



**CALIFORNIA**  
HEALTH BENEFITS REVIEW PROGRAM

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**EXECUTIVE SUMMARY:**  
**Assembly Bill 1214: Waiver of Benefits**

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A Report to the 2007-2008 California Legislature  
December 12, 2007

CHBRP 07-09

**EXECUTIVE SUMMARY:  
Analysis of Assembly Bill 1214:  
Waiver of Benefits**

**December 12, 2007**

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**Suggested Citation:**

California Health Benefits Review Program (CHBRP). (2007). *Analysis of Assembly Bill 1214: Waiver of Benefits*. Report to California State Legislature. Oakland, CA: CHBRP. 07-09.

## EXECUTIVE SUMMARY

### California Health Benefits Review Program Analysis of Assembly Bill 1214

Assembly Bill (AB) 1214, also called the “Freedom to Choose Health Benefits Act of 2007,” would allow for the development, marketing, and purchasing of health insurance products that waive a subset of benefit mandates currently in law. Specifically, as of July 1, 2008, health care service plans and insurers would be permitted to issue, renew, or amend plans or policies that omit one or more currently mandated benefits if a contract holder or policyholder in the group or individual market waives the benefit.

The intent of AB 1214 is to allow health insurance products to be customized to meet the perceived health care needs of a purchaser—generally an employer in the group market, or an individual in the individual market. In effect, AB 1214 would allow insurance carriers in the state of California to offer health insurance products exempt from benefit mandates as long as the purchaser agrees in writing to waive those benefits. AB 1214 is based on the premise that, given choices, purchasers would make decisions regarding their health benefits that best meet their own or their employees’ needs.

#### Provisions of AB 1214

AB 1214 permits policyholders to waive all benefits that are currently mandated under the California Health & Safety Code *except* for “Basic Health Care Services.” Basic Health Care Services are those services included in the minimum benefit package enacted by the Knox-Keene Health Care Service Act of 1975<sup>1</sup>. Thus, health maintenance organizations (HMOs) and preferred provider organizations (PPOs) that are regulated by the Department of Managed Health Care (DMHC) would be required to include coverage of Basic Health Care Services in all of their products. Enrollment in these plans accounts for over 90% of the privately insured market in California. AB 1214 does not affect the DMHC’s authority to conduct independent medical review; review plan designs, benefits, contracts, and marketing materials; or other enforcement activities.

AB 1214 permits policyholders to waive *all* benefits that are currently mandated by the California Insurance Code. This would affect PPOs and indemnity (fee-for-service) health insurance products that are regulated by the California Department of Insurance (CDI). Enrollment in these policies accounts for about 10% of the private fully-insured market in California. AB 1214 would not impact the CDI’s ability to enforce other consumer protections, such as operational and financial reviews of insurance carriers.

Currently, there are 40 benefit mandates to provide coverage or merely offer coverage under the California Health and Safety Code. There are 34 benefit mandates to provide coverage or offer coverage under the Insurance Code, many of which are the same mandates found in the

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<sup>1</sup> 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.

California Health and Safety Code. In addition there are 4 provider mandates that may also be waived under AB 1214—bringing the total to 44 distinct mandates.

AB 1214 requires the DMHC and CDI to prepare a disclosure form prior to July 1, 2008, that would specify the waived benefit mandates for purchasers.<sup>2</sup> The expectation is that DMHC and CDI would use their enforcement authority to ensure that plans and insurers provide sufficient written information about what mandated benefits are included and what mandated benefits and offerings are excluded so that the purchaser understand they are agreeing to waive mandated benefits.

AB 1214 *does not require* carriers to offer products that waive mandated benefits, or “limited-mandate plans.” AB 1214 *does not require* carriers to offer limited-mandate plans in conjunction with plans that offer the full array of mandated benefits. Under AB 1214, a carrier can offer a limited-mandate plan in a specific market—for example, the individual market in Los Angeles. If an individual purchaser does not waive (or demands a mandated benefit) that is excluded under a limited-mandate plan, a carrier is not required to offer the purchaser an alternative product with the benefit included. In that case, the individual purchaser would be expected to go to another carrier that offers a product that includes the desired benefit(s). The same would hold true for large- and small-group purchasers.

