



**CALIFORNIA**  
HEALTH BENEFITS REVIEW PROGRAM

---

**EXECUTIVE SUMMARY**  
Analysis of Assembly Bill 1826:  
Pain Prescriptions

---

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

# **A Report to the 2009-2010 California State Legislature**

## **EXECUTIVE SUMMARY Analysis of Assembly Bill 1826: Pain Prescriptions**

**April 16, 2010**

**California Health Benefits Review Program  
1111 Franklin Street, 11<sup>th</sup> Floor  
Oakland, CA 94607  
Tel: 510-287-3876  
Fax: 510-763-4253  
[www.chbrp.org](http://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](http://www.chbrp.org).

**Suggested Citation:**

California Health Benefits Review Program (CHBRP). (2010). *Analysis of Assembly Bill 1826: Pain Prescriptions*. Report to California State Legislature. Oakland, CA: CHBRP. 10-03.

## EXECUTIVE SUMMARY

### California Health Benefits Review Program Analysis of Assembly Bill 1826

The California Senate Committee on Health requested on February 12, 2010, 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) 1826, a bill that would impose a health benefit mandate. AB 1826 would prohibit the use of fail-first protocols as methods of utilization management for pain medications covered through an outpatient pharmacy benefit by a health care service plan or health insurer subject to regulation by the California Department of Managed Health Care (DMHC) or the California Department of Insurance (CDI) unless the health insurance is purchased by the California Public Employees' Retirement System (CalPERS).

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 1826. There are provisions in P.L.111-148 that go into effect by 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 the marginal effects of the mandate bill—specifically how the state mandate would impact benefit coverage, utilization, costs, and public health, holding all other factors constant. CHBRP's estimates of these marginal effects continue to be relevant for the 12 months that would follow implementation of the mandate.

Approximately 19.5 million Californians (51%) have health insurance that may be subject to a health benefit mandate law passed at the state level (CHBRP, 2010). Of the rest of the population, a portion is uninsured, and therefore not affected by health insurance benefit mandate

laws. Others have health insurance not subject to health insurance benefit mandate laws. Uniquely, California has a bifurcated system of regulation for health insurance subject to state level benefit mandate law. The California Department of Managed Health Care (DMHC)<sup>1</sup> regulates health care service plans that offer coverage for benefits to their enrollees through health care service plan contracts. The California Department of Insurance (CDI) regulates health insurers<sup>2</sup> that offer coverage for benefits to their enrollees through health insurance policies.

AB 1826 would place requirements on DMHC-regulated health plan contracts and CDI-regulated policies—unless purchased by the California Public Employees’ Retirement System (CalPERS). Therefore, approximately 18.7 million Californians (49%) have health insurance that would be subject to this mandate.

AB 1826 would mandate that plans and policies providing outpatient pharmacy benefits provide coverage for medication prescribed by a participating licensed health care professional for the treatment of pain “without first requiring the subscriber or enrollee to use an alternative prescription or over-the-counter product.”

Throughout this report, CHBRP uses the phrase “fail-first protocols” to reference the heterogeneous group of utilization management techniques that would be prohibited by AB 1826 for pain medications.

Cost control and clinical considerations (e.g., proof of medication intolerance, prevention of use for unapproved indications, or adherence to clinical guidelines) are common reasons for plans and insurers to implement fail-first protocols.<sup>3</sup>

Fail-first protocols may be implemented as methods of utilization management, in a variety of ways and are known by a number of terms. *Step therapy* requires an enrollee to try a first-line medication (often a generic alternative) prior to receiving coverage for a second-line medication (often a brand name medication). *Step edit* is a process by which a step-therapy prescription, submitted for payment authorization, is electronically reviewed at point of service for use of a prior, first-line medication. For either step therapy or step edit, upon decline of coverage for the prescription, a patient’s health care provider may reissue the prescription for a first-line agent covered by the patient’s plan contract or policy or appeal the decision. Alternatively, the patient may purchase the prescription at full-cost. A fail-first protocol may also be the basis for part or all of a *pre-certification* or *prior authorization* protocol, which may also require the prescriber to confirm to the plan or insurer that an alternate medication or medications have been unsuccessfully tried by the patient before the prescriber’s preferred medication is covered. However, not all prior authorization protocols have a fail-first component. Some prior authorization protocols are based on other criteria, such as intended use to treat a specific

---

<sup>1</sup> The DMHC was established in 2000 to enforce the Knox-Keene Health Care Service Plan of 1975; see Health and Safety Code, Section 1340.

