CALIFORNIA
HEALTH BENEFITS REVIEW PROGRAM

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

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

CHBRP 10-04

The California Health Benefits Review Program (CHBRP) responds to requests from the State Legislature to provide independent analyses of the medical, financial, and public health impacts of proposed health insurance benefit mandates and proposed repeals of health insurance benefit mandates. CHBRP was established in 2002 by statute (California Health and Safety Code, Section 127660, et seq). The program was reauthorized in 2006 and again in 2009. CHBRP's authorizing statute defines legislation proposing to mandate or proposing to repeal an existing health insurance benefit as a proposal that would mandate or repeal a requirement that a health care service plan or health insurer (1) permit covered individuals to obtain health care treatment or services from a particular type of health care provider; (2) offer or provide coverage for the screening, diagnosis, or treatment of a particular disease or condition; or (3) offer or provide coverage of a particular type of health care treatment or service, or of medical equipment, medical supplies, or drugs used in connection with a health care treatment or service.

A small analytic staff in the University of California's Office of the President supports a task force of faculty and staff from several campuses of the University of California, as well as Loma Linda University, the University of Southern California, and Stanford University, to complete each analysis within a 60-day period, usually before the Legislature begins formal consideration of a mandate or repeal bill. A certified, independent actuary helps estimate the financial impacts, and a strict conflict-of-interest policy ensures that the analyses are undertaken without financial or other interests that could bias the results. A National Advisory Council, drawn from experts from outside the state of California and designed to provide balanced representation among groups with an interest in health insurance benefit mandates or repeals, reviews draft studies to ensure their quality before they are transmitted to the Legislature. Each report summarizes scientific evidence relevant to the proposed mandate, or proposed mandate repeal, but does not make recommendations, deferring policy decision making to the Legislature. The State funds this work through a small annual assessment on health plans and insurers in California. All CHBRP reports and information about current requests from the California Legislature are available at the CHBRP Web site, www.chbrp.org.

A Report to the 2009-2010 California State Legislature

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

April 16, 2010

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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.

PREFACE

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:

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Director

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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), 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

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

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.

INTRODUCTION

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, pursuant to the provisions of the program's authorizing statute. AB 1904, which would allow a carrier domiciled in another state to sell a health insurance product 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. CHBRP was requested to analyze AB 1904 because it would effectively repeal or relax health benefit mandate requirements in current law.

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 is not affected by health insurance benefit mandate laws. Others have health insurance that is not subject to health insurance benefit mandate laws because those health plans or health policies are subject to other state or federal laws.

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. To increase access, 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. For example, Section 2714 allows children up to the age of 26 to enroll onto 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. 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. Further information on the provisions of

P.L.111-148 that would alter the California health insurance market and have relevance to AB 1904 is contained in this analysis.[3]

Provisions and Legislative Intent of AB 1904

Assembly Bill 1904 would allow a carrier domiciled in another state 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.

The carrier's plan or policy would be exempt from all Knox-Keene[4] licensing requirements and requirements under the California Insurance Code, as long as the plan or policy is lawfully authorized and complies with the domiciliary state's requirements.

Uniquely, California has a bifurcated system of regulation for health insurance subject to state law. The California Department of Managed Health Care (DMHC)[5] regulates health care service plans that offer coverage for benefits to their enrollees through health plan contracts. The California Department of Insurance (CDI) regulates health insurers[6] that offer coverage for benefits to their enrollees through health insurance policies.

According to the bill author, the intent of AB 1904 is to allow for the development, marketing, and purchasing of health insurance products in California that may be more affordable and thereby expand coverage to the uninsured, particularly for those who would purchase coverage in the small-group or individual market ("limited-mandate products"). The intent is to spark innovation and competition among carriers, driving down the cost of available products.

Proponents of similar bills at the federal level state that permitting the development of plans exempt from state mandates would encourage the market to develop lower-priced products, giving employers and individuals more health plan choices, and forcing state-regulated plans to compete with lower priced policies.[7] Proponents state that allowing such competition will prevent one or two

[3] Please see the section titled "Other Considerations Related to the Potential Impacts of AB 1904."
[4] Health maintenance organizations in California are licensed under the Knox-Keene Health Care Services Plan Act, which is part of the California Health and Safety Code.
[5] DMHC was established by the Knox-Keene Health Care Service Plan of 1975, See Health and Safety Code, Section 1340.
[6] 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.
[7] P.L. 111-148, enacted in March of 2010, permits states to form health care choice compacts and allows insurers to sell policies in any state participating in the compact. Insurers selling policies through a compact would only be subject to the laws and regulations of the state where the policy is written or issued, except for rules pertaining to market conduct, unfair trade practices, provider network adequacy, and consumer protections. Compacts may only be approved if it is determined that the compact will provide coverage that is at least as comprehensive and affordable as coverage provided through the state Exchanges. These compacts may not take effect before January 1, 2016. (Kaiser Family Foundation, 2010)

insurers from controlling a large portion of the market. Supporters of H.R. 2355, for example, (a federal bill allowing those in the individual insurance market to buy policies across state lines) stated that the provisions of the bill would "ensure that individuals are able to purchase affordable health insurance policies by creating a nationwide market" (PRI, 2006). In addition, the bill would "broaden and intensify competition among health plans and medical providers" and spark a "serious review" of existing regulations (Moffit, 2006). Proponents also state that the current regulatory framework of charging the younger and healthier more to subsidize the sick raises issues of equity and fairness in payment structures. Benefit mandates, in particular, proponents argue, force those who would not necessarily want or need a benefit to buy it even when they would rather purchase a less-expensive limited benefit plan (Westerfield, 2003).

