CALIFORNIA
HEALTH BENEFITS REVIEW PROGRAM

EXECUTIVE SUMMARY
Analysis of Assembly Bill 1600: Mental Health Services

A Report to the 2009-2010 California Legislature
March 19, 2010

CHBRP 10-01

A Report to the 2009-2010 California State Legislature

EXECUTIVE SUMMARY
Analysis of Assembly Bill 1600:
Mental Health Services

March 19, 2010

California Health Benefits Review Program
1111 Franklin Street, 11th Floor
Oakland, CA 94607
Tel: 510-287-3876
Fax: 510-763-4253
www.chbrp.org

Additional free copies of this and other CHBRP bill analyses and publications may be obtained by visiting the CHBRP Web site at www.chbrp.org.

Suggested Citation:

California Health Benefits Review Program (CHBRP). (2010). *Analysis of Assembly Bill 1600: Mental Health Services.* Report to California State Legislature. Oakland, CA: CHBRP. 10-01.

EXECUTIVE SUMMARY

California Health Benefits Review Program
Analysis of Assembly Bill 1600: Mental Health Services

The California Legislature has asked the California Health Benefits Review Program (CHBRP) to conduct an evidence-based assessment of the medical, financial, and public health impacts of Assembly Bill (AB) 1600 Mental Health Services, as introduced by Assembly Member Jim Beall on January 4, 2010. This bill would expand the mandated coverage for mental health benefits from the limited conditions currently covered—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 limited than coverage for other medical conditions. AB 1600 would become effective on January 1, 2011.

Under the proposed mandate, health plans and insurers would be required to cover all mental health benefits at parity for persons with all disorders defined in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV). By virtue of their inclusion in the DSM-IV, diagnosis and treatment of substance use disorders would be included and covered at parity levels. AB 1600 allows for the definition of "mental illness" to be revised according to any subsequent updates to the DSM through regulations jointly promulgated by the Deparment of Managed Health Care (DMHC) and the California Department of Insurance (CDI).

Health plans regulated by the DMHC and health policies regulated by the CDI would be subject to this proposed mandate. Medi-Cal Managed Care plans and California Public Employees' Retirement System (CalPERS) plans would not be subject to this proposed mandate. Therefore a total of 15.9 million people in California are estimated to be enrolled in plans or policies affected by AB 1600.

Under current state law, health plans and insurers are required to cover the diagnosis and medically necessary treatment of severe mental illnesses (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. 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 groups, and individual (non-group) markets.

Under the federal Mental Health Parity and Addiction Equity Act (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 law applies to all group health plans that were offered or renewed after October 3, 2009. 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 serious emotional disturbance of a child. Federal law requires large group plans that cover mental health and substance abuse (MH/SA) conditions to cover at parity. Therefore, the major impact of AB 1600 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. There are effective treatments for many of the MH/SA conditions to which AB 1600 applies. However, it is not feasible, within CHBRP's 60-day timeline, to review the existing literature on all possible treatments for MH/SA conditions that would be covered by AB 1600—more than 400 diagnoses. Instead, 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 and quality of life and reduction in illegal activity.

- When assessing the studies' implications of parity in coverage for MH/SA services, several important caveats should be kept in mind:
    - The generalizability of studies of MH/SA parity to AB 1600 is limited because
        - 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 both severe and nonsevere mental illnesses 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 illnesses 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." The effects of parity in MH/SA coverage in these studies are difficult to separate from the effects of arrangements. 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 substance use disorders,
    - 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 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 no studies that assessed the impact of MH/SA parity laws on recovery from substance use disorders, and only two studies that assessed the impact on mental health conditions:

    - 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 MH/SA parity laws are not associated with a change in suicide rates for adults.

Utilization, Cost, and Coverage Impacts

In California, 66.2% of enrollees in plans and policies subject to AB 1600 presently have coverage for non-SMI MH services and 55.3% 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 1600, coverage levels among enrollees would increase to 100% for both, providing new covered benefits for non-SMI MH services for 5.4 million enrollees and SA treatment for 7.1 million enrollees. Overall, annual costs for these additional services are projected to be 0.06% of total annual expenditures within California, or $44.9 million.

<u>Coverage</u>

- In California, SMI services are already covered under current state law, so AB 1600 focuses on the incremental effect of extending parity to non-SMI MH/SA treatment.

