



CALIFORNIA
HEALTH BENEFITS REVIEW PROGRAM

Executive Summary
Analysis of Assembly Bill 154:
Mental Health Services

A Report to the 2011-2012 California Legislature
March 20, 2011

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Analysis of Assembly Bill 154 Mental Health Services

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EXECUTIVE SUMMARY

California Health Benefits Review Program Analysis of Assembly Bill 154

The California Assembly Committee on Health requested on January 19, 2011, that the California Health Benefits Review Program (CHBRP) conduct an evidence-based assessment of the medical, financial, and public health impacts of Assembly Bill (AB) 154. AB 154, as introduced by Assembly Member Jim Beall on January 18, 2011, would expand the coverage for mental health benefits from the limited conditions currently mandated—severe mental illness for individuals of all ages and serious emotional disturbances in children—to a broader range of conditions. The bill would also extend the “parity” requirement for mental health benefits from the limited conditions covered in current law to a broader range of conditions. The parity requirement mandates that coverage for mental health benefits be no more restrictive or limited than coverage for other medical conditions. The effective date of AB 154 is January 1, 2012.

Analysis of AB 154

Approximately 21.9 million Californians (59%) have health insurance that may be subject to a health benefit mandate law passed at the state level.¹ Of the rest of the state’s population, a portion is uninsured (and so has no health insurance subject to any benefit mandate) and another portion has health insurance subject to other state law or only to federal laws.

Uniquely, California has a bifurcated system of regulation for health insurance subject to state-level benefit mandates. The California Department of Managed Health Care (DMHC)² regulates health care service plans, which offer benefit coverage to their enrollees through health plan contracts. The California Department of Insurance (CDI) regulates health insurers³, which offer benefit coverage to their enrollees through health insurance policies.

Health plans regulated by the DMHC and health policies regulated by the CDI would be subject to AB 154. Medi-Cal Managed Care plans and California Public Employees’ Retirement System (CalPERS) plans would not be subject to AB 154. Therefore, the mandate would affect the health insurance of approximately 17.2 million Californians (46%). Under the proposed mandate, health plans and insurers would be required to cover all mental health benefits at parity for persons with disorders defined in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV) excluding “V codes,” as specified in the bill, as well as nicotine dependence, subject to regulatory revision. By virtue of their inclusion in the DSM-IV, diagnosis and treatment of substance use disorders (other than nicotine dependence) would be included and covered at parity levels. V codes are a subset of the nonsevere mental health (non-SMI) mental

¹ CHBRP’s estimates are available at http://www.chbrp.org/other_publications/index.php.

² DMHC was established in 2000 to enforce the Knox-Keene Health Care Service Plan of 1975; see Health and Safety Code, Section 1340.

³ CDI licenses “disability insurers.” Disability insurers may offer forms of insurance that are not health insurance. This report considers only the impact of the benefit mandate on health insurance policies, as defined in Insurance Code, Section 106(b) or subdivision (a) of Section 10198.6.

health diagnoses that are not mandated under current California law and include a broad range of diagnoses including adult antisocial behavior and bereavement.

Under current law, health plans and insurers are required to cover the diagnosis and medically necessary treatment of “severe mental illness” (SMI) of a person of any age, and of “serious emotional disturbances” (SED) of a child. Coverage is required to be at parity, that is, under the same terms and conditions applied to other medical conditions. Such terms and conditions include but are not limited to maximum lifetime benefits, copayments, and individual and family deductibles. The state law requires parity with respect to enrollee cost-sharing for covered benefits. California’s current mental health parity law applies to the large group, small group, and individual (non-group) markets.

Under the federal MHPAEA of 2008, health plans that cover mental health or substance use disorders to groups must provide coverage that is no more restrictive than coverage for other medical/surgical benefits. This parity provision applies to financial requirements (e.g., deductibles and copayments) and treatment limitations. The federal law applies to all group health plans, but small groups with 50 or fewer employees are exempt.

