CALIFORNIA
HEALTH BENEFITS REVIEW PROGRAM

EXECUTIVE SUMMARY
Analysis of Assembly Bill 1825: Maternity Services

A Report to the 2009-2010 California Legislature
April 16, 2010

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EXECUTIVE SUMMARY

California Health Benefits Review Program Analysis of Assembly Bill 1825

The California Health Benefits Review Program (CHBRP) undertook the analysis of Assembly Bill (AB) 1825 in response to a request from the California Assembly Committee on Health on February 12, 2010, pursuant to the provisions of Senate Bill 1704 (Chapter 684, Statutes of 2006) as chaptered in Section 127660, et seq. of the California Health and Safety Code. This report provides an analysis of the medical, financial, and public health impacts of AB 1825.

AB 1825, introduced by Assembly Member Hector De La Torre, would require health insurance policies regulated by the California Department of Insurance (CDI) to cover maternity services.[1] AB 1825 defines maternity services to include prenatal care, ambulatory care maternity services, involuntary complications of pregnancy, neonatal care, and inpatient hospital maternity care including labor and delivery and postpartum care. AB 1825 is similar to legislation introduced in prior sessions: AB 98 (2009), AB 1962 (2008), Senate Bill (SB) 1555 (2004), and SB 897 (2003). AB 98, AB 1962, and SB 1555 passed the Legislature during their respective sessions and were vetoed by the Governor.[2]

AB 1825 would apply only to CDI-regulated policies (primarily preferred provider organizations), which represent approximately 13% of privately funded insurance subject to California regulation. Health care service plans (including health maintenance organizations, point-of-service plans, and some preferred provider organizations) regulated by the Department of Managed Health Care (DMHC) make up the remaining portion of the privately funded, California-regulated market. Although DMHC-regulated plans constitute the majority of this market, which contains both the group and individual market segments, CDI-regulated policies represent a substantial portion of the *individual* market—about 60%.

Current laws and regulations governing DMHC-regulated health care service plans require coverage for maternity services under provisions related to "basic health care services." DMHC-regulated plans are required to cover maternity and pregnancy-related care under laws governing emergency and urgent care.[3] Regulations defining basic health care services specifically include prenatal care as preventive care that must be covered.[4] CDI-regulated policies currently have no such requirements.

The federal Civil Rights Act requires employers that offer health insurance and have 15 or more employees to cover maternity services benefits at the same level as other health care benefits.[5] Complications of pregnancy are generally covered regardless of whether the health insurance policy provides coverage for maternity benefits. Insurers are also required to cover newborns for

[1] AB 1825 would add Section 10123.865 to the California Insurance Code.
[2] The legislative history of AB 98, AB 1962, SB 1555, and SB 897 are available at www.leginfo.ca.gov. CHBRP conducted analyses of these bills and those reports are available at http://www.chbrp.org/completed_analyses/index.php.
[3] Section 1317.1 of the California Health and Safety Code
[4] Section 1300.67 of the California Code of Regulations, Title 28
[5] The Pregnancy Discrimination Act under Title VII of the Civil Rights Act of 1964

the first 30 days of life regardless of whether the health insurance policy covers maternity services.[6]

The bill's definition of maternity services is generally consistent with the definitions of maternity services under health insurance: prenatal care (such as office visits and screening tests), labor and delivery services (including hospitalization), care resulting from complications related to a pregnancy, and postpartum/postnatal care.

In 2008, the birth rate in California was 69.0 per 1,000 women of childbearing age (CDPH, 2008b). In 2006, the majority (85.9%) of births were to mothers who initiated prenatal care in the first trimester, with only 0.6% of women receiving no prenatal care (CDPH, 2008b). Overall in California, there are approximately 75 maternal pregnancy-related deaths and 3,000 infant deaths per year (CDPH, 2007b; MOD 2003-2005). Infant mortality is most frequently caused by birth defects (23.5% of deaths), followed by prematurity and low birth weight (15.6% of deaths), maternal complications of pregnancy (6.0% of deaths), and SIDS (5.2% of deaths) (CDPH, 2005). As will be discussed in further detail in the *Medical Effectiveness* section, specific prenatal care services can be effective in reducing the rate of preterm births, low–birth weight babies, transmission of infectious diseases, and other related infant and maternal morbidity and mortality.