<sup>2</sup> The 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.

<sup>3</sup> Personal communication with content experts M. Durham and D. Stern.

medical problem or diagnosis or confirmation that the patient meets other criteria such as age or specified comorbidities. Some, but not all, *generic or therapeutic substitution* protocols may be subject to AB 1826. AB 1826 would not affect a formulary that includes only a generic medication and not its brand-name equivalent. However, AB 1826 would prohibit generic substitution when used as part of a fail-first protocol that explicitly requires the use of a generic before another medication (e.g., a specific brand-name version of the generic medication) within the formulary is covered.

Prescription medications may be covered through an enrollee's medical benefits or through an outpatient pharmacy benefit if the enrollee's plan contract or policy includes an outpatient pharmacy benefit. Medications consumed during an inpatient hospital stay are generally covered by an enrollee's medical benefit. Similarly, medications consumed during a visit to a provider's office—like many injected and intravenous anticancer medications—may be covered by an enrollee's medical benefit. However, because fail-first protocols generally are not used as methods of utilization management for medications covered through a medical benefit, this analysis is focused on pain medications covered through outpatient pharmacy benefits.

This analysis assumes that AB 1826 would not increase the number of enrollees with an outpatient pharmacy benefit. All health insurance regulated by the DMHC or CDI must cover prescription medications delivered during a hospital stay. Therefore, the language of the bill, which addresses plans and policies covering prescription medications, could be interpreted as requiring all plans and all policies (even those without an outpatient pharmacy benefit) to cover prescribed pain medication (effectively expanding coverage for pain medications). However, regulators are likely to consider legislative intent when interpreting a mandate,<sup>4</sup> and such an expansion of benefit coverage is not the intent according to the preamble provided by the Legislative Counsel's Office included in the introduced version of AB 1826.

Therefore, CHBRP's analysis assumes that the bill would prohibit only fail-first protocols as a method of utilization management, but would not expand coverage for pain medications or require coverage of medications not in the plan's or insurer's existing drug formulary. However, it should be noted that the language of the bill is not clear on this point.

It is important to note that physicians and other providers would not be subject to AB 1826. The bill, as a health insurance benefit mandate, would affect health plans and health insurers, not providers. Although providers, independent of plan/policy protocols, may direct a patient to try any number of alternate medications before prescribing a particular pain medication, provider prescribing practice would not be subject to the bill's mandate.

No current California mandate requires an outpatient pharmacy benefit to cover prescription medications. No current California mandate prohibits use of fail-first protocols with prescription medications.

CHBRP found no mandates current in other states prohibiting the use of fail-first protocols with prescription medications.

---

<sup>4</sup> Personal communication with S. Lowenstein, DMHC.

## Medical Effectiveness

Because of the heterogeneity of causal conditions and types of pain (acute and chronic), there is no standard treatment for pain. Pain treatment varies according to type, severity, and duration of pain, as well as the causal condition (if known), patient comorbidities, and other factors (e.g., medication intolerance or patient compliance). Health care providers use clinical judgment to select among various pain medications and treatments in efforts to resolve or control pain for individual patients.

As described in the introduction, CHBRP uses the phrase “fail-first protocols” to reference a heterogeneous group of utilization management techniques that would be prohibited by AB 1826 for pain medications. For some enrollees, no pain medications are subject to fail-first protocols. Other enrollees, depending on the provisions of their plan contracts or insurance policies, have outpatient pharmacy benefits that make coverage for between 1 and 38 pain medications subject to fail-first protocols.<sup>5</sup> It is possible that two enrollees with plan contracts from a single health plan (or policies from a single insurer) might not have outpatient pharmacy benefits for pain medications that are subject to the same list of fail-first protocols—or one of them might not be subject to any list at all.