As discussed, those with health insurance subject to state law currently have coverage at parity for severe mental illness, as well as SED of a child. Federal law requires large group plans that cover MH/SA conditions to cover at parity. Therefore, the major impact of AB 154 would be for non-SMI/SED conditions, and the plans most affected would be those purchased by small groups and individuals.

Medical Effectiveness

- Mental illness and substance use disorders are among the leading causes of death and disability in the United States and California. Psychotherapy and prescription drugs are effective treatments for many of the MH/SA conditions to which AB 154 applies. For example,
 - Multiple RCTs have found that prescription medications are effective treatments for generalized anxiety disorder, obsessive-compulsive disorder, panic disorder, alcohol use disorders, and opioid use disorders.
 - RCTs have also found cognitive behavioral therapy and other forms of psychotherapy to be effective treatments for generalized anxiety disorder, obsessive-compulsive disorder, panic disorder, alcohol use disorders, cocaine use disorders, marijuana use disorders, and opioid use disorders.
- It is not feasible, within CHBRP’s 60-day timeline, to review the existing literature on all possible treatments for all of the MH/SA conditions that would be covered by AB 154—more than 400 diagnoses. Therefore, the effectiveness review for this report summarizes the literature on the effects of parity in coverage for MH/SA services on utilization, cost, access, process of care, and the health status of persons with MH/SA conditions.

- The impact of MH/SA parity legislation on the health status of persons with MH/SA conditions depends on a hypothetical chain of events. Parity reduces consumers' out-of-pocket costs for MH/SA services. Lower cost sharing may lead to greater utilization of these services. If consumers obtain more MH/SA services, and if these services are appropriate and effective, their mental health may improve or they may recover from substance use disorders. Improvement in mental health and recovery from substance use disorders may lead to greater productivity, better quality of life, and reduction in illegal activity.
- When assessing the studies' findings regarding the effects of parity in coverage for MH/SA services, several important caveats about the generalizability of studies of MH/SA parity to AB 154 should be kept in mind, specifically:
 - No studies have examined the effects of parity in coverage for nonsevere mental health conditions separately from severe mental health conditions. Health plans and health insurers in California are already required to cover severe mental illnesses at parity.
 - Only a few studies have assessed the impact of parity in coverage for substance use disorder services separately from mental health services.
 - In most studies, most subjects had some level of coverage for mental health conditions and for substance use disorders prior to the implementation of parity and thus, may have responded differently than Californians enrolled in DMHC-regulated health plans or CDI-regulated health insurance policies that do not cover services for non-severe mental health conditions or for substance use disorders.
 - Many employers that have implemented parity in MH/SA coverage have simultaneously contracted with managed behavioral health organizations that use a range of techniques to manage utilization of MH/SA services. These arrangements are typically characterized as behavioral health "carve outs." In these studies, the effects of parity in MH/SA coverage are difficult to separate from the effects of utilization management.
- Findings from studies of parity in coverage for MH/SA services suggest that when parity is implemented in combination with a range of techniques for management of MH/SA services and is provided to persons who already have some level of coverage for these services:
 - Consumers' out-of-pocket costs for MH/SA services decrease.
 - There is a small decrease in health plans' expenditures *per user* of MH/SA services.
 - Rates of growth in the use and cost of MH/SA services slow.
 - Utilization of MH/SA services increases slightly among

