CALIFORNIA
HEALTH BENEFITS REVIEW PROGRAM

EXECUTIVE SUMMARY
Analysis of Assembly Bill 1904: Out-of-State Carriers

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

CHBRP 10-04

A Report to the 2009-2010 California State Legislature

EXECUTIVE SUMMARY
Analysis of Assembly Bill 1904: Out-of-State Carriers

April 16, 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 1904: Out-of-State Carriers.* Report to California State Legislature. Oakland, CA: CHBRP. 10-04.

EXECUTIVE SUMMARY

California Health Benefits Review Program Analysis of Assembly Bill 1904

The California Assembly Committee on Health requested on February 16, 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) 1904. This bill would repeal all existing state health benefit mandates for carriers domiciled in another state which would be allowed to offer, sell, or renew a health plan or insurance policy in California without holding a license issued by the California Department of Managed Health Care (DMHC) or without a certificate of authority issued by the Insurance Commissioner. The bill would exempt the carrier's plan contract or policy from requirements otherwise applicable to plans and insurers providing health care coverage in this state if the plan contract or policy complies with the domiciliary state's requirements, and the carrier is lawfully authorized to issue the plan contract or policy in that state and to transact business there. In response to this request, CHBRP undertook this analysis pursuant to the provisions of the program's authorizing statue.

Potential Effects of 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 further 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 1904.

There are provisions in P.L.111-148 that go into effect by 2014 and afterwards that would dramatically affect the California health insurance market and its regulatory environment. These major long-term provisions of P.L.111-148 would require that most U.S. citizens and qualified legal residents have health insurance and that large employers offer health insurance coverage or a tax-free credit to their employees. Of particular relevance to the analysis of AB 1904, P.L.111-148 would establish state-based health insurance exchanges for the small-group and individual markets. Subsidies for low-income individuals would be available to purchase into the exchanges. How these provisions are implemented in California will 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 short-term provisions in P.L.111-148 that go into effect within 6 months of enactment that would expand the number of Californians obtaining health insurance and their sources of health insurance. Some of these provisions include:

- Children up to the age of 26 years will be allowed to enroll in their parent's health plan or policy (effective 6 months following enactment). This provision may decrease the number of uninsured and/or potentially shift those enrolled with individually purchased insurance to group purchased insurance.

- Denials to offer health insurance due to preexisting conditions will be prohibited (effective 6 months following enactment). This provision may decrease the number of uninsured, or shift enrollment in California Children Services or Healthy Families to those with privately purchased health insurance.

- A temporary high-risk pool for those with preexisting conditions will be established (effective 90 days following enactment). How California chooses to implement this provision would have implications for health insurance coverage for those high-risk individuals who are currently without health insurance and/or are on California's Major Risk Medical Insurance Plan (MRMIP).

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 Federal Health Care Reform 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. Further information on the provisions of Federal Health Care Reform that would alter the California health insurance market and have relevance to AB 1904 is contained in this analysis.[1]

The Impact of Allowing Limited-Mandate Plans to Compete in the California Market

Medical Effectiveness

CHBRP's assessment of the medical effectiveness of the preventive, diagnostic, and treatment services for which coverage is mandated under current law draws upon its previous reports on AB 1214 and SB 92. The report on AB 1214 summarized evidence regarding the medical effectiveness of 31 of the 44 mandates that were in force in 2007. This evidence was summarized a second time in CHBRP's report on SB 92, along with evidence regarding two additional mandates that were signed into law in 2008. The current report presents evidence contained in the previous reports along with evidence regarding the effectiveness of services to which a new mandate enacted in 2009 applies. Thirteen mandates were not analyzed because they do not require coverage for specific diseases or health care services, require coverage for a vaccination that has yet to be approved by the Food and Drug Administration (i.e., AIDS vaccine), or apply to such a large number of diseases that the evidence cannot be summarized briefly (e.g., off-label use of prescription drugs).

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

[1] Please see the section titled "Other Considerations Related to the Potential Impacts of AB 1904."

The amount and strength of the evidence regarding the medical effectiveness of the services for which coverage may be excluded under AB 1904 varies. The outcomes that are most important for assessing effectiveness also differ.

Nevertheless, many of the mandates and mandated offerings addressed by AB 1904 require health insurance products to provide coverage for health care services for which there is strong evidence of effectiveness.