- CHBRP estimates that 15,876,000 enrollees would be in plans or policies subject to the mandate. However, services for non-SMI MH/SA services would already be covered at parity for those covered by most large employers (>50 employees) under MHPAEA at the time AB 1600 would take effect, so the impact of AB 1600 would be most extensive in the small-group and individual markets.

- Premandate, 66.18% of enrollees with either DMHC-regulated health plan contracts or CDI-regulated policies subject to AB 1600 have parity coverage for non-SMI MH/SA services, 32.42% have less than full parity coverage, and 1.41% have no coverage. Also, 55.29% have parity coverage for substance use disorders, 34.74% have less than full parity coverage, and 9.98% have no coverage. Postmandate, 100% of these individuals would have coverage for both non-SMI MH and SA treatment, which would represent a 51% increase in the number

of enrollees with coverage for non-SMI MH treatment and an 81% increase in the number of enrollees with coverage for SA treatment.

Utilization

- The relative impact of the legislation will be greater for SA than mental health services. CHBRP estimates that among enrollees with either DMHC-regulated health plan contracts or CDI-regulated policies subject to AB 1600, utilization would increase by 10.46 outpatient mental health visits (4.75%) and 3.13 outpatient substance use visits (16.15%) per 1,000 members as a result of the mandate. Annual inpatient days per 1,000 members would increase by 0.02 (0.58%) for mental health and by 0.69 (10.10%) 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 insured individuals 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 insured individuals subject to state regulation are estimated to increase by about $44.9 million, or 0.06%.
- Of the $44.9 million increase, $26.6 million will be due to increased coverage for treatment of non-SMI MH, and $18.3 million will be due to increased coverage for treatment of SA.
- AB 1600 is estimated to increase premiums by about $63 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 $25.4 million per year, or 0.06%.
    - Enrollee contributions toward premiums for either privately funded group coverage or for publicly funded group coverage (including Healthy Families, AIM or MRMIP) are estimated to increase by $8.3 million per year, or 0.06%.

- The total premiums for enrollees who purchase their own DMHC-regulated plan contracts or CDI-regulated policies would increase by about $28.8 million, or 0.48%.
- The increase in premium costs would be partly offset by a decline in individual out-of-pocket expenditures (e.g., deductibles, copayments) of about $18.2 million (−0.31%).

- The projected impact varies slightly by market segment. Among DMHC-regulated health plans, total PMPM premiums would increase by $0.08 in the large-group market, $0.27 in the small-group market, and $0.64 in the individual market. For CDI-regulated plans, total PMPM premiums would increase by $0.26 in the large-group market, $1.45 in the small-group market, and $1.61 in the individual market.

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 multiple disorders (that would be covered under AB 1600) on which these approaches may be applied renders a medical effectiveness analysis of mental health care treatment outside of the scope of this analysis; and (2) the literature review found an insufficient number of studies in the peer-reviewed scientific literature that specifically address physical, mental health, and social outcomes related to the implementation of mental health parity laws to evaluate whether mental health parity has an impact on these health 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, reduced employment absenteeism, reduced cessation of employment, and improved social outcomes, such as a decrease in criminal activity.

- There is insufficient evidence to evaluate the effect of parity in private insurance coverage for non-SMI and substance use disorders on incarceration.

- AB 1600 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 1600 is expected to benefit the approximately 223,000 individuals with new coverage for MH services and the 1.6 million individuals with new coverage for SA services.

- It is likely that AB 1600 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 1600 will have positive health outcomes for some of those enrollees who 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 health and social outcomes. At present, the literature does not

examine these issues, and therefore, the impact of AB 1600 on these outcomes is unknown.

- Although the lifetime prevalence for mental disorders is similar for males and females, gender differences exist with regard to specific mental disorder diagnoses, with some having a much higher frequency in males and others in females. Overall, adult women are more likely to use mental health services than adult men.

- Race and poverty influence the risk of developing a MH/SA and the chance that treatment will be sought. There is substantial variation both across and within racial groups with respect to the prevalence of and treatment for MH/SA disorders. AB 1600 has the potential to reduce racial disparities in coverage for mental health treatment. There is no evidence, however, that AB 1600 would differentially increase utilization of MH/SA treatment among minorities or that AB 1600 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 1600 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 1600 would reduce lost productivity for those who are newly covered for MH/SA benefits, the total impact of AB 1600 on economic costs cannot be estimated.