- persons with moderate levels of symptoms of mood and anxiety disorders,
 - persons employed by moderately small firms (50-100 employees), who have poor mental health and/or low incomes.
- In states that have enacted MH/SA parity laws:
 - Parents of children with chronic mental illnesses are less likely to report that paying for health care services for their children creates financial hardship.
 - Persons with mental health needs are more likely to perceive that their health insurance and access to care have improved.
- The effect of MH/SA parity on outpatient visits for MH/SA conditions depends on whether persons were enrolled in a fee-for-service (FFS) plan or a health maintenance organization (HMO) prior to the implementation of parity. MH/SA parity is associated with a decrease in outpatient visits among persons enrolled in FFS plans (when coupled with behavioral health carve outs) and an increase in visits among persons enrolled in HMOs that tightly managed utilization of MH/SA services prior to implementation of parity.
- Findings regarding the impact of MH/SA parity on the number of inpatient admissions for MH/SA conditions are inconsistent.
 - Two studies report that MH/SA parity is associated with a decrease in inpatient admissions for MH/SA conditions per 1,000 enrollees.
 - One study finds that MH/SA parity is associated with an increase in total inpatient admissions for substance use disorder treatment regardless of insurance status and an increase in the probability that an admission for inpatient substance use disorder treatment would be covered by privately funded health insurance.
- A single study suggests that the impact of MH/SA parity laws on inpatient length of stay and total charges for inpatient admissions varies across mental health conditions.
- The association between MH/SA parity laws and small increases in use of MH/SA services by persons with symptoms of MH/SA conditions may, in turn, be associated with improvement in mental health. However, very little research has been conducted on the effects of MH/SA parity on the provision of recommended treatment regimens or on the direct effects of parity on mental health status or recovery from substance use disorders. The literature search identified only three studies that assessed the impact of MH/SA parity on receipt of recommended care or health outcomes:

- One study reported that MH/SA parity is associated with modest improvements in receipt of a recommended amount and duration of treatment for depression.
- One study found that persons with parity in coverage for MH/SA services were more likely to be diagnosed with a substance use disorder than persons who did not have parity in coverage but were no more like to initiate or engage in substance use disorder treatment.
- One study found that MH/SA parity laws are not associated with a change in suicide rates for adults.

Benefit Coverage, Utilization, and Cost Impacts

In California, 74.1% of enrollees in plans and policies subject to AB 154 presently have coverage for non-SMI MH services and 63.5% have coverage for SA treatment that is at parity with their coverage for medical services, even with the federal MHPAEA regulations in effect. Under AB 154, coverage levels among enrollees would increase to 100% for both, providing new covered benefits for non-SMI MH services for 4.5 million enrollees and SA treatment for 6.3 million enrollees. Overall, annual costs within California for these additional covered benefits are projected to be 0.04% of total annual expenditures, or \$41.4 million.

Coverage

- In California, SMI services are already covered under current state law, so AB 154 focuses on the incremental effect of extending parity to non-SMI MH/SA treatment.
- CHBRP estimates that 17,247,000 enrollees would be in plans or policies subject to the mandate. Because, services for non-SMI MH/SA services would already be covered at parity for those enrollees in large group plans or policies (>50 employees) under MHPAEA at the time AB 154 would take effect, the impact of AB 154 would be most extensive in the small-group and individual markets.
- In terms of coverage impact on public programs:
 - AB 154 exempts CalPERS HMOs and Medi-Cal Managed Care Plans; therefore, this bill would not directly affect these plans.
 - The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) required States' Children's Health Insurance Programs (S-CHIP) to comply with the federal MHPAEA. California's S-CHIP program, Healthy Families, provides coverage for MH/SA treatment, including non-SMI and SED conditions, and has altered coverage to achieve parity. Therefore, this bill would not directly affect Healthy Families plans.
 - Access for Infants and Mothers (AIM) and the Major Risk Medical Insurance Program (MRMIP) have coverage for non-SMI and SA that are less than parity so this bill would

affect these plans. The cost impacts for publicly funded insurance plans reflect effects on these plans only.

- Premandate, 74.10% of enrollees with either DMHC-regulated health plan contracts or CDI-regulated policies subject to AB 154 have parity coverage for non-SMI MH/SA services, 25.78% have less than full parity coverage, and 0.12% have no coverage. Also, 63.46% have parity coverage for substance use disorders, 25.46% have less than full parity coverage, and 11.08% have no coverage. Postmandate, 100% of these individuals would have coverage for both non-SMI MH/SA treatment, which would represent a 35% increase in the number of enrollees with parity coverage for non-SMI MH treatment and a 58% increase in the number of enrollees with parity coverage for SA treatment.
- CHBRP has analyzed similar bills in prior years. Based on a review of prior years' analyses, it appears that coverage for non-SMI MH/ SA benefits have increased. For example in 2005, 0% of the market had coverage for non-SMI benefits at full parity; 92% had coverage with limited coverage and 8% had no coverage. For SA benefits, 0% had coverage at full-parity, 82% had limited coverage and 18% had no coverage. The increase in rates of coverage at full parity for non-SMI and SA benefits for those with insurance from 2005 to 2011 may be attributed to the enactment of the federal MHPAEA.