Potential Effects of Federal Health Care Reform

On March 23, 2010, the federal government enacted the federal "Patient Protection and Affordable Care Act" (P.L.111-148), which was amended by the "Health Care and Education Reconciliation Act" (H.R.4872) that the President signed into law on March 30, 2010. These laws (referred to as P.L.111-148) came into effect after CHBRP received a request for analysis for AB 1825. There are provisions in P.L.111-148 that have effective dates of 2014 and beyond that would dramatically affect the California health insurance market and its regulatory environment. For example, the law would establish state-based health insurance exchanges with minimum benefit standards for the small-group and individual markets. How these provisions are implemented in California would largely depend on regulations to be promulgated by federal agencies, and statutory and regulatory actions to be undertaken by the California state government.

There are also provisions in P.L.111-148 that go into effect within the short term or within 6 months of enactment that would expand the number of Californians obtaining health insurance and their sources of health insurance. For example, one provision would allow children to enroll onto their parent's health plan or policy until they turn 26 years of age (effective 6 months following enactment). This may decrease the number of uninsured and/or potentially shift those enrolled with individually purchased insurance to group purchased insurance. These and other short-term provisions would affect CHBRP's baseline estimates of the number and source of health insurance for Californians in 2010. Given the uncertainty surrounding implementation of these provisions and given that P.L.111-148 was only recently enacted, the potential effects of these short-term provisions are not taken into account in the baseline estimates presented in this report. It is important to note that CHBRP's analysis of specific mandate bills typically address

[6] Insurance Code Section 10119 and Redlands Community Hospital v. New England Mutual (1994) 23 Cal. App. 4th 89

the marginal effects of the mandate bill—specifically how the state mandate would impact coverage, utilization, costs, and public health, holding all other factors constant.

Medical Effectiveness

The *Medical Effectiveness* and *Public Health Impacts* sections of this report focus on the outcomes associated with prenatal care services because (1) a majority of births occur in the hospital setting regardless of insurance status, (2) prenatal care services use would be most affected by the potential for out-of-pocket costs and thus most directly impacted by AB 1825, and (3) AB 1825 would not affect coverage for infants. The *Utilization, Cost, and Benefit Coverage Impacts* analysis includes the full range of services that are considered to be "maternity services."

Studies of prenatal care can be divided into two major groups:

- Studies of the impact of variation in the number of prenatal care visits that pregnant women receive, and
- Studies of the effectiveness of specific medical services provided to pregnant women (e.g., laboratory tests and medications).

Randomized controlled trials (RCTs) have consistently found no statistically significant association between the number of prenatal visits pregnant women receive and birth outcomes for either infants or for mothers. However, there is clear and convincing evidence from multiple RCTs that the following prenatal care services are effective in producing better birth outcomes for mothers and infants:

- Smoking cessation counseling
- Ultrasound to identify structural abnormalities and determine gestational age
- Folic acid to prevent neural tube defects
- Screening and treatment for asymptomatic bacteriuria
- Screening for hepatitis B
- Screening and treatment for human immunodeficiency virus
- Calcium supplements and aspirin for prevention of preeclampsia
- Magnesium sulfate for prevention of eclamptic seizures in women with preeclampsia
- Screening and prophylactic and therapeutic treatment for Rh(D) incompatibility
- Progestational agents to prevent preterm delivery
- Corticosteroids to promote maturation of lungs in fetuses scheduled for preterm delivery due to preeclampsia or other complications

- Magnesium sulfate to prevent neurological impairment in fetuses at risk for preterm delivery
- External cephalic version for breech presentation at term
- Membrane sweeping and induction of labor for prevention of postterm pregnancies

In addition, there is a preponderance of evidence from nonrandomized studies and/or a small number of RCTs that the following prenatal care services are effective:

- Screening for domestic violence
- Screening for Down syndrome, hemoglobinopathies, and Tay-Sachs disease
- Screening and treatment for chlamydia, gonorrhea, and syphilis
- Screening for group B streptococcus
- Screening and treatment for gestational diabetes
- Screening and treatment for bacterial vaginosis, trichomonas vaginalis, and Candida species to prevent preterm delivery
- Iron supplements for treatment of iron deficiency anemia
- Blood pressure monitoring to screen for hypertensive disorders
- Screening for atypical red blood cell alloantibodies other than Rh(D) incompatibility
- Ultrasound to diagnose placenta previa

Utilization, Cost, and Coverage Impacts

Current Coverage of Maternity Benefits

AB 1825 would apply only to CDI-regulated health insurance policies subject to the California Insurance Code. It would require all CDI-regulated policies to cover maternity services. About 2,438,000 Californians, or 13% of enrollees in health insurance plans and policies subject to state regulation, are in the CDI-regulated market.