- Another potential benefit of AB 1600 is that it would eliminate a health insurance disparity in the individual and small-group insurance markets between psychological and non-MH/SA health conditions and could therefore help to destigmatize MH/SA treatment.

Table 1. AB 1600 Impacts on Benefit Coverage, Utilization, and Cost, 2010

	Before Mandate	After Mandate	Increase/ Decrease	Change After Mandate
Benefit Coverage				
Total enrollees with health insurance subject to state-level benefit mandates (a)	19,487,000	19,487,000	0.00%	0%
Total enrollees with health insurance subject to AB 1600	15,876,000	15,876,000	0.00%	0%
Mental Health Other Than Severe Mental Illness (non-SMI MH)				
Percentage of insured individuals with full parity coverage	66.18%	100.00%	33.82%	51%
Percentage of insured individuals with nonparity coverage	32.42%	0.00%	−32.42%	−100%
Percentage of insured individuals with no coverage	1.41%	0.00%	−1.41%	−100%
Number of insured individuals with full parity coverage	10,506,000	15,876,000	5,370,000	51%
Number of insured individuals with nonparity coverage	5,146,000	0	−5,146,000	−100%
Number of insured individuals with no coverage	223,000	0	−223,000	−100%
Substance Use Disorders (SA)				
Percentage of insured individuals with full parity coverage	55.29%	100.00%	44.71%	81%
Percentage of insured individuals with nonparity coverage	34.74%	0.00%	−34.74%	−100%
Percentage of insured individuals with no coverage	9.98%	0.00%	−9.98%	−100%
Number of insured individuals with full parity coverage	8,777,000	15,876,000	7,099,000	81%
Number of insured individuals with nonparity coverage	5,515,000	0	−5,515,000	−100%
Number of insured individuals with no coverage	1,584,000	0	−1,584,000	−100%
Utilization and Cost				
Mental Health Other Than Severe Mental Illness (non-SMI MH)				
Annual inpatient days per 1,000 enrollees	3.10	3.12	0.02	0.58%
Annual outpatient visits per 1,000 enrollees	220.37	230.83	10.46	4.75%
Average cost per inpatient day	$842.43	$842.59	$0.16	0.02%
Average cost per outpatient visit	$84.72	$84.75	$0.03	0.04%

Table 1. AB 1600 Impacts on Benefit Coverage, Utilization, and Cost, 2010 (cont'd)

	Before Mandate	After Mandate	Increase/ Decrease	Change After Mandate
Substance Use Disorders (SA)				
Annual inpatient days per 1,000 members	6.81	7.50	0.69	10.10%
Annual outpatient visits per 1,000 members	19.38	22.51	3.13	16.15%
Average cost per inpatient day	$783.83	$786.27	$2.44	0.31%
Average cost per outpatient visit	$80.13	$80.17	$0.04	0.05%
Expenditures				
Mental Health Other Than Severe Mental Illness (non-SMI MH)				
Premium expenditures by private employers for group insurance	$43,519,324,000	$43,533,146,000	$13,822,000	0.03%
Premium expenditures for individually purchased insurance	$5,992,795,000	$6,013,893,000	$21,098,000	0.35%
Premium expenditures by individuals with group insurance, CalPERS, Healthy Families, AIM, or MRMIP (b)	$12,820,614,000	$12,825,553,000	$4,939,000	0.04%
CalPERS employer expenditures (c)	$3,267,842,000	$3,267,842,000	$0	0.00%
Medi-Cal state expenditures	$4,015,596,000	$4,015,596,000	$0	0.00%
Healthy Families state expenditures (d)	$910,306,000	$911,017,000	$711,000	0.08%
Enrollee out-of-pocket expenditures for covered benefits (deductibles, copayments, etc.)	$5,961,186,000	$5,947,203,000	−$13,983,000	−0.23%
Enrollee expenses for noncovered benefits	$0	$0	$0	N/A
Total Annual Expenditures	$76,487,663,000	$76,514,250,000	$26,587,000	0.03%
Substance Use Disorders (Including Nicotine) (SA)				
Premium expenditures by private employers for group insurance	$43,519,324,000	$43,530,887,000	$11,563,000	0.03%
Premium expenditures for individually purchased insurance	$5,992,795,000	$6,000,488,000	$7,693,000	0.13%
Premium expenditures by individuals with group insurance, CalPERS, Healthy Families, AIM, or MRMIP (b)	$12,820,614,000	$12,823,934,000	$3,320,000	0.03%
CalPERS employer expenditures (c)	$3,267,842,000	$3,267,842,000	$0	0.00%
Medi-Cal state expenditures	$4,015,596,000	$4,015,596,000	$0	0.00%
Healthy Families state expenditures (d)	$910,306,000	$910,286,000	−$20,000	0.00%
Individual out-of-pocket expenditures for covered benefits (deductibles, copayments, etc.)	$5,961,186,000	$5,956,956,000	−$4,230,000	−0.07%
Out-of-pocket expenditures for noncovered benefits	$0	$0	$0	N/A
Total Annual Expenditures	$76,487,663,000	$76,505,989,000	$18,326,000	0.02%