Utilization

- CHBRP estimates that among enrollees with either DMHC-regulated health plan contracts or CDI-regulated policies subject to AB 154, utilization would increase by 7.41 outpatient mental health visits (2.62%) and 2.32 outpatient substance use visits (15.81%) per 1,000 members. Annual inpatient days per 1,000 members would decrease by 0.02 (0.56%) for mental health and increase by 0.72 (11.76%) for substance use disorders.
- Increased utilization would result from an elimination of benefit limits (e.g., annual limits on the number of hospital days and outpatient visits) and a reduction in cost sharing, because current coinsurance rates are often higher for non-SMI MH/SA treatment than for other health care. Utilization would also increase among enrollees who previously had no coverage for conditions other than the SMI diagnoses covered under current state law.
- Two factors would mitigate the estimated increases in utilization. First, direct management of non-SMI MH/SA treatment is already substantial (e.g., due to the use of managed behavioral health care organizations or other utilization management processes), attenuating the influence of visit limits and cost-sharing requirements on utilization. Second, prior experience with parity legislation suggests that health plans are likely to respond to the mandate by further increasing utilization management (e.g., shifting patient care from inpatient to outpatient settings). More stringent management of care would partly offset increases due to more generous coverage.
- Although utilization of behavioral health care is also limited by factors other than limited insurance coverage (e.g., social stigma, limited availability of specialty providers), the CHBRP estimates, which are based on empirical utilization data, implicitly take these barriers into account.

Costs

- Total net annual expenditures among enrollees subject to state regulation are estimated to increase by about \$41.4 million, or 0.04%.
- Of the \$41.4 million increase, \$24.5 million will be due to increased coverage for treatment of non-SMI MH, and \$17.0 million will be due to increased coverage for treatment of SA.
- AB 154 is estimated to increase premiums by \$67.4 million. The distribution of the impact on premiums is as follows:
 - The total premium contributions from private employers who purchase group insurance are estimated to increase by \$28.4 million per year, or 0.05%.
 - Premiums for MRMIB plans are estimated to increase by \$134,000 (0.01%).
 - Enrollee contributions toward premiums for those in privately funded group insurance and publicly funded group coverage subject to the bill are estimated to increase by \$7.3 million per year, or 0.05%.
 - The total premiums for enrollees who purchase their own DMHC-regulated plan contracts or CDI-regulated policies (individually purchased) would increase by about \$31.5 million, or 0.47%.
 - The increase in premium costs would be partly offset by a decline in enrollee out-of-pocket expenditures (e.g., deductibles, copayments) of about \$25.9 million (−0.34%). The decrease in patient cost sharing is due to the fact that insurers would be covering a greater proportion of patient expenses if AB 154 were implemented.

The projected impact varies slightly by market segment. Among DMHC-regulated health plans, total PMPM premiums would increase by \$0.05 in the large-group market, \$0.26 in the small-group market, and \$0.61 in the individual market. For CDI-regulated plans, total PMPM premiums would increase by \$0.16 in the large-group market, \$1.64 in the small-group market, and \$1.62 in the individual market.

- No measurable change in the number of uninsured is projected to occur as a result of AB 154 because on average, premiums are estimated to increase by less than 1%.

Public Health Impacts

- It is not possible to quantify the anticipated impact of the mandate on the public health of Californians because (1) the numerous approaches for treating MH/SA disorders and the large number of disorders covered by AB 154 render a medical effectiveness analysis of mental health care treatment outside the scope of this analysis; and (2) there are insufficient data in the scientific literature to evaluate whether introduction of parity laws similar to AB 154 has an impact on MH/SA health and social outcomes.