Findings regarding the medical effectiveness of specific health care services for which coverage could be excluded under AB 1904 are as follows:

- There is *clear and convincing evidence* from multiple, well-designed randomized controlled trials (RCTs) that the following tests and treatments *are medically effective*: cancer screening tests for breast, cervical, and colorectal cancers; screening tests for the human immunodeficiency virus (HIV); diagnostic procedures and treatments for breast cancer; medications, services, and supplies for diabetes management; services for the diagnosis and treatment of osteoporosis; medication and psychosocial treatments for severe mental illness and alcoholism; some preventive services for children and adolescents; prescription contraceptive devices; diagnosis and treatment of infertility; and home care services for elderly and disabled adults.

- A *preponderance of evidence* from nonrandomized studies and/or RCTs with major weaknesses indicates that the following tests and treatments *are medically effective*: liver and kidney transplantation services for persons with HIV; medical formulas and foods for persons with phenylketonuria; prosthetic devices; orthotic devices for some conditions; special footwear for persons with rheumatoid arthritis; acupuncture; pain management medication for persons with terminal illnesses; pediatric asthma management services; prenatal diagnosis of genetic disorders; expanded alpha-fetoprotein screening; and surgery for the jawbone and associated bone joints.

- The evidence of effectiveness is *ambiguous* for prosthetic devices used by persons who have had a laryngectomy; special footwear for persons with diabetes; breast reconstruction surgery following mastectomy; and hospice care.

- There is *insufficient evidence* to determine whether the following tests and treatments are effective: tests for screening and diagnosis of lung cancer, oral cancer, and skin cancer; orthotic devices for some conditions; general anesthesia for dental procedures; screening the blood lead levels of children at increased risk for lead poisoning; orthodontic services for persons with oral clefts; reconstructive surgery for clubfoot and craniofacial abnormalities; and home care for children. *The term "insufficient evidence" indicates that available evidence is not sufficient to determine whether or not a health care service is effective. It is used when no research studies have been completed or when only a small number of poorly designed studies are available. It is not the same as "evidence of no effect." A health care service for which there is insufficient evidence might or might not be found to be effective if more evidence were available.*

- There is *insufficient evidence* to determine whether longer lengths of inpatient stays are associated with better outcomes for females who have a mastectomy or lymph node dissection, or whether prohibiting insurers from excluding coverage for illnesses or injuries due to an insured being intoxicated or under the influence of a controlled substance (unless prescribed by a physician) increases the provision of screening and counseling for alcohol and substance abuse. *Again, insufficient evidence may or may not mean that a treatment would be found to have no effect if more evidence were available.*

- A *preponderance of evidence* from nonrandomized observational studies indicate that screening for bladder cancer, ovarian cancer, pancreatic cancer, and testicular cancer, and screening the blood lead levels of children at average risk for lead poisoning are *not medically effective*.

- Findings from two recently published RCTs suggest that using the prostate specific antigen test (PSA) to screen asymptomatic men for prostate cancer *has no or a very small effect on prostate cancer-specific mortality.*

Potential Cost and Coverage Impacts of AB 1904

This section addresses the issue of the added costs of California health insurance benefit mandates on the entire market by summarizing the existing literature and expert opinion on the premium savings associated with limited-mandate plans sold across state lines. (For the purposes of this analysis, "limited-mandate plans" are defined as those plans covering specific benefits that evidence suggests would continue to be covered in health insurance markets absent the legal requirement to do so). In addition, three hypothetical scenarios presenting a potential maximum, low-impact, and very low-impact cost estimate are provided because of the uncertainty of how insurers would respond were AB 1904 enacted.

- Limited-mandate plans would be expected to exclude coverage for some benefits required by California state law, or change the scope of coverage for some benefits, such as annual or life-time benefit limits or cost-sharing. While individual benefit mandates typically raise premiums by less than 1%, the cumulative annual cost of the state's mandated benefits is between 5% and 19% of the total premium for the health insurance product. Studies of the *marginal* cost of benefit mandates (i.e., the cost of the benefit minus the cost of the benefit that would be covered in the absence of the legal requirement imposed by the mandate) indicate that the marginal costs are lower than the total cumulative annual costs, ranging from 2% to 5% of premiums.

- Potential market responses include the following:

    - In-state carriers may move their base or "domicile" to another state if they consider it advantageous to compete with other carriers that offer products not subject to California regulations in the group market. It is not clear how quickly California's largest insurers, which are for-profit (with the exception of Kaiser Foundation Health Plan and Blue Shield of California), might establish out-of-state domiciles in order to offer limited-

mandate policies in California. Blue Cross and Blue Shield Plans, for example, are not allowed to compete in the same market per Blue Cross and Blue Shield Association rules.