Of more than 200 prescription medications used to treat pain, 54 are subject to fail-first protocols for at least some portion of enrollees with health insurance subject to AB 1826 whose health insurance includes an outpatient pharmacy benefit. However, among the 54 medications identified, there is variation in frequency of medications subject to fail-first protocols: two medications are present on four fail-first protocol lists; two medications are present on three lists, 12 medications are on two lists (but not all 12 are present on a single list), and each of the remaining 38 medications is on one list.

In the use of fail-first protocols as methods of utilization management for coverage of pain medications through outpatient pharmacy benefits, there appears to be no pattern among DMHC-regulated health plans and CDI-regulated insurers. Not all enrollees have benefit coverage subject to fail-first protocols for pain medications. No single pain medication appears on all fail-first protocol lists. No particular class of drugs appears on all fail-first protocol lists. Due to this heterogeneity, CHBRP did not review comparative-effectiveness studies for particular pain medications.

The medical effectiveness portion of this analysis considers the question: “*As methods of utilization management, do fail-first protocols for pain medications affect health outcomes, such as pain control or quality of life?*”

- CHBRP found no medical effectiveness literature addressing the *direct* effects of fail-first protocols on resolving or controlling pain.

---

<sup>5</sup> The carrier-submitted fail-first protocol lists were not always limited to pain medications. Each submission was reviewed by the pharmacist content expert, Melissa Durham, PharmD, and culled as appropriate. The list was further reviewed and culled to ensure the medication was subject to the fail-first protocols protocol addressed in AB 1826. A second request asked carriers to clarify ambiguous language and to verify the accuracy of the reviewed and culled list. Clarified responses were incorporated accordingly into the fail-first protocol lists.

- A single small study looked at quality of life in relation to fail-first protocols and found no evidence of effect.
  - CHBRP found two studies reporting little or no effect on medical service utilization (an *indirect* health outcome for effectiveness of pain control) among state Medicaid populations following implementation of prior authorization protocols for non-steroidal anti-inflammatory drugs, a class of drugs commonly used to treat pain. Study limitations include small sample size, use of weaker study methodologies, limited generalizability of study populations, and lack of direct health outcome measures.
  - The remaining studies of fail-first protocols focused on drug classes unrelated to pain medications and on cost-effectiveness rather than clinical endpoints. All study authors recommended that future studies of fail-first protocols include clinical and quality of life endpoints.
- CHBRP finds insufficient evidence to characterize the medical effectiveness of fail-first protocols for pain medications. Therefore, CHBRP concludes that the impact of AB 1826 on the medical effectiveness of pain treatment is unknown. The lack of evidence for the effectiveness of fail-first protocols is not evidence that these protocols produce either positive or negative health outcomes.

### **Utilization, Cost, and Coverage Impacts**

Table 1 summarizes the estimated benefit coverage, utilization, and cost impacts of AB 1826.

This analysis is focused on pain medications covered through an outpatient pharmacy benefit. Although pain medications can be covered through a medical benefit (as is the case, for example, during a hospital admission), the fail-first protocols prohibited by AB 1826 generally affect coverage of pain medications when coverage is provided through an outpatient pharmacy benefit.

In Table 1 and throughout this report, the terms “cost” and “costs per prescription” are used. Cost is the total of amount paid by health plans/insurers and enrollees, unless otherwise noted in the text. Cost per prescription is the average cost for a 30-day supply of the prescribed medication, as paid by the health plan or insurer and the enrollee (through any applicable cost sharing).

Due to the heterogeneity of fail-first protocol lists, a select set of brand-name pain medications present on at least one list was generated for use in the cost and utilization analysis. Cost is not the only possible cause for a medication to be on a fail-first protocol list. However, the cost analysis focused on the select set of brand name medications that make up 84% of the total cost of pain medications that appear on at least one fail-first protocol list.