- The scope of potential outcomes related to MH/SA treatment includes reduced suicides, reduced symptomatic distress, reduced injuries, reduced pregnancy-related complications, improved quality of life, improved medical outcomes, and reduced adverse social outcomes, such as absenteeism, loss of employment, and criminal activity. While it is likely that improvements in these outcomes will occur for some individuals, at present there is insufficient literature examining these issues in the context of health insurance parity laws, and, therefore, the public health impact of AB 154 on these outcomes is unknown.
- There is insufficient evidence to evaluate the effect of parity in private insurance coverage for non-SMI and substance use disorders on incarceration.
- AB 154 will increase insurance coverage for MH/SA treatment. For many individuals, increased coverage will likely reduce the administrative burden and financial hardship associated with MH/SA disorders. In particular, AB 154 is expected to benefit the approximately 20,800 individuals with new coverage for MH services and the 1.9 million individuals with new coverage for SA treatment.
- It is likely that AB 154 will also have positive health outcomes for those enrollees who are newly covered for MH or SA services. In addition, it is likely that AB 154 will have positive health outcomes for some enrollees whose coverage is expanded from limited MH/SA benefits to full parity. However, to estimate these benefits at the population level, it is necessary to examine research on the relationship between mental health parity laws and social outcomes. At present, there is insufficient literature examining these issues, and therefore the impact of AB 154 on these outcomes is unknown.
- Gender differences exist with regard to specific mental disorder diagnoses, with some having a much higher frequency in females and others in males. Overall, adult women are more likely to use mental health services than adult men. There is no evidence, however, that AB 154 would decrease disparities with regard to health outcomes.
- There is substantial variation both between and within racial groups with respect to the prevalence and treatment for MH/SA disorders. AB 154 has the potential to reduce racial disparities in coverage for mental health treatment. There is no evidence, however, that AB 154 would decrease disparities with regard to health outcomes.
- MH/SA disorders are a substantial cause of mortality and disability in the United States. Substance use, in particular, often results in premature death. At present, there is insufficient evidence that AB 154 would result in a reduction of premature death.
- MH/SA disorders are associated with sizeable economic costs from lost productivity. Although it is likely that AB 154 would reduce lost productivity for those who are newly covered for MH/SA benefits, the total economic impact of AB 154 cannot be estimated.
- AB 154 would eliminate a health insurance disparity in the individual and small-group insurance markets between mental and medical health conditions and could therefore help to destigmatize MH/SA treatment.

Potential Effects of the Federal Affordable Care Act

The federal “Patient Protection and Affordable Care Act” (P.L.111-148) and the “Health Care and Education Reconciliation Act” (H.R.4872) were enacted in March 2010. These laws (together referred to as the “Affordable Care Act [ACA]”) are expected to dramatically affect the California health insurance market and its regulatory environment, with most changes becoming effective in 2014. How these provisions are implemented in California will largely depend on pending legal actions, funding decisions, regulations to be promulgated by federal agencies, and statutory and regulatory actions to be taken by California state government. The provisions that go into effect during these transitional years (2011-2013) would affect the baseline, or current enrollment, expenditures, and premiums. It is important to note that CHBRP’s analysis of specific mandate bills typically address the marginal effects of the mandate bill—specifically, how the proposed mandate would impact benefit coverage, utilization, costs, and public health, holding all other factors constant. CHBRP’s estimates of these marginal effects are presented in this report.

Essential health benefits

The ACA requires that, beginning in 2014, certain health insurance plans cover a minimum floor of specified benefits, referred to as “Essential Health Benefits” (EHBs). This includes health insurance sold in the small group and individual markets, as well as all “Qualified Health Plans” (QHPs) purchased through the California Health Benefit Exchange.⁴

The EHBs explicitly include “[m]ental health and substance use disorder services, including behavioral health treatment.”⁵ The provisions also require that the scope of the EHBs be equal to the scope of benefits provided under a typical employer plan. Furthermore, the parity requirements of the federal Mental Health Parity and Addiction Equity Act (MHPAEA) will also apply to QHPs “in the same manner and to the same extent” as they apply to health insurance issuers and group health plans, though this provision’s interaction with the MHPAEA’s small employer exemption remains unclear.

