coverage for the treatment of infertility, except in vitro fertilization, under those terms and conditions as may be agreed upon between the group subscriber and the plan. Every plan shall communicate the availability of that coverage to all group contract holders and to all prospective group contract holders with whom they are negotiating.
1367.3(b)(2)(D)	10119.8	Screen for blood lead levels in children		X	X		X		For health care service plan contracts within the scope of this section that are issued, amended, or renewed on and after January 1, 1993, screening for blood lead levels in children at risk for lead poisoning, as determined by a physician and surgeon affiliated with the plan, when the screening is prescribed by a physician and surgeon affiliated with the plan. This subparagraph shall be applicable to all children and shall not be limited to children 17 and 18 years of age.
1374.72	10123.15 [10144.5]	Biologically based severe mental disorders			X		X		Every group policy of disability insurance which covers hospital, medical, and surgical expenses on a group basis, and which offers coverage for disorders of the brain shall also offer coverage in the same manner for the treatment of the following biologically based severe mental disorders: schizophrenia, schizo-affective disorder, bipolar disorders and delusional depressions, and pervasive developmental disorder. Coverage for these mental disorders shall be subject to the same terms and conditions applied to the treatment of other disorders of the brain; however, an insurer may reserve the right to confirm diagnoses and to review the appropriateness of specific treatment plans as necessary to ensure that coverage under this section is provided for only those diagnostic and treatment services which are medically necessary.
1374.17	10123.21	Transplantation services: Human immunodeficiency virus (HIV)				X		x	A health care service plan shall not deny coverage that is otherwise available under the plan contract for the costs of solid organ or other tissue transplantation services based upon the enrollee or subscriber being infected with the human immunodeficiency virus.
	10125	Mental and nervous disorders			X		X		On and after January 1, 1974, every insurer issuing group disability insurance which covers hospital, medical, or surgical expenses shall offer coverage for expenses incurred as a result of mental or nervous disorders, under the terms and conditions which may be agreed upon between the group policyholder and the insurer.
<i>Source: California Health Benefits Review Program, 2007</i>									

*This document is valid as of 12/2006 and subject to changes to the CA Health and Safety Code, the CA Insurance Code and other laws and regulations which may impact the source codes used in this document.

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

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

The cost analysis in this report was prepared by the Cost Team, which consists of CHBRP task force members and staff, specifically from the University of California, Los Angeles, and Milliman Inc. (Milliman). Milliman is an actuarial firm and provides data and analyses per the provisions of CHBRP authorizing legislation.

Data Sources

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

Private Health Insurance

1. The latest (2005) California Health Interview Survey (CHIS), which is utilized to estimate insurance coverage for California's population and distribution by payer (i.e., employment-based, privately purchased, or publicly financed). The biannual CHIS is the largest state health survey conducted in the United States, collecting information from over 40,000 households. More information on CHIS is available at www.chis.ucla.edu.
2. The latest (2006) California Employer Health Benefits Survey is utilized to estimate:
 - Size of firm
 - Percentage of firms that are purchased/underwritten (versus self-insured)
 - Premiums for plans regulated by the Department of Managed Health Care (DMHC) (primarily health maintenance organizations [HMOs])
 - Premiums for policies regulated by the California Department of Insurance (CDI) (primarily preferred provider organizations [PPOs])
 - Premiums for high-deductible health plans (HDHP) for the California population covered under employment-based health insurance

This annual survey is released by the California Health Care Foundation/Center for Studying Health System Change (CHCF/HSC) and is similar to the national employer survey released annually by the Kaiser Family Foundation and the Center for Studying Health System Change. More information on the CHCF/HSC is available at

www.chcf.org/topics/healthinsurance/index.cfm?itemID=127480.

3. Milliman data sources are relied on to estimate the premium impact of mandates. Milliman's projections derive from the Milliman Health Cost Guidelines (HCGs). The HCGs are a health care pricing tool used by many of the major health plans in the United States (see www.milliman.com/tools_products/healthcare/Health_Cost_Guidelines.php). Most of the data sources underlying the HCGs are claims databases from commercial health insurance plans. The data are supplied by health insurance companies, Blue Cross and Blue Shield plans, HMOs, self-funded employers, and private data vendors. The data are mostly from

loosely managed healthcare plans, generally those characterized as preferred provider plans or preferred provider organizations (PPOs). The HCGs currently include claims drawn from plans covering 4.6 million members. In addition to the Milliman HCGs, CHBRP's utilization and cost estimates draw on other data, including the following:

- The MEDSTAT MarketScan Database, which includes demographic information and claim detail data for approximately 13 million members of self-insured and insured group health plans.
 - An annual survey of HMO and PPO pricing and claim experience, the most recent survey (2006 Group Health Insurance Survey) contains data from 6 major California health plans regarding their 2005 experience.
 - Ingenix MDR Charge Payment System, which includes information about professional fees paid for healthcare services, based upon approximately 800 million claims from commercial insurance companies HMOs and self-insured health plans.
 - These data are reviewed for generalizability by an extended group of experts within Milliman, but are not audited externally.
4. An annual survey by CHBRP of the seven largest providers of health insurance in California (Aetna, Blue Cross of California, Blue Shield of California, CIGNA, Health Net, Kaiser Foundation Health Plan, and PacifiCare) to obtain estimates of baseline enrollment by purchaser (i.e., large and small group and individual) type of plan (i.e., DMHC or CDI regulated), cost-sharing arrangements with enrollees and average premiums. Enrollment in these seven firms represents 82% of enrollees in full service health plans regulated by DMHC and 46% of lives covered by comprehensive health insurance products regulated by the CDI.

Public Health Insurance

1. Premiums and enrollment in DMHC- and CDI-regulated plans by self-insured status and firm size are obtained annually from CalPERS for active state and local government public employees and their family members who receive their benefits through CalPERS. Enrollment information is provided for fully funded, Knox-Keene-licensed health care service plans—which is about 75% of CalPERS total enrollment. CalPERS self-funded plans—approximately 25% of enrollment—are not subject to state mandates. In addition, CHBRP obtains information on current scope of benefits from health plans' evidence of coverage (EOCs) publicly available at www.calpers.ca.gov.
2. Enrollment in Medi-Cal Managed Care (Knox-Keene-licensed plans regulated by DMHC) is estimated based on CHIS and data maintained by the Department of Health Services (DHS). DHS supplies CHBRP with the statewide average premiums negotiated for the Two-Plan Model, as well as generic contracts which summarize the current scope of benefits. CHBRP assesses enrollment information online at www.dhs.ca.gov/admin/ffdmb/mcss/RequestedData/Beneficiary%20files.htm.
3. Enrollment data for other public programs: Healthy Families, Access for Infants and Mothers (AIM), and the Major Risk Medical Insurance Program (MRMIP) are estimated based on CHIS and data maintained by the Major Risk Medical Insurance Board (MRMIB). The basic minimum scope of benefits offered by participating plans under these programs must comply

with all requirements of the Knox-Keene Act, and thus these plans are affected by changes in coverage for Knox-Keene–licensed plans. CHBRP does not include enrollment in the Post-MRMIB Guaranteed-Issue Coverage Products as these individuals are already included in the enrollment for individual health insurance products offered by private carriers. Enrollment figures for AIM and MRMIP are included with enrollment for Medi-Cal in presentation of premium impacts. The enrollment information is obtained online at www.mrmib.ca.gov/. Average statewide premium information is provided to CHBRP by MRMIB staff.

General Caveats and Assumptions

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

- Prevalence of mandated benefits before and after the mandate may be different from CHBRP assumptions.
- Utilization of mandated services before and after the mandate may be different from CHBRP assumptions.
- Random fluctuations in the utilization and cost of health care services may occur.

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

- Cost impacts are shown only for people with insurance.
- The projections do not include people covered under self-insured employer plans because those plans are not subject to state-mandated minimum benefit requirements.
- Employers and employees will share proportionately (on a percentage basis) in premium rate increases resulting from the mandate. In other words, the distribution of premium paid by the subscriber (or employee) and the employer will be unaffected by the mandate.
- For state sponsored programs for the uninsured, the state share will continue to be equal to absolute dollar amount of funds dedicated to the program.
- When cost savings are estimated, they reflect savings realized for one year. Potential long-term cost savings or impacts are estimated if existing data and literature sources are available and provide adequate detail for estimating long-term impacts. For more information on CHBRP’s criteria for estimating long-term impacts please see: www.chbrp.org/documents/longterm_impacts_final011007.pdf

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

- Population shifts by type of health insurance coverage. If a mandate increases health insurance costs, then some employer groups or individuals may elect to drop their coverage. Employers may also switch to self-funding to avoid having to comply with the mandate.
- Changes in benefit plans. To help offset the premium increase resulting from a mandate, members or insured may elect to increase their overall plan deductibles or copayments.

Such changes would have a direct impact on the distribution of costs between the health plan and the insured person, and may also result in utilization reductions (i.e., high levels of patient cost sharing result in lower utilization of health care services). CHBRP did not include the effects of such potential benefit changes in its analysis.