- Out-of-state carriers who hold a license from the DMHC or certificate of authority from the CDI would be able to sell their limited-mandate policies after the passage of AB 1904. These carriers would likely choose to sell products in California that would be most competitive in the small employer group market and the individual market. Policies by out-of-state carriers may tend to be lower in cost than policies by in-state carriers because presumably carriers would elect to be domiciled in a state with minimal insurance requirements, regulatory review, or oversight. Still, the deep discounts of the in-state Blue Cross and Blue Shield Plans and combined low provider price/high utilization management of Kaiser Permanente will continue to provide lower premiums. Out-of-state carriers that currently have a presence in California (i.e., currently have contracts with providers and already have a share of enrollment) would be well-positioned to develop, market, and sell out-of-state policies under AB 1904.
- Out-of-state carriers not currently licensed in California would be permitted to sell limited-mandate policies after the passage of AB 1904. These carriers may not have the same market presence and ability to obtain advantageously priced contracts with providers in the same way carriers that already have a presence in California are able to, especially for managed care products, which tend to offer comprehensive benefits with defined provider networks. In-state carriers are able to negotiate substantial discounts with provider networks because of such factors as the number of beneficiaries they may bring to the providers, their experience in negotiating with specific provider networks and vice versa, and because of economies of scale in administration of arrangements between health plans and provider networks.

- Three hypothetical scenarios presenting a potential maximum, low-impact, and very low-impact cost estimate are provided because of the uncertainty of how insurers would respond were AB 1904 enacted. In this analysis, Scenario 1 assumes that out-of-state carriers would have an immediate impact on all market segments. Scenario 2 assumes that out-of-state carriers would have a limited impact on the low-income segment, below 350% of the 2010 Federal Poverty Level (FPL), enrolled in the individual market only. Scenario 3 assumes that out-of-state carriers would have a more limited impact on the very low-income segment, below 200% of the Federal Poverty Level (FPL), enrolled in the small groups and individual markets. Under all the scenarios, people who are currently uninsured but will purchase insurance following the passage of AB 1904, are assumed to purchase the cheapest available plans. Specifically:

  - **Scenario 1: Maximum Impact.** This extreme hypothetical scenario assumes that limited-mandate plans would be purchased by all (i.e., 100%) currently insured Californians in lieu of their current plans. Buyers in all market segments (large group, small group, and individual) and all insurance products (high-deductible, low-deductible, and no-deductible policies) would respond to the lower premiums offered by limited-mandate policies, and would switch to those policies in response to a lower-cost alternative. This scenario projects the impacts of all currently insured persons purchasing policies that are otherwise identical to their current policies, except without a subset of the benefit mandates. This scenario represents the most extreme possible response and

should be considered an absolute upperbound. The probability of this scenario occuring is small; therefore, we also analyzed the sensitivity of this scenario, by varying the percentage of insured Californians that would switch from their current plans to limited-mandate plans.

- **Scenario 2: Low Income Impact.** Because of evidence that employees in the group market prefer generous benefits, and because there is evidence that those in the individual market are the most price-sensitive, this scenario assumes that limited-mandate policies would have an impact only on the price-sensitive segment of the individual market. However, in contrast to Scenario 1, where it is assumed that all the plan participants will switch over, and based on actuarial experience demonstrating take-up by only part of the considered population, this scenario also assumes that only 40% of all those insured in this market segment with incomes below 350% of the FPL ($37,905 for a single person, $77,175 for a family of four) who now own the least expensive individual policies in the DMHC and CDI-regulated segment of the market currently available, will purchase limited-mandate plans. The data from California Health Interview Survey (CHIS) 2007 indicates that about 38% of those insured in the individual market have incomes below 350% of the FPL; thus this scenario assumes that about 16% of the individual market participants will switch to limited-mandate plans. This scenario falls within the range of possibility were AB 1904 enacted.
- **Scenario 3: Very Low Income Impact.** This scenario is similar to Scenario 2, and assumes that limited-mandate policies would only have an impact on the most price-sensitive segment of the individual and small-group markets. This scenario also assumes that 40% of all those currently insured in the individual market segment with incomes below 200% of the FPL ($21,660 for a single person, $44,100 for a family of four) who currently own DMHC and CDI-regulated individual policies, and 20% of the small group segment with incomes below 200% of the FPL, will purchase limited-mandate plans. The data from CHIS 2007 indicates that about 17.5% of those insured in the small-group and individual markets have incomes below 200% of the FPL; as in Scenario 2, only some of these individual market participants will switch to limited-mandate plans. This scenario falls within the range of possibility were AB 1904 enacted.