Therefore, it is possible that many of the impacts of AB 154 as it applies to QHPs in the Exchange would be mitigated by these ACA requirements, contingent upon: (1) if there are any differences between the mental health/substance abuse (MH/SA) covered benefits included in the EHBs and the benefits required under AB 154; and, (2) whether the small employer exemption of federal mental health parity (MHPAEA) is applied to QHPs purchased by small groups in the Exchange, or if those QHPs are required to comply with MHPAEA.

Additionally, the ACA requires in 2014 that states “make payments...to defray the cost of any additional benefits” required of QHPs sold in the Exchange.⁶ Beginning in 2014, AB 154 may incur a fiscal liability for the state for benefits that are determined to exceed the MH/SA benefits

⁴ Affordable Care Act, Section 2707 and Section 1302(b).

⁵ Affordable Care Act, Section 1302(b)(1)(E).

⁶ Affordable Care Act, 1311(d)(3)(B).

included in the EHBs. This potential liability would depend on three factors: (1) differences in the scope of MH/SA benefits in the final EHB package and the scope of mandated benefits in AB 154; (2) the number of enrollees in QHPs; and, (3) the method used to calculate the cost of additional benefits.

However, on March 3, 2010, the Author's office indicated that they intend to make the following amendment.

“Notwithstanding any provision of this bill, for any state funded health care program, the benefits will not exceed those required per the Federal Patient Affordable Care Act of 2010.”

Given this provision, AB 154's requirements for state-funded health care programs to cover MH/SA benefits could not exceed the requirements of the ACA as they apply to these programs. Depending on the interpretation of “state funded health care program,” this language would effectively exempt the MRMIB plans currently subject and, beginning in 2014, exempt the QHPs sold in the Exchange from any of the bill's requirements exceeding the EHBs. In this case, any resulting potential fiscal liability for state-funded health care programs would be mitigated by this provision.

Table 1. AB 154 Impacts on Benefit Coverage, Utilization, and Cost, 2011

	Before Mandate	After Mandate	Increase/ Decrease	Change After Mandate
Benefit Coverage				
Total enrollees with health insurance subject to state-level benefit mandates (a)	21,902,000	21,902,000	0.00%	0%
Total enrollees with health insurance subject to AB 154 (b)	17,247,000	17,247,000	0.00%	0%
Mental Health Other Than Serious Mental Illness (SMI)				
Percentage of enrollees with full parity coverage	74.10%	100.00%	25.90%	35%
Percentage of enrollees with nonparity coverage	25.78%	0.00%	-25.78%	-100%
Percentage of enrollees without coverage	0.12%	0.00%	-0.12%	-100%
Number of enrollees with full parity coverage	12,781,000	17,247,000	4,466,000	35%
Number of enrollees with nonparity coverage	4,446,000	0	-4,446,000	-100%
Number of enrollees without coverage	21,000	0	-21,000	-100%
Substance Abuse				
Percentage of enrollees with full parity coverage	63.46%	100.00%	36.54%	58%
Percentage of enrollees with nonparity coverage	25.46%	0.00%	-25.46%	-100%
Percentage of enrollees without coverage	11.08%	0.00%	-11.08%	-100%
Number of enrollees with full parity coverage	10,945,000	17,247,000	6,302,000	58%
Number of enrollees with nonparity coverage	4,392,000	0	-4,392,000	-100%
Number of enrollees without coverage	1,911,000	0	-1,911,000	-100%
Utilization and Cost				
Mental Health Other Than Severe Mental Illness (SMI)				
Annual inpatient days per 1,000 members	3.27	3.25	-0.02	-0.56%
Annual outpatient visits per 1,000 members	282.47	289.88	7.41	2.62%
Substance Abuse				
Annual inpatient days per 1,000 members	6.13	6.85	0.72	11.76%
Annual outpatient visits per 1,000 members	14.68	17.00	2.32	15.81%

Table 1. AB 154 Impacts on Benefit Coverage, Utilization, and Cost, 2011 (Cont'd)