## Consumer Choice

- If AB 1214 were to pass into law, employees of large groups would likely have choices among health insurance products, as their employers would likely offer a limited-mandate plan in conjunction with other health insurance products (for example, an HMO). Traditionally, small firms offer their employees fewer health insurance product options than large firms. In 2005, 92% of California’s large firms offered their workers a choice of health insurance products versus 64% of small firms. After passage of AB 1214, if a small firm chooses to offer *only* a limited-mandate plan, an employee may not have other choices. In the individual market, it is highly likely that carriers would develop limited-mandate plans after passage of AB 1214. Thus consumers in the individual market would have choices among health insurance products to the extent carriers make those products available in their service areas.
- A key assumption behind AB 1214 is that consumers have the information, knowledge, and skills to effectively assess their insurance options. The available research indicates that in general, the population’s knowledge and understanding of health insurance is very limited, as are the skills needed to apply the knowledge. Efforts have been made to develop decision-support tools to help consumers weigh options and make choices among health insurance products. The limited research on the effectiveness of those tools is not sufficient to assess whether consumers are making informed decision as a result of using these tools.

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<sup>2</sup> Subdivision (C) under Sections 1367.08 and 10119.3.

## Medical Effectiveness of Current Mandates: Summary of Evidence

AB 1214 would permit the waiver of 44 health insurance benefit mandate and mandated offering statutes that address numerous health care services for a wide range of diseases and conditions.

CHBRP reviewed evidence regarding the medical effectiveness of 31 of the 44 mandates to which AB 1214 would apply. Thirteen mandates were not analyzed because they do not require coverage for specific diseases or health care services, require coverage for a vaccination that has yet to be approved by the Food and Drug Administration, or apply to such a large number of diseases that the evidence cannot be summarized briefly.

For this analysis, CHBRP relied primarily on meta-analyses, systematic reviews, and evidence-based practice guidelines, because these types of studies synthesize findings from multiple studies. Previous CHBRP reports were reviewed where applicable. Individual studies were examined only if meta-analyses, systematic reviews, or evidence-based practice guidelines were not available or if no such syntheses had been published recently. If no studies had been published, CHBRP relied on clinical practice guidelines based on expert opinion.

The amount and strength of the evidence regarding the medical effectiveness of the services for which coverage could be waived under AB 1214 varies. The outcomes that are most important for assessing effectiveness also differ.

**Nevertheless, most of the mandates and mandated offerings addressed by AB 1214 require health insurance products to provide coverage for health care services for which there is strong evidence of effectiveness.**

Findings regarding the medical effectiveness of specific health care services for which coverage could be waived under AB 1214 are as follows:

- There is *clear and convincing evidence* from multiple, well-designed randomized controlled trials (RCTs) that the following tests and treatments *are medically effective*: cancer screening tests for breast, cervical, and colorectal cancers; diagnostic procedures and treatments for breast cancer; diabetes management medications, services, and supplies; services for the diagnosis and treatment of osteoporosis; medication and psychosocial treatments for severe mental illness and alcoholism; some preventive services for children and adolescents; prescription contraceptive devices; diagnosis and treatment of infertility; and home care services for elderly and disabled adults.
- A *preponderance of evidence* from nonrandomized studies and/or RCTs with major weaknesses indicates that the following tests and treatments *are medically effective*: liver and kidney transplantation services for persons with the human immunodeficiency virus (HIV); medical formulas and foods for persons with phenylketonuria; prosthetic devices; orthotic devices for some conditions; special footwear for persons with rheumatoid arthritis; acupuncture; pain management medication for persons with terminal illnesses; pediatric asthma management; prenatal diagnosis of genetic disorders; expanded alpha-fetoprotein screening; and surgery for the jawbone and associated bone joints.

- The evidence of the effectiveness is *ambiguous* for prosthetic devices used by persons who have had a laryngectomy; special footwear for persons with diabetes; breast reconstruction surgery following mastectomy; and hospice care.
- There is *insufficient evidence* to determine whether the following tests and treatments are effective: tests for screening and diagnosis of prostate cancer, lung cancer, oral cancer, and skin cancer; orthotic devices for some conditions; general anesthesia for dental procedures; screening the blood lead levels of children at increased risk for lead poisoning; reconstructive surgery for clubfoot and craniofacial abnormalities; and home care for children.
- There is *insufficient evidence* to determine whether longer lengths of inpatient stays are associated with better outcomes for females who have a mastectomy or lymph node dissection.
- A *preponderance of evidence* from nonrandomized observational studies indicate that screening for bladder cancer, ovarian cancer, pancreatic cancer, and testicular cancer, and screening the blood lead levels of children at average risk for lead poisoning is *not medically effective*.