- Adverse Selection. Theoretically, individuals or employer groups who had previously foregone insurance may now elect to enroll in an insurance plan postmandate because they perceive that it is to their economic benefit to do so.
- Health plans may react to the mandate by tightening their medical management of the mandated benefit. This would tend to dampen the CHBRP cost estimates. The dampening would be more pronounced on the plan types that previously had the least effective medical management (i.e. PPO plans).
- Variation in existing utilization and costs, and in the impact of the mandate, by geographic area and delivery system models: Even within the plan types CHBRP modeled (HMO—including HMO and POS plans and non-HMO-including PPO and FFS policies), there are likely variations in utilization and costs by these plan types. Utilization also differs within California due to differences in the health status of the local commercial population, provider practice patterns, and the level of managed care available in each community. The average cost per service would also vary due to different underlying cost levels experienced by providers throughout California and the market dynamic in negotiations between health plans and providers. Both the baseline costs prior to the mandate and the estimated cost impact of the mandate could vary within the state due to geographic and delivery system differences. For purposes of this analysis, however, CHBRP has estimated the impact on a statewide level.

Bill Analysis-Specific Caveats and Assumptions

Information on health care expenditures for this bill's analysis came from the large national commercial claims dataset described above, which includes the inpatient and outpatient utilization and expenditures of 7 million people. Some adjustments were made to reflect the California population and market conditions. National datasets were used because their sample size is larger than California data, thus allowing for more precise statistical estimates.

In addition to the assumptions and caveats listed above, the cost analysis for SB 365 made the following assumptions:

- The mandated benefits that would be eliminated are limited to the coverage of specific services, diseases, or provider types. Mandates related to requirements that insurance coverage be made available to certain types of individuals (typically high-cost patients) are not included in the cost estimates.
- The premiums charged by insurers for the riders fully cover the cost of the services, so that eliminating the riders would not affect the basic cost of coverage.
- As percentages, the cost-sharing and load factors (administrative costs plus profit) are approximately constant for all levels of spending in the ranges considered here. In combination, these assumptions imply that the percent reduction would be approximately the same for insurance premiums as for covered health care expenditures. These assumptions are likely to hold if insurance markets are reasonably competitive (so that

insurers do not increase their profit margins as a result of the new cost savings) and the expenditure decreases are not too large. To the extent that a carrier's administrative costs are fixed, a reduction in the premium base of over 5% could cause carriers to increase their percentage administration load. This would cause the percentage decrease in premiums to be slightly less the percentage decrease in the cost for covered benefits, implying that the CHBRP cost model is overstating the premium savings associated with SB 365.

- The overall reduction in utilization of health care resulting from the passage of SB 365 would not be large enough to affect the market (i.e., demand for services would not be reduced sufficiently by the loss of insurance coverage to cause prices charged by healthcare providers to fall). If this assumption is incorrect and the elimination of insurance benefits for certain types of services (e.g., behavioral health care) reduces demand for the services enough to bring down their price, then SB 365 could lead to additional cost savings not included in the CHBRP estimate.

Appendix E: Information Submitted by Outside Parties

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

No information was submitted directly by interested parties for this analysis.

For information on the processes for submitting information to CHBRP for review and consideration please visit www.chbrp.org/requests.html.

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A group of faculty and staff undertakes most of the analysis that informs reports by the California Health Benefits Review Program (CHBRP). The CHBRP **Faculty Task Force** comprises rotating representatives from six University of California (UC) campuses and three private universities in California. In addition to these representatives, there are other ongoing contributors to CHBRP from UC. This larger group provides advice to the CHBRP staff on the overall administration of the program and conducts much of the analysis. The CHBRP **staff** coordinates the efforts of the Faculty Task Force, works with Task Force members in preparing parts of the analysis, and coordinates all external communications, including those with the California Legislature. The level of involvement of members of the CHBRP Faculty Task Force and staff varies on each report, with individual participants more closely involved in the preparation of some reports and less involved in others.

As required by the CHBRP authorizing legislation, UC contracts with a certified actuary, Milliman Inc. (Milliman), to assist in assessing the financial impact of each benefit mandate bill. Milliman also helped with the initial development of CHBRP methods for assessing that impact.

The **National Advisory Council** provides expert reviews of draft analyses and offers general guidance on the program to CHBRP staff and the Faculty Task Force. CHBRP is grateful for the valuable assistance and thoughtful critiques provided by the members of the National Advisory Council. However, the Council does not necessarily approve or disapprove of or endorse this report. CHBRP assumes full responsibility for the report and the accuracy of its contents.

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