All Services Covered by Mandate				
Premium expenditures by private employers for group insurance	\$52,713,266,000	\$52,741,667,000	\$28,401,000	0.05%
Premium expenditures for individually purchased insurance	\$6,724,851,000	\$6,756,367,000	\$31,516,000	0.47%
Premium expenditures by enrollees with privately funded and publicly funded group insurance (c)	\$15,173,472,000	\$15,180,794,000	\$7,322,000	0.05%
CalPERS HMO employer expenditures	\$3,465,785,000	\$3,465,785,000	\$0	0.00%
Medi-Cal Managed Care Plans state expenditures	\$8,657,688,000	\$8,657,688,000	\$0	0.00%
MRMIB Plan expenditures (d)	\$1,050,631,000	\$1,050,765,000	\$134,000	0.01%
Enrollee out-of-pocket expenses for covered benefits (deductibles, copayments, etc.)	\$7,548,415,000	\$7,522,476,000	-\$25,939,000	-0.34%
Enrollee expenses for noncovered benefits (e)	\$0	\$0	\$0	N/A
Total Expenditures	\$95,334,108,000	\$95,375,542,000	\$41,434,000	0.04%

Source: California Health Benefits Review Program, 2011.

Notes: (a) This population includes persons with privately funded and publicly funded (e.g., CalPERS HMOs, Medi-Cal Managed Care Plans, Healthy Families Program, AIM, MRMIP) health insurance products regulated by the DMHC or CDI. Population includes enrollees aged 0 to 64 years and enrollees 65 years or older covered by employment-sponsored insurance.

(b) This population includes persons that are in plans and policies subject to AB 154. Therefore this population excludes enrollees in CalPERS HMOs and Medi-Cal Managed Care Plans.

(c) Premium expenditures by enrollees include employee contributions to employer-sponsored health insurance and enrollee contributions for publicly purchased insurance.

(d) MRMIB Plan expenditures include expenditures for 874,000 enrollees of the Healthy Families Program, 8,000 enrollees of MRMIP and 7,000 enrollees of the AIM program.

(e) Includes only those expenses that are paid directly by enrollees or other sources to providers for services related to the mandated benefit that are not currently covered by insurance. This only includes those expenses that will be newly covered, postmandate. Other components of expenditures in this table include all health care services covered by insurance.

Key: AIM=Access for Infants and Mothers; CalPERS HMOs=California Public Employees' Retirement System Health Maintenance Organizations; CDI=California Department of Insurance; DMHC=Department of Managed Health; MRMIB=Managed Risk Medical Insurance Board; MRMIP=Major Risk Medical Insurance Program.

Acknowledgments

This report provides an analysis of the medical, financial, and public health impacts of Assembly Bill 154. In response to a request from the California Assembly Committee on Health on January 19, 2011, the California Health Benefits Review Program (CHBRP) undertook this analysis pursuant to the program's authorizing statute.

Edward Yelin, PhD, Janet Coffman, MPP, PhD, and Mi-Kyung (Miki) Hong, MPH, all of the University of California, San Francisco, prepared the medical effectiveness analysis. Stephen L. Clancy, MLS, AHIP, of the University of California, Irvine, conducted the literature search. Stephen A. McCurdy, MD, MPH, and Meghan Soulsby, MPH, of the University of California, Davis, prepared the public health impact analysis. Todd Gilmer, PhD, of the University of California, San Diego, prepared the cost impact analysis. Robert Cosway, FSA, MAAA, of Milliman, provided actuarial analysis. Howard H. Goldman, MD, PhD, at the University of Maryland School of Medicine provided technical assistance with the literature review and expert input on the analytic approach. Susan Philip, MPP, and David Guarino of CHBRP staff prepared the background section and synthesized the individual sections into a single report. 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 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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All CHBRP bill analyses and other publications are available on the CHBRP Web site, www.chbrp.org.

Susan Philip, MPP
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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 CHBRP's authorizing legislation, UC contracts with a certified actuary, Milliman Inc., to assist in assessing the financial impact of each legislative proposal mandating or repealing a health insurance benefit. 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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