CHBRP's survey of the largest health plans and insurers in the state indicates the following:

- *Entire CDI-regulated market*: Among the Californians who are estimated to be currently enrolled in CDI-regulated policies, 61% have coverage for maternity benefits, including prenatal care and delivery services. All enrollees have coverage for complications of pregnancy.

- *CDI-regulated policies in the large- and small-group insurance markets*: An estimated 100% of enrollees currently have maternity benefits. Therefore, the proposed mandate would impact only the enrollees in individual (non-group) CDI-regulated policies.

- *CDI-regulated policies in the individual (non-group) insurance market:* An estimated 18% of all enrollees and 19% of female enrollees aged 20 to 44 currently have maternity coverage.

    - Of those who do not currently have coverage for maternity services, about 25% are women of childbearing age (19 to 44).
    - There is evidence that risk segmentation has already had a substantial impact on the CDI-regulated individual market, because in a previous analysis of SB 1555 in 2004, CHBRP estimated that approximately 82% of those in the individual market had maternity benefits.

- *Public programs*: The Medi-Cal and Aid to Infants and Mothers (AIM) programs cover maternity services for women who qualify. Pregnant women who are in households with incomes less than or equal to 200% of the federal poverty level (FPL) generally qualify for Medi-Cal. AIM provides coverage for both uninsured and underinsured women between 200% and 300% of the FPL. AIM defines underinsured women as those with privately funded insurance who face out-of-pocket costs for maternity services greater than $500. CHBRP estimates that approximately 3,483 or 29% of women with privately funded insurance who will deliver babies during 2010 and have no maternity benefits when they become pregnant may qualify for Medi-Cal or AIM.

    - Based on data from AIM, there is evidence of current cost-shifting to that program. As of 2009, 1,433 or 9% of the women enrolled in AIM were simultaneously enrolled in privately funded health insurance policies that did not cover maternity services. Another 1,741 or 10% of AIM enrollees were enrolled in privately funded insurance policies that did cover maternity services.

    - CHBRP estimates that 12,172 or 3% of women enrolled in CDI-regulated policies with no maternity benefits at the time of pregnancy would give birth during 2010.

        - Of these women, CHBRP estimates that 2,666 would switch to Medi-Cal and another 817 would enroll in AIM following pregnancy. This is because their income eligibility would change following pregnancy (since pregnant women are considered a household of two and presumably their household income would not increase).

        - Another 391 of these women may transfer to policies covering maternity that are offered by their existing carrier.

        - The remaining 8,298 women would not have insurance coverage pre-mandate for their prenatal care and delivery.

<u>Post-mandate Benefit Coverage, Cost, and Utilization</u>

- AB 1825 would expand maternity services coverage to approximately 963,000 enrollees with CDI-regulated individual policies, including about 240,700 women aged 19 to 44 years.

- CHBRP estimates that there would not be a direct impact on Medi-Cal enrollment as a result of AB 1825. Those 2,666 women who currently have no maternity coverage and qualify for Medi-Cal after pregnancy would still shift to Medi-Cal post-mandate due to their income levels.

- There are 1,433 women enrolled in AIM who are currently enrolled in CDI-regulated individual policies that do not cover maternity services; these women would have maternity coverage post-mandate. However, the out-of-pocket cost of maternity services in those policies would likely still be greater than $500 (adding up deductibles and copayments), so those women would still qualify for AIM. As AIM would be the secondary payer if women retain their privately funded policies, there may be a shift of costs from AIM onto the private insurers, depending on whether AIM plans seek reimbursement from those insurers.

- CHBRP estimates that approximately 8,298 pregnancies would be newly covered under CDI-regulated insurance policies post-mandate. The impact of expanded benefit coverage on utilization is summarized below:

    - Overall, the mandate is estimated to have no impact on the number of deliveries, since the birth rate is not expected to change post-mandate.

    - Most women are likely to continue to face large out-of-pocket expenditures for maternity services regardless of whether or not their insurance policy includes maternity benefits. This is because about 70% of the women in CDI-regulated individual policies are currently in high-deductible health plans (HDHPs) and prenatal care is usually subject to an HDHP minimum annual deductible of $1,200 for individual plans and $2,400 for family plans as reported by the federal Internal Revenue Service (IRS). HDHPs generally do not exempt maternity/prenatal services from the high deductibles (KFF, 2007a), so a high level of cost sharing is required for maternity services. Even the women currently enrolled in non-HDHPs frequently face high cost-sharing requirements in the CDI-regulated individual market, and some might also choose to switch to HDHPs post-mandate in order to save on premiums.