### Potential Public Health Impacts: Effects of Waiving Specific Benefit Mandates

Using three criteria (medical effectiveness findings, scope of the public health problem, and the type of impact of the public health problem), public health impacts were estimated if coverage for a particular benefit was dropped. Benefits with either “clear and convincing” or a “preponderance” of evidence of their medical effectiveness were categorized into six different groups based on scope and type of impact. **Broad** public health scope was defined as conditions affecting a large segment of the population (1 in 20 persons or more), **moderate** public health scope was defined as conditions affecting between 1 in 2,000 and 1 in 20 persons, and **limited** public health scope was defined as conditions affecting a more limited segment of the population (1 in 2,000 or less). The **type** of the public health impact was defined in terms of mortality or **morbidity** impact. Mortality (rates of death within a population) and morbidity (rates of the incidence and prevalence of disease) are commonly used measures for health status in a community. For those benefits where there was evidence of “no impact,” a conclusion of **no impact on public health** was drawn. For benefits where there was either “insufficient” or “ambiguous” medical effectiveness evidence or no prevalence data, a conclusion of **unknown** impact on public health was drawn.

Mandates with a potential impact of **broad public health scope** if coverage is dropped:

- **Mortality impact:** cancer screening tests for breast, cervical, and colorectal cancers; diagnostic tests and treatments for breast cancer; diabetes management medications, services, and supplies; medication and psychosocial treatments for severe mental illness and alcoholism; preventive services for children and adolescents; and pediatric asthma management.
- **Morbidity impact:** prescription contraceptive devices.

Mandates with a potential impact of **moderate public health scope** if coverage is dropped:

- **Mortality impact:** services for the diagnosis and treatment of osteoporosis and prenatal diagnosis of genetic disorders.
- **Morbidity impact:** prosthetic devices; orthotic devices for some conditions; pain management medication for persons with terminal illnesses; acupuncture; general anesthesia for dental procedures; diagnosis and treatment of infertility, and surgery for the jawbone and associated bone joints.

Mandates with a potential impact of **limited public health scope** if coverage is dropped:

- **Mortality impact:** medical formulas and foods for persons with phenylketonuria, and expanded alpha-fetoprotein screening.
- **Morbidity impact:** special footwear for persons with rheumatoid arthritis, home care services for elderly and disabled adults, and hospice care.

Mandates with evidence of **no impact on public health** if coverage is dropped:

- Screening the blood lead levels of children at average risk for lead poisoning.

Mandates with an **unknown impact on public health** if coverage is dropped:

- Tests for screening and diagnosis of prostate cancer, transplantation services for persons with HIV; prosthetic devices for persons who have had a laryngectomy; special footwear for persons with diabetes; reconstructive surgery for breast cancer; and reconstructive surgery for clubfoot and craniofacial abnormalities.

## **Potential Cost Impacts of AB 1214**

### Analytic Approach

- Because there are currently 44 mandates under California law, the number of possible combinations of these 44 benefits that insurers might offer, if they were no longer mandated, is virtually limitless. For its analysis of AB 1214, CHBRP employed a simplifying assumption regarding the expected design of health plan benefit designs if AB 1214 were to be enacted. This assumption was that insurers would all offer three prototypes of the limited-mandate plans for four market segments: one for the DMHC-regulated group and individual markets, one for the CDI-regulated group market, and one for the CDI-regulated individual market. The rationale for which mandates would remain and which would be eliminated from each of the three prototype plans was based on: (1) review of grey literature (e.g., not peer reviewed), (2) review of plans offered in other states with laws that allowed for the development of plans not subject to state mandates, (3) review of low-premium plans currently offered in California, and (4) discussion with a content expert.
- In addition to the simplifying assumption that only three prototypes of the limited-mandate plans would be offered in the market, CHBRP employed a scenario approach to the analysis of the cost impacts of AB 1214. These scenarios were necessary because of the difficulty associated with estimating how many employers would offer these limited-mandate plans in

the group market and how many individuals would purchase these plans in the individual market. Therefore, CHBRP's analysis models the maximum short-term savings theoretically possible using the following two scenarios:

- **Scenario 1 (High Impact)**—Substitution of all current health insurance products with the three prototype limited-mandate plans. This scenario assumes all insurers would offer these limited-mandate plans in every market, and all currently insured Californians would purchase these limited-mandate plans instead of their current health insurance products.
- **Scenario 2 (Low Impact)**—Substitution of all high-deductible health plans (HDHPs) currently available in the market with limited-mandate HDHPs. This scenario assumes that only those who currently have lower-premium plans (i.e., HDHPs) would be interested in purchasing health insurance products with limited mandates, and that everyone currently with an HDHP would purchase a less-expensive HDHP with limited mandates. In addition, this scenario also accounts for the substitution of some full-benefit products with limited-benefit HDHPs because of the change in relative prices (i.e., premiums) of HDHPs compared to full-benefit plans.

Both scenarios overstate the impact of AB 1214, because not everyone would switch from their current plans to limited-mandate plans. Therefore, these scenarios should be thought of as **upper bounds**, in the short term rather than actual estimates of how the market might respond to AB 1214. They are useful because they show **at most** the short-term savings that might be possible if there was broad acceptance of these policies.

#### Scenario 1 Findings

- Under this scenario, total premiums and member copayments among the commercially insured population would decline by \$3.324 billion dollars, a reduction of 4.893%. However, out-of-pocket expenditures for services that would no longer be covered would increase by \$1.427 billion—less than the projected decrease in premiums, reflecting primarily lower spending on services no longer covered by insurance. The net impact on premiums and out-of-pocket expenditures would be a reduction of \$1.898 billion, or 2.763%.
- About 26,000 Californians would become insured as a result of this scenario. This would increase expenditures for premiums and for out-of-pocket expenditures by \$56 million among these individuals.
- Therefore, the combined effect on those currently insured in the commercial market and on those newly insured would be a reduction in premium and out-of-pocket expenditures of \$1.842 billion, or 2.393%.

#### Scenario 2 Findings:

- Under this scenario, total premiums and member copayments among the commercially insured population would decline by \$255 million dollars, a reduction of 0.372%. However, out-of-pocket expenditures for services that would no longer be covered would increase by \$101 million—less than the projected decrease in premiums, reflecting primarily lower

spending on services no longer covered by insurance. The net impact on premiums and out-of-pocket expenditures would be a reduction of \$154 million, or 0.225%.

- About 22,000 Californians would become insured as a result of this scenario. This would increase expenditures for premiums and out-of-pocket expenditures by \$38 million among these individuals.
- Therefore, the combined effect on those currently insured in the commercial market and on those newly insured would be a reduction in premium and out-of-pocket expenditures of \$116 million, or 0.151%.

#### Potential Long-Term Impacts of AB 1214

Adverse risk selection is likely to occur as a result of AB 1214 in subsequent years after the bill's implementation. Lower-risk individuals (e.g. those with less health care needs) would be more likely to switch to limited-mandate products that become available in the market, leaving higher-risk individuals in those insurance products with more generous benefits. This segmentation of risk would further increase the premium difference between generous-mandate insurance products and limited-mandate insurance products. Under certain circumstances, it is possible that generous-mandate insurance products could be driven out of some market segments entirely because they are no longer price competitive.

Although it is difficult to predict the ultimate percentage impact of adverse risk selection on premiums, the segmentation of risk, particularly in the individual market, is likely to increase the magnitude of the premium differences estimated in this report, which are based solely on the actuarial value of excluded benefit mandates. Risk selection is likely to magnify the premium differences because low-risk individuals who are most likely to switch into limited-mandate insurance products are also least likely to use those services that are excluded from coverage. The net impact of adverse risk selection over time would be an increase in premiums for those who remain in generous-mandate insurance products and a decline in premiums for those who select limited-mandate insurance products.

While individuals in limited-mandate insurance products pay lower premiums, they would potentially face large out-of-pocket expenditures if they require services for a condition that was previously covered by a mandated benefit but is now excluded from their current insurance benefit package. According to numerous studies, individuals are substantially less likely to use services for which they have no insurance coverage. In these instances, the costs of these services would be borne fully by the individual, either in the form of out-of-pocket expenditures or reduced health status if the individual decides to forgo care because it is too expensive. In the latter case, the costs of the care may eventually be borne by health care providers and by taxpayers in the form of uncompensated care. It may also be borne by public programs or by nonprofit organizations if the individual qualifies for services provided by those entities. For example, a woman enrolled in a policy without any reproductive or maternity benefits may obtain certain services at Planned Parenthood or may qualify for California's Access to Infants and Mothers program (AIM) if she becomes pregnant.