- Using the aforementioned scenarios, CHBRP estimates that the potential impact of AB 1904 may be:

  <u>Scenario 1 Findings: All Currently Insured Switch Their Current Insurance to a Limited-Mandate Version of the Same Plan or Policy (see Table 1A)</u>

  - Under this scenario, with 100% of currently insured switching to limited-mandate plans, total expenditures among the currently insured population would decline by about $2.0 billion, a reduction of 2.62%. This overall reduction in expenditures includes a shift in costs from insurer to insured of about $1.5 billion for benefits currently mandated that would no longer be covered, but that would still be utilized.
  - An estimated 87,000 Californians would become insured as a result of the reduced premiums in this scenario, representing a 1.31% decrease in the number of uninsured.

These newly insured individuals would account for an increase in overall expenditures of about $210.9 million.

- Therefore, the combined effect on overall health expenditures of this scenario would be a net savings of about $1.8 billion, or 2.01%.
- The impact of limited-mandate plans changes linearly with the percentage switching. For example, if only 50% of the currently insured will switch from their current plans to a limited-mandate plan, the total expenditure will decline by about $1.0 billion, a reduction of 1.31%, with cost shifting from insurer to insured of about $0.75 billion. Therefore, the overall net savings is about $0.79 billion, or 0.89%.

Scenario 2 Findings: Specified Percentage of Currently Insured Individuals with Incomes Below 350% FPL Switch to Limited-Mandate Policies (see Table 1B)

- Under this scenario, total expenditures among the currently insured population would decline by about $35.0 million, a reduction of 0.05%. This overall reduction in expenditures includes a shift in costs from insurer to insured of about $20.1 million for currently mandated services that would no longer be covered.
- An estimated 12,000 Californians would become insured as a result of the reduced premiums in this scenario, representing a 0.18% decrease in the number of uninsured. These newly insured individuals would account for an increase in overall expenditures of about $15.6 million.
- Therefore, the combined effect on overall health expenditures of this scenario would be a net savings of about $19.4 million, or 0.02%.

Scenario 3 Findings: Specified Percentages of Currently Insured With HDHPs in the CDI-Regulated Individual Market and Specified Percentages of Currently Insured in Small Groups, with Incomes Below 200% FPL, Switch to Limited-Mandate Policies (see Table 1C)

- Under this scenario, total expenditures among the currently insured population would decline by about $31.0 million, a reduction of 0.04%. This overall reduction in expenditures includes a shift in costs from insurer to insured of about $19.4 million for benefits currently mandated that would no longer be covered but would still be utilized.
- An estimated 28,000 Californians would become insured as a result of the reduced premiums in this scenario, representing a 0.42% decrease in the number of uninsured. These newly insured individuals would account for an increase in overall expenditures of about $55.2 million.
- Therefore, the combined effect on overall health expenditures of this scenario would be a net increase of about $24.2 million, or 0.03%.

- CHBRP estimates, as noted above, that Scenario 1 is highly unlikely, while Scenarios 2 and 3 are within the range of possibilities. Therefore, it is possible that implementation of AB 1904 will result in a small change (increase or decrease) in overall health expenditures. This

change would be highly dependent on the pattern and extent of switching from full-mandate plans to limited-mandate plans.

Impact on the Number of Uninsured Persons of AB 1904

The estimated impact of AB 1904 on the number of uninsured differs between the three scenarios. According to Scenario 1, as detailed in Table 1A, an estimated 87,000 Californians would become insured as a result of the reduced premiums in this scenario, representing a 1.31% decrease in the number of uninsured. According to Scenario 2, as detailed in Table 1B, an estimated 12,000 Californians would become insured as a result of the reduced premiums in this scenario, representing a 0.18% decrease in the number of uninsured. According to Scenario 3, as detailed in Table 1C, an estimated 28,000 Californians would become insured as a result of the reduced premiums in this scenario, representing a 0.42% decrease in the number of uninsured.

Table 1A. AB 1904 Potential Impacts on Benefit Coverage, Utilization, and Cost, 2010, Under Scenario 1: Limited-Mandate Benefit Plans Offered to and Taken by Everyone in All Market Segments