Table 1. AB 1600 Impacts on Benefit Coverage, Utilization, and Cost, 2010 (cont'd)

	Before Mandate	After Mandate	Increase/ Decrease	Change After Mandate
All Services Covered by Mandate				
Premium expenditures by private employers for group insurance	$43,519,324,000	$43,544,710,000	$25,386,000	0.06%
Premium expenditures for individually purchased insurance	$5,992,795,000	$6,021,587,000	$28,792,000	0.48%
Premium expenditures by individuals with group insurance, CalPERS, Healthy Families, AIM, or MRMIP (b)	$12,820,614,000	$12,828,874,000	$8,260,000	0.06%
CalPERS employer expenditures (c)	$3,267,842,000	$3,267,842,000	$0	0.00%
Medi-Cal state expenditures	$4,015,596,000	$4,015,596,000	$0	0.00%
Healthy Families state expenditures (d)	$910,306,000	$910,997,000	$691,000	0.08%
Individual out-of-pocket expenditures for covered benefits (deductibles, copayments, etc.)	$5,961,186,000	$5,942,974,000	−$18,212,000	−0.31%
Out-of-pocket expenditures for noncovered benefits	$0	$0	$0	N/A
Total Annual Expenditures	$76,487,663,000	$76,532,580,000	$44,917,000	0.06%

Source: California Health Benefits Review Program, 2010.

Notes: (a) This population includes privately insured (group and individual) and publicly insured (e.g., CalPERS, Medi-Cal, Healthy Families, AIM, MRMIP) individuals enrolled in health insurance products regulated by DMHC or CDI. Population includes enrollees aged 0-64 years and enrollees 65 years or older covered by employment-sponsored insurance.

(b) Premium expenditures by individuals include employee contributions to employer-sponsored health insurance and member contributions to public insurance.

(c) Of the CalPERS employer expenditures, about 58%, or $71,920, would be state expenditures for CalPERS members who are state employees; however, CHBRP estimates no impact of the mandate on CalPERS employer expenditures.

(d) Healthy Families state expenditures include expenditures for 7,000 covered by the Major Risk Medical Insurance Program (MRMIP) and 7,000 covered by the Access for Infants and Mothers (AIM) program.

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 Care; N/A=not applicable.

Acknowledgements

This report provides an analysis of the medical, financial, and public health impacts of Assembly Bill 1600, a bill to expand the mandated coverage for mental health benefits from the limited conditions currently covered—severe mental illness 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. In response to a request from the California Assembly Committee on Health on January 19, 2010, 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. Helen Halpin, PhD, and Nicole Bellows, PhD, of the University of California, Berkeley, prepared the public health impact analysis. Robert M. Kaplan, PhD, Shana Alex Lavarreda, PhD, MPP, of the University of California, Los Angeles, prepared the cost impact analysis. Robert Cosway, FSA, MAAA, of Milliman, provided actuarial analysis. Howard Goldman, MD, PhD, 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. Cherie Wilkerson provided editing services. A subcommittee of CHBRP's National Advisory Council (see final pages of this report) and a member of the CHBRP Faculty Task Force, Wayne Dysinger, MD, MPH, of Loma Linda 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:

California Health Benefits Review Program
1111 Franklin Street, 11th Floor
Oakland, CA 94607
Tel: 510-287-3876
Fax: 510-763-4253
www.chbrp.org

All CHBRP bill analyses and other publications are available on the CHBRP Web site, www.chbrp.org.

Susan Philip, MPP
Director

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.