## Outpatient Pharmacy Benefit Coverage

Not all enrollees subject to AB 1826 have an outpatient pharmacy benefit. Of those who do, not all have outpatient pharmacy benefit coverage for pain medications that is subject to any fail-first protocol. Among enrollees whose benefit coverage is subject to one or more fail-first protocols, there is a great deal of variation, depending on the provisions of the enrollee's plan contract or policy, as to which or how many pain medications are on a fail-first protocol list. Benefit coverage is described below.

- 18,667,000 enrollees in DMHC-regulated health plans or CDI-regulated policies have health insurance subject to AB 1826.
  - 18,146,000 (97.2%) enrollees have outpatient pharmacy benefit coverage. Benefit coverage details for these enrollees is as described below:
    - 8,258,000 (45.5%) have benefit coverage subject to fail-first protocols for one or more pain medications.
    - 8,950,000 (49.3%) have benefit coverage not subject to fail-first protocols and so would not be affected the mandate.
    - 417,000 (2.2%) have generic-only outpatient pharmacy benefit coverage and would not be affected by the mandate because generic medications are not generally present on fail-first protocol lists.<sup>6</sup>
  - 521,000 (2.8%) enrollees do not have outpatient pharmacy benefit coverage and so would not be affected by AB 1826.

## Utilization

- Prescriptions for identified FDA-approved medications commonly used for pain (generic and brand-name) are estimated to be 610 per 1,000 enrollees per year. AB 1826 is not expected to measurably affect this number because outpatient pharmacy benefit coverage is not expanded by this mandate and the mandate is not expected to result in an increase in diagnosis or treatment of pain.
- AB 1826 is expected to affect the percentage make up of filled pain prescriptions in terms of generic versus brand name medications. Premandate, generic pain medications are estimated to be 88% of all filled pain prescriptions and brand-names about 12%. Postmandate, the percentage of generic medications would decrease and there would be an increase in the percentage of brand-name medications previously subjected to fail-first protocols. Pain medications formerly on fail-first protocol lists, predominantly brand name medications, would become a greater percentage of filled prescriptions and there would be a concomitant decrease in prescriptions for the alternative medications the protocols had indicated should be tried first.

---

<sup>6</sup> Personal communication with content experts M. Durham and D. Stern.

- The cost and utilization analysis focuses on a select set of brand-name medications in order to assess the cost impacts of AB 1826, but the impact of the mandate would be similar for other pain medications that had previously been on a fail-first protocol list.

## Costs

- Total annual expenditures are estimated to increase by \$27.7 million or 0.0363% due to increases in premiums and enrollee out-of-pocket expenditures resulting from the increase in the average cost per prescription for pain medications. The restriction of fail-first protocols is expected to increase the number of more expensive brand-name pain medications as a percentage of all prescriptions for pain. Premandate, it is estimated that brand-name medications are only 12% of all pain prescriptions but make up 54.5% of total cost. These percentages are expected to increase postmandate.
- The average cost per prescription associated with the select set of pain medications on at least one fail-first protocol list is projected to increase \$30 or 14% due to the higher percentage of more expensive, brand-name pain prescriptions being filled. The premandate average includes a blend of the select set of brand name pain medications and their generic alternatives. The postmandate average reflects the select set alone. Therefore, the postmandate increase in average cost per prescription reflects the decrease in generic and increase in brand-name medications. The per-unit cost of the medications themselves is not expected to increase.
- Enrollee out-of-pocket expenses for covered benefits are expected to increase by \$3.19 million or 0.0535 % due to the increased use of the select set of brand-name pain medications, many of which are subject to higher cost sharing requirements than are their alternatives that a fail-first protocol would have indicated.
- AB 1826 is estimated to increase insurance premiums. The distribution of the impact on premiums is as follows:
  - Total premiums for private employers purchasing group health insurance are estimated to increase by \$9.33 million, or 0.0214%.
  - Enrollee contributions toward premiums for group insurance regulated by the DMHC or CDI are estimated to increase by \$2.97 million, or 0.0232%.
  - Total premiums for purchasers of individual market health insurance are estimated to increase by \$2.04 million, or 0.0340%.
  - Total employer premium expenditures for CalPERS HMOs would not increase, because AB 1826 exempts CalPERS from the mandate.
- State expenditures for Medi-Cal HMOs are estimated to increase by \$8.12 million or 0.2023%.