    - Certain types of screening tests are not included in the standard prenatal care fee and might be used more frequently post-mandate if they are part of the maternity benefit, thereby affecting costs. The amount of the increase is difficult to estimate, as these tests would be subject to HDHP deductibles and women may treat them as out-of-pocket costs.

- Among all enrollees in state-regulated policies (both CDI-regulated and DMHC-regulated), total annual health expenditures are estimated to increase by $40 million, or 0.1%, as a result of this mandate ("Total Annual Expenditures" in Table 1). As the total number of deliveries and average cost associated with each delivery is not expected to increase, the mandate primarily shifts costs from individuals to insurers. CHBRP assumes that the administrative expenses for health policies would increase in proportion to the increase in their covered health care costs, leading to an estimated increase in overall expenditures. Note that the increase in total expenditures is a total of:

    - The increase in premium expenditures in the individual market: $120 million, or 2%, ("Premium expenditures for individually purchased insurance" in Table 1).

- The increase in out-of-pocket expenditures for maternity benefits covered by insurance (e.g., copayments and deductibles): $28.8 million, or 0.5%, ("Individual out-of-pocket expenditures for covered benefits" in Table 1).
- The reduction in out-of-pocket expenditures for maternity benefits not currently covered by insurance: $108.8 million ("Out-of-pocket expenditures for noncovered benefits" in Table 1).

- All of the costs of the mandate would be concentrated in the CDI-regulated individual market, where total expenditures are estimated to increase by 1% and premiums by 5% ("Total Expenditure" and "Insured Premiums", Table 5). Per member per month (PMPM) premiums are estimated to increase by an *average* of $8.48 in this market.
  - In 2009, California passed AB 119 into law prohibiting insurers from gender rating, or charging differential premiums based on gender for contracts issued, amended, or renewed on or after January 1, 2011. Therefore, the premium and cost calculations in this report assume all gender-rated policies would be converted to gender-neutral pricing prior to the implementation of AB 1825.
  - Insurance premiums in the individual market are stratified by age bands, so premiums are likely to increase more for younger individuals (particularly ages 19 to 29) than for older individuals (ages 30 to 64). CHBRP estimates that for the majority of individuals in the CDI-regulated individual market who do not currently have maternity benefits, AB 1825 would *increase* average premiums by 2% to 28% among those aged 19 to 44 years, depending on the age of the enrollee. Among the minority of individuals aged 19 to 44 years in the CDI-regulated individual market who currently have maternity benefits, AB 1825 is expected to *decrease* average premiums by 0.5% to 20%.
  - In addition to varying with age, premium changes could vary across policies. Post-mandate, women of a given age might self-select into policies with a high or low level of cost sharing based on their expected need for maternity care.

- The estimated premium increases may result in approximately 9,335 newly uninsured. It is likely that these newly uninsured would disproportionately consist of younger people, if they experience the greatest premium increases.

Public Health Impacts

- CHBRP is unable to estimate what the impact of AB 1825 would have on the utilization of prenatal care, but a range is provided. A lower bound estimate would assume that there would be no increase in the utilization of effective prenatal care services because these pregnant women would likely still face high out-of-pocket costs. An upper bound estimate would assume that all 8,298 newly covered pregnancies would have financial barriers to prenatal care removed and thus an increase in the utilization of effective prenatal care services would be expected. To the extent that AB 1825 increases utilization of effective prenatal care services, there is a potential that this mandate could lead to a reduction in infant

and maternal mortality and improve health outcomes, such as the rates of low birth weight or preterm births, infectious disease transmissions, and respiratory distress syndrome.

- Females enrolled in plans in the individual health insurance market without coverage for maternity benefits are currently paying $108.8 million out-of-pocket for noncovered maternity services. AB 1825 would shift these costs from female enrollees to increase premiums across both male and female enrollees. Therefore, this mandate would differentially reduce the out-of-pocket costs for female enrollees.

- Racial disparities in utilization of prenatal care exist in California, with black women utilizing prenatal care at lower rates. In addition, babies born to black women have poorer health outcomes, such as increased rates of preterm birth, low birth weight, and infant mortality. There is no evidence to suggest that AB 1825 would have an impact on prenatal care utilization rates among black women specifically, or reduce these disparities in health outcomes.