Faculty Task Force

Helen Halpin, ScM, PhD, *Vice Chair for Public Health*, University of California, Berkeley
Robert Kaplan, PhD, *Vice Chair for Cost*, University of California, Los Angeles
Ed Yelin, PhD, *Vice Chair for Medical Effectiveness*, University of California, San Francisco
Wayne S. Dysinger, MD, MPH, Loma Linda University Medical Center
Susan Ettner, PhD, University of California, Los Angeles
Theodore Ganiats, MD, University of California, San Diego
Sheldon Greenfield, MD, University of California, Irvine
Kathleen Johnson, PharmD, MPH, PhD, University of Southern California
Thomas MaCurdy, PhD, Stanford University
Joy Melnikow, MD, MPH, University of California, Davis

Task Force Contributors

Wade Aubry, MD, University of California, San Francisco
Yair Babad, PhD, University of California, Los Angeles
Nicole Bellows, PhD, University of California, Berkeley
Tanya G. K. Bentley, PhD, University of California, Los Angeles
Dasha Cherepanov, PhD, University of California, Los Angeles
Janet Coffman, MPP, PhD, University of California, San Francisco
Mi-Kyung Hong, MPH, University of California, San Francisco
Shana Lavarreda, PhD, MPP, University of California, Los Angeles
Stephen McCurdy, MD, MPH, University of California, Davis
Sara McMenamin, PhD, University of California, Berkeley
Ying-Ying Meng, DrPH, University of California, Los Angeles
Alexis Munoz, MPH, University of California
Dominique Ritley, MPH, University of California, Davis
Chris Tonner, MPH, University of California, San Francisco
Lori Uyeno, MD, University of California, Los Angeles

National Advisory Council

Lauren LeRoy, PhD, President and CEO, Grantmakers In Health, Washington, DC, *Chair*

John Bertko, FSA, MAAA, Former Vice President and Chief Actuary, Humana, Inc., Flagstaff, AZ
Deborah Chollet, PhD, Senior Fellow, Mathematica Policy Research, Washington, DC
Michael Connelly, JD, President and CEO, Catholic Healthcare Partners, Cincinnati, OH
Maureen Cotter, ASA, Founder and Owner, Maureen Cotter & Associates, Inc., Dearborn, MI
Susan Dentzer, Editor-in-Chief of Health Affairs, Washington, DC
Joseph Ditre, JD, Executive Director, Consumers for Affordable Health Care, Augusta, ME
Allen D. Feezor, Deputy Secretary for Health Services, North Carolina Department of Health and Human Services, Raleigh, NC
Charles "Chip" Kahn, MPH, President and CEO, Federation of American Hospitals, Washington, DC
Jeffrey Lerner, PhD, President and CEO, ECRI Institute Headquarters, Plymouth Meeting, PA
Trudy Lieberman, Director, Health and Medicine Reporting Program, Graduate School of Journalism, City University of New York, New York City, NY
Marilyn Moon, PhD, Vice President and Director, Health Program, American Institutes for Research, Silver Spring, MD
Carolyn Pare, CEO, Buyers Health Care Action Group, Bloomington, MN
Michael Pollard, JD, MPH, Senior Fellow, Institute for Health Policy Solutions, Washington, DC
Karen Pollitz, MPP, Project Director, Georgetown University Health Policy Institute, Washington, DC
Christopher Queram, President and CEO, Wisconsin Collaborative for Healthcare Quality, Madison, WI
Richard Roberts, MD, JD, Professor of Family Medicine, University of Wisconsin-Madison, Madison, WI
Frank Samuel, LLB, Former Science and Technology Advisor, Governor's Office, State of Ohio, Columbus, OH
Patricia Smith, President and CEO, Alliance of Community Health Plans, Washington, DC
Prentiss Taylor, MD, Regional Center Medical Director, Advocate Health Centers, Advocate Health Care, Chicago, IL

CHBRP Staff

Susan Philip, MPP, Director
Garen Corbett, MS, Principal Policy Analyst
David Guarino, Policy Analyst
John Lewis, MPA, Principal Policy Analyst
Karla Wood, Program Specialist

California Health Benefits Review Program
University of California
Office of the President
1111 Franklin Street, 11th Floor
Oakland, CA 94607
Tel: 510-287-3876 Fax: 510-763-4253
chbrpinfo@chbrp.org **www.chbrp.org**

The California Health Benefits Review Program is administered by the Office of Health Sciences and Services at the University of California, Office of the President, John D. Stobo, M.D., Senior Vice President – Health Sciences and Services.