	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	19,574,000	87,000	0.45%
Total enrollees with health insurance subject to AB 1904	15,882,000	15,969,000	87,000	0.55%
Number of individuals who retain current insurance	15,882,000	—	−15,882,000	−100.00%
Number of individuals who purchase limited-mandate policies	0	15,969,000	15,969,000	0.000%
Number of uninsured individuals	6,624,000	6,537,000	−87,000	−1.31%
Total number of individuals	26,111,000	26,111,000	0	0.00%
Expenditures				
For Those Members Currently Insured				
Premium expenditures by private employers for group insurance	$43,519,324,000	$41,380,288,000	−$2,139,036,000	−4.92%
Premium expenditures for individually purchased insurance	$5,992,795,000	$5,692,995,000	−$299,800,000	−5.00%
Premium expenditures by individuals with group insurance, CalPERS, Healthy Families, AIM, or MRMIP (b)	$12,820,614,000	$12,200,994,000	−$619,620,000	−4.83%
CalPERS employer expenditures (c)	$3,267,842,000	$3,103,270,000	−$164,572,000	−5.04%
Medi-Cal state expenditures (d)	$4,015,596,000	$4,015,596,000	$0	0.00%
Healthy Families state expenditures	$910,306,000	$910,306,000	$0	0.00%
Individual out-of-pocket expenditures for covered benefits (deductibles, copayments, etc.)	$5,961,186,000	$5,672,708,000	−$288,478,000	−4.84%
Out-of-pocket expenditures for noncovered benefits	$0	$1,508,319,000	$1,508,319,000	0.000%
Total annual expenditures for pre- and post-AB 1904 insured members	$76,487,663,000	$74,484,476,000	−$2,003,187,000	−2.62%
For Those Newly Insured Members				
Premium expenditures by private employers for group insurance	$0	$223,688,000	$223,688,000	NA
Premium expenditures for individually purchased insurance	$0	$31,099,000	$31,099,000	NA
Premium expenditures by individuals with group insurance, CalPERS, Healthy Families, AIM, or MRMIP (b)	$0	$64,821,000	$64,821,000	NA
CalPERS employer expenditures	$0	$17,191,000	$17,191,000	NA
Medi-Cal state expenditures	$0	$0	$0	NA
Healthy Families state expenditures	$0	$0	$0	NA

Table 1A. AB 1904 Potential Impacts on Benefit Coverage, Utilization, and Cost, 2010, Under Scenario 1: Limited-Mandate Benefit Plans Offered to and Taken by Everyone in All Market Segments (cont'd.)

	Before Mandate	After Mandate	Increase/ Decrease	Change After Mandate
For Those Newly Insured Members (con't)				
Individual out-of-pocket expenditures for covered benefits (deductibles, copayments, etc.)	$0	$30,129,000	$30,129,000	NA
Out-of-pocket expenditures for noncovered benefits	$164,367,000	$8,297,000	−$156,070,000	−94.95%
Total annual expenditures for pre- and post-AB 1904 insured members	$164,367,000	$375,225,000	$210,858,000	128.28%
For the Uninsured				
Total annual expenditures for pre- and post-AB 1904 uninsured	$12,356,720,000	$12,356,720,000	$0	0.00%
Total Annual Expenditures	$89,008,750,000	$87,216,421,000	−$1,792,329,000	−2.01%

Source: California Health Benefits Review Program, 2010.
Notes: (a) This population includes persons insured with private funds (group and individual) and public funds (e.g., CalPERS Medi-Cal, Healthy Families, AIM, MRMIP) enrolled in health plans and policies 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.
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; NA=not applicable.

Table 1B. AB 1904 Potential Impacts on Benefit Coverage, Utilization, and Cost, 2010, Under Scenario 2: Limited-Mandate Benefit Plans Offered to and Taken by Specified Percentage of Individuals With Earnings up to 350% FPL

	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	19,499,000	12,000	0.06%
Total enrollees with health insurance subject to AB 1904	15,882,000	15,894,000	12,000	0.08%
Number of individuals who retain current insurance	15,882,000	15,584,000	−298,000	−1.88%
Number of individuals who purchase limited-mandate policies	0	310,000	310,000	0.000%
Number of uninsured individuals	6,624,000	6,612,000	−12,000	−0.18%
Total number of individuals	26,111,000	26,111,000	0	0.00%
Expenditures				
For Those Members Currently Insured				
Premium expenditures by private employers for group insurance	$43,519,324,000	$43,519,324,000	$0	0.00%
Premium expenditures for individually purchased insurance	$5,992,795,000	$5,947,289,000	−$45,506,000	−0.76%
Premium expenditures by individuals with group insurance, CalPERS, Healthy Families, AIM, or MRMIP (b)	$12,820,614,000	$12,820,614,000	$0	0.00%
CalPERS employer expenditures	$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	$910,306,000	$910,306,000	$0	0.00%
Individual out-of-pocket expenditures for covered benefits (deductibles, copayments, etc.)	$5,961,186,000	$5,951,537,000	−$9,649,000	−0.16%
Out-of-pocket expenditures for noncovered benefits	$0	$20,138,000	$20,138,000	0.000%
Total annual expenditures for pre- and post-AB 1904 insured members	$76,487,663,000	$76,452,646,000	−$35,017,000	−0.05%
For Those Newly Insured Members				
Premium expenditures by private employers for group insurance	$0	$0	$0	NA
Premium expenditures for individually purchased insurance	$0	$31,099,000	$31,099,000	NA
Premium expenditures by individuals with group insurance, CalPERS, Healthy Families, AIM, or MRMIP (b)	$0	$0	$0	NA
CalPERS employer expenditures	$0	$0	$0	NA
Medi-Cal state expenditures	$0	$0	$0	NA
Healthy Families state expenditures	$0	$0	$0	NA

Table 1B. AB 1904 Potential Impacts on Benefit Coverage, Utilization, and Cost, 2010, Under Scenario 2: Limited-Mandate Benefit Plans Offered to and Taken by Specified Percentage of Individuals with Earning up to 350% FPL (cont'd.)