**Table 1. Potential Cost Impacts of AB 1214—Waiver of Mandated Benefits (Scenario 1)**

	<b>Before Enactment of AB 1214</b>	<b>After Enactment of AB 1214</b>	<b>Increase/ Decrease</b>	<b>% Change After Enactment</b>
<b>Coverage</b>				
Number of individuals whose insurance products are subject to AB 1214 (1)	17,335,000	17,361,000	26,000	0.150%
Number of uninsured individuals	4,882,000	4,856,000	-26,000	-0.533%
<b>Total number of individuals</b>	22,217,000	22,217,000	--	0.000%
<b>Expenditures</b>				
<i>For those members who were originally insured</i>				
Premium expenditures by private employers for group insurance	43,944,936,000	41,794,783,000	-2,150,153,000	-4.893%
Premium expenditures for individually purchased insurance	5,515,939,000	5,272,163,000	-243,776,000	-4.419%
CalPERS employer expenditures	2,631,085,000	2,498,581,000	-132,504,000	-5.036%
Premium expenditures by employees with group insurance or CalPERS	11,468,688,000	10,913,374,000	-555,314,000	-4.842%
Member Copayments (deductibles, copayments, etc)	5,117,856,000	4,875,351,000	-242,505,000	-4.738%
Expenditures for non-covered services (2)	--	1,426,520,000	1,426,520,000	N/A
<b>Total annual expenditures for originally insured members</b>	68,678,504,000	66,780,772,000	-1,897,732,000	-2.763%
<i>For those Newly Insured Members</i>				
Premium expenditures by private employers for group insurance	--	62,614,000	62,614,000	N/A
Premium expenditures for individually purchased insurance	--	7,899,000	7,899,000	N/A
CalPERS employer expenditures	--	3,743,000	3,743,000	N/A
Premium expenditures for employees with group insurance or CalPERS	--	16,349,000	16,349,000	N/A
Member Copayments (deductibles, copayments, etc)	--	7,303,000	7,303,000	N/A
Expenditures for non-covered services (2)	44,266,000	2,137,000	-41,882,000	-95.145%
<b>Total annual expenditures for newly insured members</b>	44,266,000	100,045,000	56,026,000	127.292%
<i>For the Uninsured</i>				
<b>Total annual expenditures for the uninsured</b>	8,230,350,000	8,230,350,000	--	0.000%
<b>Total annual expenditures</b>	76,952,873,000	75,111,167,000	-1,841,706,000	-2.393%

Source: California Health Benefits Review Program, 2007.

Notes: The population includes individuals and dependents in California who have private insurance (group and individual) or are enrolled in CalPERS HMO. (1) All population figures include enrollees aged 0 to 64 years and enrollees 65 years or older covered by employment-based coverage. (2) Benefits not covered due to the waiver of benefits under AB 1214.

Key: DMHC = California Department of Managed Care, CDI = California Department of Insurance, CalPERS = California Public Employees' Retirement System; HMO = health maintenance organization and point of service plans.