- State expenditures for the Healthy Families Program, the Aid to Infants and Mothers (AIM) program, and the Major Risk Medical Insurance Program (MRMIP) are estimated to increase by \$2.10 million or 0.2310 %.

#### Impact on the Number of Uninsured Persons

- CHBRP estimates no measurable impact of the mandate on the number of uninsured persons.

#### **Public Health Impacts**

- Pain is a prevalent condition in the U.S. population, with approximately 26% of adults experiencing chronic pain (i.e. pain lasting 6 months or longer). Pain varies widely in its presentation and duration and is caused by a wide array of known and unknown origins.
- Although there is some evidence that fail-first protocols can lead to lower levels of patient satisfaction, delays in receiving medications, and higher rates of unfulfilled prescriptions, this research is not generalizable to populations outside of those studied. Therefore, the public health impact of AB 1826 is unknown.
- CHBRP did not identify any literature that examined the relationship between fail-first protocols and gender or race/ethnicity. In addition, CHBRP does not know the extent to which AB 1826 would impact people of different genders or racial/ethnic groups differentially. Therefore, the impact of AB 1826 on gender and racial/ethnic disparities in pain management is unknown.
- Pain conditions are known to be relevant factors in terms of lost productivity and associated economic loss through days missed from work, as well as reduced ability to perform tasks at work. No research was identified that assessed the impact of fail-first protocols for pain medications on measures of productivity. Therefore, the impact of AB 1826 on lost productivity and economic loss associated with conditions requiring the use of pain medications is unknown.

**Table 1. AB 1826 Impacts on Benefit Coverage, Utilization, and Cost, 2010**

	Before Mandate	After Mandate	Increase/ Decrease	Change After Mandate
<b>Benefit Coverage</b>				
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 1826	18,667,000	18,667,000	0	0%
Percentage of enrollees with outpatient pharmacy benefit	97.2%	97.2%	0.0%	0%
Percentage of enrollees with outpatient pharmacy benefit coverage subject to fail-first protocols	45.5%	-	45.5%	-100%
Percentage of enrollees with outpatient pharmacy benefit coverage NOT subject to fail-first protocols	49.3%	97.2%	49.3%	103%
Percentage of enrollees with generic-only outpatient pharmacy coverage (not affected by fail-first protocols)	2.2%	2.2%	0.0%	0%
Percentage of enrollees with NO outpatient pharmacy benefit (not affected by fail-first protocols)	2.8%	2.8%	0.0%	0%
Number of enrollees with outpatient medication coverage	18,146,000	18,146,000	0	0%
Number of enrollees with outpatient benefit coverage subject to fail-first protocols	8,258,000	-	8,258,000	-100%
Number of enrollees with outpatient benefit coverage NOT subject to fail-first protocols	8,950,000	18,146,000	9,196,000	103%
Number of enrollees with generic-only outpatient pharmacy benefit coverage	417,000	417,000	0	0%
Number of enrollees with NO outpatient pharmacy benefit coverage	521,000	521,000	0	0%
<b>Utilization and Cost</b>				
Number of pain prescriptions per 1,000 enrollees per year	610	610	0	0%
Average cost per prescription associated with a select set of brand name prescription medications on at least one fail-first protocol list (c)	\$215	\$244	\$30	14%