- In California, 10.9% of babies are born preterm and there are 3,000 infant deaths each year. It is estimated that each premature birth costs society approximately an average of $51,600. To the extent that AB 1825 increases the utilization of effective prenatal care that can reduce outcomes such as preterm births and related infant mortality, there is a potential to reduce morbidity and mortality and the associated societal costs.

- As a result of AB 1825, premiums in the CDI-regulated individual market are estimated to increase on average by approximately 4.7%, thus increasing the number of uninsured by approximately 9,335 people. Losing one's health insurance has many harmful consequences beyond the health outcomes presented in this analysis.

Table 1. SB/AB 1825 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	0%
Total enrollees with health insurance subject to AB 1825				
In large and small group plans	1,259,000	1,259,000	0	0%
In individual plans	1,179,000	1,179,000	0	0%
Total	2,438,000	2,438,000	0	0%
Percentage of enrollees with maternity coverage				
In large and small group plans	100%	100%	0%	0%
In individual plans	18%	100%	82%	446%
Total	61%	100%	39%	65%
Number of enrollees with coverage				
In large and small group plans	1,259,000	1,259,000	0	0%
In individual plans	216,000	1,179,000	963,000	446%
Total	1,475,000	2,438,000	963,000	65%
Utilization and Cost				
Number of enrollees with uncomplicated pregnancies				
Covered by insurance	19,041	27,339	8,298	44%
Covered by AIM or Medi-Cal	3,483	3,483	0	0%
Not covered by insurance	8,298	0	(8,298)	-100%
Total	30,822	30,822	0	0%
Average cost per uncomplicated delivery	$12,959	$12,959	$0	0%
Expenditures				
Premium expenditures by private employers for group insurance	$43,519,324,000	$43,519,324,000	$0	0%
Premium expenditures for individually purchased insurance	$5,992,795,000	$6,112,798,000	$120,003,000	2%
Premium expenditures by persons with group insurance, CalPERS HMOs, Healthy Families Program, AIM or MRMIP (b)	$12,820,614,000	$12,820,614,000	$0	0%
CalPERS HMO employer expenditures	$3,267,842,000	$3,267,842,000	$0	0%
Medi-Cal HMOs state expenditures	$4,015,596,000	$4,015,596,000	$0	0%
Healthy Families state expenditures (c)	$910,306,000	$910,306,000	$0	0%
Enrollee out-of-pocket expenses for covered benefits (deductibles, copayments, etc.)	$5,961,186,000	$5,989,966,000	$28,780,000	0.5%
Enrollee expenses for noncovered benefits	$108,756,000	$0	($108,756,000)	-100%
Total Annual Expenditures	$76,596,419,000	$76,636,446,000	$40,027,000	0.1%

Source: California Health Benefits Review Program, 2010.

Notes: (a) This population includes privately funded (group and individual) and publicly funded (e.g., CalPERS HMOs, Medi-Cal HMOs, Healthy Families Program, AIM, MRMIP) individuals enrolled in health insurance plans/policies 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) Premium expenditures by individuals include employee contributions to employer-sponsored health insurance and member contributions to public insurance. (c) Healthy Families Program state expenditures include expenditures for 7,000 persons covered by the Major Risk Medical Insurance Program (MRMIP) and 7,000 persons 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.

Acknowledgements

This report provides an analysis of the medical, financial, and public health impacts of Assembly Bill 1825, a bill to mandate the coverage of Maternity Services. In response to a request from the California Assembly Committee on Health on February 12, 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 Chris Tonner, MPH, all of the University of California, San Francisco, prepared the medical effectiveness analysis. Min-Lin Fang, MLIS, of the University of California, San Francisco, conducted the literature search. Helen Halpin, PhD, Sara McMenamin, PhD, and Alexis Muñoz, MPH, of the University of California, Berkeley, prepared the public health impact analysis. Robert Kaplan, PhD, Dasha Cherepanov, PhD, Tanya G. K. Bentley, PhD, and Yair Babad, PhD, all of the University of California, Los Angeles, prepared the cost impact analysis. Robert Cosway, FSA, MAAA, of Milliman, provided actuarial analysis. Alina Salganicoff, PhD, of the Kaiser Family Foundation, and Aaron Caughey, MD, PhD, of the University of California, San Francisco, provided technical assistance with the literature review and expert input on the analytic approach. Garen Corbett, MS, and Susan Philip, MPP, of CHBRP staff prepared the background section and synthesized the individual sections into a single report. Sarah Ordódy 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, Susan Ettner, PhD, of the University of California, Los Angeles, 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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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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