**Table 2. Potential Cost Impacts of AB 1214—Waiver of Mandated Benefits (Scenario 2)**

	<b>Before Enactment of AB 1214</b>	<b>After Enactment of AB 1214</b>	<b>Increase/ Decrease</b>	<b>% Change After Enactment</b>
<b>Coverage</b>				
Number of individuals whose insurance products are subject to AB 1214 (1)	17,335,000	17,357,000	22,000	0.127%
Number of uninsured individuals	4,882,000	4,860,000	-22,000	-0.451%
<b>Total number of individuals</b>	<b>22,217,000</b>	<b>22,217,000</b>	<b>--</b>	<b>0.000%</b>
<b>Expenditures</b>				
<i>For those members who were originally insured</i>				
Premium expenditures by private employers for group insurance	43,944,936,000	43,702,812,000	-242,124,000	-0.551%
Premium expenditures for individually purchased insurance	5,515,939,000	5,392,503,000	-123,436,000	-2.238%
CalPERS employer expenditures	2,631,085,000	2,631,085,000	--	0.000%
Premium expenditures by employees with group insurance or CalPERS	11,468,688,000	11,476,886,000	8,198,000	0.071%
Member Copayments (deductibles, copayments, etc)	5,117,856,000	5,219,881,000	102,025,000	1.994%
Expenditures for non-covered services (2)	--	100,865,000	100,865,000	N/A
<b>Total annual expenditures for originally insured members</b>	<b>68,678,504,000</b>	<b>68,524,032,000</b>	<b>-154,472,000</b>	<b>-0.225%</b>
<i>For those Newly Insured Members</i>				
Premium expenditures by private employers for group insurance	--	14,907,000	14,907,000	N/A
Premium expenditures for individually purchased insurance	--	38,502,000	38,502,000	N/A
CalPERS employer expenditures	--	--	--	N/A
Premium expenditures for employees with group insurance or CalPERS	--	3,924,000	3,924,000	N/A
Member Copayments (deductibles, copayments, etc)	--	17,242,000	17,242,000	N/A
Expenditures for non-covered services (2)	37,533,000	1,236,000	-36,297,000	-96.707%
<b>Total annual expenditures for newly insured members</b>	<b>37,533,000</b>	<b>75,811,000</b>	<b>38,278,000</b>	<b>101.985%</b>
<i>For the Uninsured</i>				
<b>Total annual expenditures for the uninsured</b>	<b>8,236,837,000</b>	<b>8,236,837,000</b>	<b>--</b>	<b>0.000%</b>
<b>Total annual expenditures</b>	<b>76,952,874,000</b>	<b>76,836,680,000</b>	<b>-116,194,000</b>	<b>-0.151%</b>

Source: California Health Benefits Review Program, 2007.

Notes: The population includes individuals and dependents in California who have private insurance (group and individual) or are enrolled in CalPERS HMO. (1) All population figures include enrollees aged 0 to 64 years and enrollees 65 years or older covered by employment-based coverage. (2) Benefits not covered due to the waiver of benefits under AB 1214.

Key: DMHC = California Department of Managed Care, CDI = California Department of Insurance, CalPERS = California Public Employees' Retirement System; HMO = health maintenance organization and point of service plans.

## ACKNOWLEDGEMENTS

Janet Coffman, MPP, PhD, Miki Hong, MPH, Wade Aubry, MD, and Edward Yelin, PhD, all of the University of California, San Francisco, conducted the medical effectiveness analysis. Wayne Dysinger, MD, MPH, of Loma Linda University and Ted Ganiats, MD, of the University of California, San Diego provided input on the medical effectiveness analysis of the preventive services benefit mandates. Susan Ettner, PhD, of University of California, Los Angeles provided input on the medical effectiveness analysis of mental health and substance abuse benefit mandates and Michael Cabana, MD, of the University of California, San Francisco provided input on the medical effectiveness analysis of the pediatric asthma mandate. Steve Clancy, MLIS, of the University of California, Irvine, Penny Coppernoll-Blach, MLIS, of the University of California, San Diego, and Min-Lin Fang, MLIS, of the University of California, San Francisco, conducted the literature search. Melinda Beeuwkes Buntin, PhD, of RAND Inc., provided technical assistance and expert input on the analytic approach. Helen Halpin, PhD, of the University of California, Berkeley, and Susan Philip, MPP of CHBRP staff prepared the literature analysis on consumers' ability to use information to make informed health care coverage decisions. Sara McMEnamin, MPH, PhD, and Helen Halpin, PhD, both of the University of California, Berkeley, prepared the public health impact analysis. Gerald Kominski, PhD, and Nadereh Pourat, PhD, of the University of California, Los Angeles, prepared the cost impact analysis. Jay Ripps, FSA, MAAA, of Milliman, Inc., provided actuarial analysis. Susan Philip, MPP, and Cynthia Robinson, MPP, of CHBRP staff prepared the Introduction and synthesized the individual sections into a single report. Sarah Ordódy, BA, provided editing services. A subcommittee of CHBRP's National Advisory Council (see final pages of this report) and two members of the CHBRP Faculty Task Force—Harold Luft, PhD, of the University of California, San Francisco, and Thomas MaCurdy, PhD, of Stanford University—reviewed the analysis for its accuracy, completeness, clarity, and responsiveness to the Legislature's request.

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

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Susan Philip  
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## CALIFORNIA HEALTH BENEFITS REVIEW PROGRAM COMMITTEES AND STAFF

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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The California Health Benefits Review Program is administered by the Division of Health Affairs at the University of California Office of the President, Wyatt R. Hume, DDS, PhD, Provost and Executive Vice President - Academic and Health Affairs.