	Before Mandate	**After Mandate**	**Increase/ Decrease**	**Change After Mandate**
For Those Newly Insured Members (con't)				
Individual out-of-pocket expenditures for covered benefits (deductibles, copayments, etc.)	$0	$6,577,000	$6,577,000	NA
Out-of-pocket expenditures for non-covered benefits	$22,919,000	$839,000	−$22,080,000	−96.34%
Total annual expenditures for pre- and post-AB 1904 insured members	$22,919,000	$38,515,000	$15,596,000	68.05%
For the Uninsured				
Total annual expenditures for pre- and post-AB 1904 uninsured	$12,498,167,000	$12,498,167,000	$0	0.00%
Total Annual Expenditures	$89,008,749,000	$88,989,328,000	−$19,421,000	−0.02%

Source: California Health Benefits Review Program, 2010.
Notes: See notes to Table 1A.
Key: See key to Table 1A.

Table 1C. AB 1904 Potential Impacts on Benefit Coverage, Utilization, and Cost, 2010, Under Scenario 3: Limited-Mandate Benefit Plans Offered to and Taken by Specified Percentage of Individuals in Small Groups and Individual Insurance Segments With Earnings up to 200% FPL

	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	19,515,000	28,000	0.14%
Total enrollees with health insurance subject to AB 1904	15,882,000	15,910,000	28,000	0.18%
Number of individuals who retain current insurance	15,882,000	15,616,000	−266,000	−1.67%
Number of individuals who purchase limited-mandate policies	0	294,000	294,000	0.000%
Number of uninsured individuals	6,624,000	6,596,000	−28,000	−0.42%
Total number of individuals	26,111,000	26,111,000	0	0.00%
Expenditures				
For Those Members Currently Insured				
Premium expenditures by private employers for group insurance	$43,519,324,000	$43,505,832,000	−$13,492,000	−0.03%
Premium expenditures for individually purchased insurance	$5,992,795,000	$5,969,107,000	−$23,688,000	−0.40%
Premium expenditures by individuals with group insurance, CalPERS, Healthy Families, AIM, or MRMIP (b)	$12,820,614,000	$12,815,399,000	−$5,215,000	−0.04%
CalPERS employer expenditures (c)	$3,267,842,000	$3,267,842,000	$0	0.00%
Medi-Cal state expenditures (d)	$4,015,596,000	$4,015,596,000	$0	0.00%
Healthy Families state expenditures	$910,306,000	$910,306,000	$0	0.00%
Individual out-of-pocket expenditures for covered benefits (deductibles, copayments, etc.)	$5,961,186,000	$5,953,173,000	−$8,013,000	−0.13%
Out-of-pocket expenditures for non-covered benefits	$0	$19,421,000	$19,421,000	0.000%
Total annual expenditures for pre- and post-AB 1904 insured members	$76,487,663,000	$76,456,676,000	−$30,987,000	−0.04%
For Those Newly Insured Members				
Premium expenditures by private employers for group insurance	$0	$42,696,000	$42,696,000	NA
Premium expenditures for individually purchased insurance	$0	$31,099,000	$31,099,000	NA
Premium expenditures by individuals with group insurance, CalPERS, Healthy Families, AIM or MRMIP (b)	$0	$16,501,000	$16,501,000	NA
CalPERS employer expenditures	$0	$0	$0	NA
Medi-Cal state expenditures	$0	$0	$0	NA
Healthy Families state expenditures	$0	$0	$0	NA

Table 1C. AB 1904 Potential Impacts on Benefit Coverage, Utilization, and Cost, 2010, Under Scenario 3: Limited-Mandate Benefit Plans Offered to and Taken by Specified Percentage of Individuals in Small Groups and Individual Insurance Segments with Earnings up to 200% FPL (cont'd.)