**Table 1. AB 1826 Impacts on Benefit Coverage, Utilization, and Cost, 2010 (Cont'd)**

	<b>Before Mandate</b>	<b>After Mandate</b>	<b>Increase/ Decrease</b>	<b>Change After Mandate</b>
<b>Expenditures</b>				
Premium expenditures by private employers for group insurance	\$43,519,324,000	\$43,528,652,000	\$9,328,000	0.0214%
Premium expenditures for individually purchased insurance	\$5,992,795,000	\$5,994,830,000	\$2,035,000	0.0340%
Premium expenditures by persons with group insurance, CalPERS HMOs, Healthy Families Program, AIM or MRMIP (b)	\$12,820,614,000	\$12,823,585,000	\$2,971,000	0.0232%
CalPERS HMO employer expenditures (d)	\$3,267,842,000	\$3,267,842,000	\$0	0.0000%
Medi-Cal HMOs state expenditures	\$4,015,596,000	\$4,023,718,000	\$8,122,000	0.2023%
Healthy Families Program state expenditures (e)	\$910,306,000	\$912,409,000	\$2,103,000	0.2310%
Enrollee out-of-pocket expenses for covered benefits (deductibles, copayments, etc.)	\$5,961,186,000	\$5,964,374,000	\$3,188,000	0.0535%
Enrollee expenses for noncovered benefits (f)	-	-	-	-
<b>Total Annual Expenditures</b>	<b>\$76,487,663,000</b>	<b>\$76,515,410,000</b>	<b>\$27,747,000</b>	<b>0.0363%</b>

Source: California Health Benefits Review Program, 2010.

Notes: (a) This population includes persons enrolled in privately funded (group and individual) and publicly funded (e.g., CalPERS HMOs, Medi-Cal HMOs, Healthy Families Program, AIM, MRMIP) 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 beneficiary contributions to public insurance.

(c) The premandate average includes a blend of the select set of brand name pain medications and their generic alternatives. The postmandate average reflects the select set alone. Therefore, the postmandate increase in average cost per prescription reflects the decrease in generic and increase in brand-name medications. The per-unit cost of the medications themselves is not expected to increase.

(d) AB 1826 exempts CalPERS from the mandate. Were CalPERS to be subject to the mandate, about 58% of the identified CalPERS expenditures would be for CalPERS HMO enrollees who are state employees.

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

(f) CHBRP is unable to estimate relevant over-the-counter medication expenses, prescription medication expenses for enrollees with no outpatient pharmacy benefit, or prescription medication expenses for enrollees with an outpatient pharmacy benefits whose prescription would not have been covered (premandate) due to a fail-first protocol.

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 (AB) 1826 (Huffman) Pain Prescriptions. 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. Joy Melnikow, MD, MPH, Stephen McCurdy, MD, MPH, and Dominique Ritley, MPH, all of the University of California, Davis, prepared the medical effectiveness analysis. Bruce Abbott, MLS, of the University of California, Davis, conducted the literature search. Helen Halpin, ScM, PhD, Sara McMenamin, PhD, and Nicole Bellows, PhD, all of the University of California, Berkeley, and Alexis Muñoz, MPH, of the University of California, San Diego, prepared the public health impact analysis. Ying-Ying Meng, DrPH, and Lori Uyeno, MD, both of the University of California, Los Angeles, prepared the cost impact analysis. Jay Ripps, FSA, MAAA, and Susan Pantely, FSA, MAAA, of Milliman, provided actuarial analysis. Melissa Durham, PharmD, of the University of Southern California, and Debbie Stern, RPh, of Rxperts, provided technical assistance with the literature review and expert input on the analytic approach. John Lewis, MPA, and Susan Philip, MPP, both 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, Kathleen Johnson, PharmD, MPH, PhD, of the University of Southern California, 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, 11<sup>th</sup> Floor**  
**Oakland, CA 94607**  
**Tel: 510-287-3876**  
**Fax: 510-763-4253**  
[www.chbrp.org](http://www.chbrp.org)

All CHBRP bill analyses and other publications are available on the CHBRP Web site, [www.chbrp.org](http://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 L. 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  
\* Professor Yelin recused himself from participation or review of this analysis.

### 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 Muñoz, 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, 11<sup>th</sup> Floor**

**Oakland, CA 94607**

**Tel: 510-287-3876 Fax: 510-763-4253**

**[chbrpinfo@chbrp.org](mailto:chbrpinfo@chbrp.org) [www.chbrp.org](http://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.