	Before Mandate	**After Mandate**	**Increase/ Decrease**	**Change After Mandate**
For Those Newly Insured Members (con't)				
Individual out-of-pocket expenditures for covered benefits (deductibles, copayments, etc.)	$0	$16,039,000	$16,039,000	NA
Out-of-pocket expenditures for non-covered benefits	$53,285,000	$2,150,000	−$51,135,000	−95.97%
Total annual expenditures for pre- and post-AB 1904 insured members	$53,285,000	$108,485,000	$55,200,000	103.59%
For the Uninsured				
Total annual expenditures for pre- and post-AB 1904 uninsured	$12,467,802,000	$12,467,802,000	$0	0.00%
Total Annual Expenditures	$89,008,750,000	$89,032,963,000	$24,213,000	0.03%

Source: California Health Benefits Review Program, 2010.
Notes: See notes to Table 1A.
Key: See key to Table 1A and 1B.

Public Health Impacts

Using the projections from the hypothetical scenarios discussed above, the primary health benefit of AB 1904 could be an expansion of the insured population to an estimated 12,000 to 28,000 persons. Compared to the insured, uninsured individuals obtain less preventive, diagnostic, and therapeutic care, are diagnosed at more advanced stages of illness, have a higher risk of death, and have poorer self-reported health. In addition to the issues of health and health care access, the absence of health insurance can also cause substantial stress and worry due to lack of coverage, as well as financial instability if health problems emerge. As a result, the estimated 12,000 to 28,000 persons who are expected to no longer be uninsured due to AB 1904 would likely realize improved health outcomes and reduced financial burden for medical expenses.

Having less comprehensive or limited-mandate health insurance exposes individuals to the financial and health risks of becoming *underinsured* if insurers drop coverage for effective health services currently mandated in California. AB 1904 could result in an estimated 266,000 to 298,000 previously insured persons moving from a plan with mandated benefits to one where coverage of mandated benefits is no longer required. With out-of-pocket expenditures for non-covered benefits expected to increase by an estimated $19.4 million to $20.1 million, these insured persons have an increased risk of foregoing treatment for services no longer covered under limited-mandate policies. In particular, the absence of coverage for effective preventive services could result in diagnosis at more advanced stages of disease, more costly illness, and premature death. Additionally, it is possible that persons moving to limited-mandate plans could develop a preexisting medical condition that would exclude them from moving back to a plan with full coverage for these health problems.

In order to assess the public health impact if coverage for a particular benefit was excluded from a plan, three criteria were used: the medical effectiveness findings, the scope of the public health problem (broad, moderate, or limited), and the type of public health problem (mortality or morbidity). Table 2 details the current California mandates that have expected public health impacts if coverage were dropped.

Table 2. Summary of Public Health Scope and Type of Mandate Impact for Current California Mandates

Public Health Scope	Current California Mandated Benefits
Broad (1 in 20 persons or more)	Mandates with Potential Mortality Impact • Cancer screening tests for breast, cervical, and colorectal cancers • Diagnostic tests and treatments for breast cancer • Diabetes management medications, services, and supplies • Medication and psychosocial treatments for severe mental illness and alcoholism • Preventive services for children and adolescents • Pediatric asthma management Mandates with Potential Morbidity Impact • Prescription contraceptive devices (morbidity related to problems occurring from unplanned pregnancy)
Moderate (fewer than 1 in 20 persons to 1 in 2,000 persons)	Mandates with Potential Mortality Impact • HIV testing • Services for the diagnosis and treatment of osteoporosis • Prenatal diagnosis of genetic disorders Mandates with Potential Morbidity Impact • Prosthetic devices • Orthotic devices for some conditions • Special footwear for persons with rheumatoid arthritis • Pain management medication for persons with terminal illnesses • Acupuncture • Diagnosis and treatment of infertility • Surgery for the jawbone and associated bone joints
Limited (1 in 2,000 persons or fewer)	Mandates with Potential Mortality Impact • Medical formulas and foods for persons with phenylketonuria • Expanded alpha-fetoprotein screening Mandates with Potential Morbidity Impact • Home care services for elderly and disabled adults • Hospice care

Source: California Health Benefits Review Program, 2010.

Screening the blood lead levels of children at average risk for lead poisoning is not expected to have a positive public health impact. Additionally, a number of mandates have an unknown impact on public health if coverage is dropped, including tests for screening and diagnosis of prostate cancer, transplantation services for persons with HIV, the intoxication exclusion[2], prosthetic devices for persons who have had a laryngectomy, special footwear for persons with diabetes, reconstructive surgery for breast cancer, reconstructive surgery for clubfoot and craniofacial abnormalities, general anesthesia for dental procedures, and orthodontic services for persons with oral clefts.

Based on the prototype limited-mandate plans, the medically effective mandated benefits that are most likely to be dropped following AB 1904 include: alcoholism treatments and parity in coverage for severe mental illness/coverage for mental and nervous disorders, phenylketonuria (PKU) treatment with medical formula and foods, expanded alpha-fetoprotein screening (AFP), prescription contraceptive devices, acupuncture, infertility treatments, jawbone or associated bone joint surgery, orthotics and prosthetics, special footwear for persons with rheumatoid arthritis, and home care services for elderly and disabled adults.

A number of mandates are associated with health benefits primarily for females (e.g., breast/cervical cancer, maternity care-related mandates, and prescription contraceptives). An estimated 266,000 to 298,000 previously insured persons could move from a California plan with mandated benefits to one in another state where coverage of mandated benefits is no longer required. Within this category, females would be at greater risk for underinsurance and reduced access to these services compared to males.

In California, racial and ethnic minorities are more likely to be low income and more likely to be uninsured compared to whites. An estimated 12,000 to 28,000 of these people may gain insurance by purchasing it from an out-of-state vendor. Among the newly insured, a larger proportion of minorities compared to whites could change from being uninsured to insured under AB 1904. It is important to note, however, that coverage under AB 1904 policies would likely attract low-risk enrollees rather than those uninsured with chronic or high-risk conditions.

Impact of Exempting Out-of-State Policies from California's Consumer Protections and Financial Solvency Requirements

AB 1904 would exempt out-of-state policies from California consumer protection requirements, and enrollees of such plans would have to contact the domicile state's insurance commissioner to deal with denied claims or other disputes. If disputes were to escalate, enrollees would have to seek resolution in an out-of-state court. Depending on the state, resource constraints—such as time, number of employees, and budget—may prevent regulators from providing assistance to out-of-state consumers and may prevent regulators from enforcing policies. Given the size and population of California, its regulatory agencies' capacity is far greater than those of other states in terms of personnel, budget, and resources. For example, the Departments of Insurance in South Dakota and Wyoming have budgets of $1.8 million (2009) and $4.5 million (2007-2008),

[2] The intoxication exclusion mandate prohibits insurance companies from excluding coverage for injuries resulting from or related to intoxication.

respectively, compared with the CDI's $205 million (2010-2011). In addition, the insurance departments in some states have taken the position that it is not in their jurisdiction to assist consumers who are out of state. Marketing practices are an example: out-of-state policies, depending on where they are domiciled, may be prohibited from being solely marketed to a younger and healthier population, but again, enforcing such activities across state lines would be resource intensive.

- AB 1904 would exempt out-of-state policies from California-specific requirements regarding financial reporting and solvency. All states require insurance products to maintain adequate reserves to be financially solvent and able to pay claims. However, these requirements and the capacity to monitor solvency of their carriers vary across states. In addition, funds that are set up to pay for claims if a carrier becomes insolvent may not cover out-of-state consumers or may not be adequate to pay for all eligible consumers (for example, if the carrier is domiciled in a small state with few insurers paying into the insolvency fund). If a claim is denied by an out-of-state carrier, the consumer would need to work with the out-of-state carrier, per their arbitration rules, and potentially the out-of-state regulatory agency if there are applicable external grievance processes in place.

- AB 1904 would exempt out-of-state policies from California-specific requirements prohibiting health plans from engaging in unfair payment practices to providers. Again, although all states require insurance products to pay claims in a timely fashion, it is unclear whether other states have protections similar to California's.

Acknowledgements

This report provides an analysis of the medical, financial, and public health impacts of AB 1904, a bill to exempt all current California health insurance mandates for carriers domiciled in another state offering their plans in California. In response to a request from the California Assembly Committee on Health on February 16, 2010, the California Health Benefits Review Program (CHBRP) undertook this analysis pursuant to the program's authorizing statute. Janet Coffman, MPP, PhD, and Edward Yelin, PhD, of the University of California, San Francisco prepared the medical effectiveness analysis. Penny Coppernoll-Blach, MLIS, of the University of California, San Diego, conducted the literature search. Helen Halpin, PhD, Nicole Bellows, PhD, and Sara McMenamin, PhD, of the University of California, Berkeley, prepared the public health impact analysis. Robert Kaplan, PhD, Yair Babad, PhD, and Shana Lavarreda, PhD, MPP, all of the University of California, Los Angeles, prepared the cost impact analysis. Robert Cosway, FSA, MAAA, provided actuarial analysis. H.E. (Ted) Frech, III, PhD, of the University of California, Santa Barbara, provided technical assistance with the literature review and expert input on the analytic approach. Garen Corbett, MS, 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, Thomas MaCurdy, PhD, of Stanford University, reviewed the analysis for its accuracy, completeness, clarity, and responsiveness to the Legislature's request.

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

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 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

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, 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.