The bill seeks to meet these various policy objectives by allowing these out-of-state carriers' products to:

- No longer be subject to California health benefit mandates.
- No longer be subject to California premium requirements, patient protection requirements, fiduciary and financial requirements, and provider access mandates.

Background and Discussion on Carriers' Domicile

For a health plan to be considered "domiciled" in a state means that the insurance company must be headquartered in that state. Currently about two-thirds of Californians with privately purchased health insurance are in state-regulated health plans or insurance policies offered by an entity domiciled in California ("in-state carrier"). About one-third of California insured are covered by a carrier domiciled in another state ("out-of-state carrier"). Four of the seven major carriers are currently domiciled outside California. See Table 3 for a summary of where these carriers are currently domiciled and the corresponding share of the California market.

Table 3. California Market Share for Private Health Insurance by Insurer and State of Domicile

Insurer/CA Affiliate	Domicile (Headquarters) of Insurer	States in Which Insurer Is Licensed	CA Market Share (CDI)	CA Market Share (DMHC)	Combined
Kaiser Permanente/Kaiser Foundation Health Plan, Inc.	Oakland, CA	9 states, including California and the District of Columbia	0%	40%	33%
Blue Shield of California/Blue Shield of California and Blue Shield of California Life & Health Insurance Company	San Francisco, CA	California	16%	20%	19%
Wellpoint, Inc./Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company	Indianapolis, IN	14 states, including California	43%	19%	23%
Heath Net, Inc./Health Net of California and Health Net Life Insurance Company	Woodland Hills, CA	Subsidiaries licensed in 50 states and the District of Columbia	8%	8%	8%
United HealthGroup, Inc./PacifiCare of California, PacifiCare Life and Health Insurance Company, and United HealthCare Insurance Company	Minnetonka, MN	Subsidiaries licensed in 50 states and the District of Columbia	8%	6%	6%
Aetna, Inc./Aetna Health of California and Aetna Life Insurance Company	Hartford, CT	Subsidiaries licensed in 50 states and the District of Columbia	12%	4%	5%
CIGNA Corporation/Cigna Healthcare of California	Philadelphia, PA	Subsidiaries licensed in 50 states and the District of Columbia	3%	2%	2%

Source: California Health Benefits Review Program analysis of data from Hoovers Inc. Available at www.hoovers.com. Accessed April 6, 2010; DMHC enrollment data as of December, 2009; CDI Covered Lives Data Call for expense reimbursement Health Insurance products, December 31, 2008.

There is uncertainty as to how carriers would react in the short and long term if AB 1904 were to pass into law. Based on input from content experts and a review of the available literature on how products that are exempt from state-regulation would affect the market, AB 1904 would affect carriers differently based on where they are domiciled, their business strategy, and whether they currently offer California-regulated products.

In-State Carriers

Carriers currently domiciled in California would not be expected to stop developing, marketing, or selling all Knox-Keene licensed (DMHC-regulated) plans or CDI-regulated policies in the short term. These carriers that have Knox-Keene licensed plans would be expected to maintain those licenses and continue to offer managed care products, especially to large- or mid- sized groups that may demand a state-regulated product that comes with a comprehensive set of benefits and predictable provider network. In-state carriers with DMHC-regulated products may move their headquarters to another state if they consider it advantageous to compete with other carriers that develop and sell products not subject to California regulations. In-state carriers who currently have CDI-regulated products would also maintain certificate of authority in California. CDI-regulated products are subject to less stringent requirements (such as benefit mandates) than DMHC-regulated plans and are already able to develop and sell products with lower premiums than DMHC-regulated products.

These carriers may also consider moving their headquarters out of state if they thought it advantageous to develop out-of-state licensed products to obtain any savings beyond that which might be obtained under CDI-regulated products, and to compete with other carriers. For example, the CDI-regulated market is not subject to certain benefit mandates or to benefit design requirements and has been free to develop high-deductible health plans (HDHPs) without coverage for services (such as maternity care) with high coinsurance levels (e.g., above 30%). In-state carriers offering out-of-state products would operate based on the rules of the state in which these products are licensed. Assuming they would elect to sell plans licensed in states with more lax rules than California (as discussed further in this report), they could potentially market these products to healthier individuals and build benefit packages with fewer covered benefits and lower premiums.

Out-of-State Carriers Currently Licensed in California

Carriers that are currently domiciled outside of California but have Knox-Keene licensed plans or CDI-regulated policies would be able to sell their out-of-state policies in the short run, immediately following the passage of AB 1904. Again, these carriers would be likely to sell products in California that would be most competitive in the small-employer group market and the individual market. These out-of-state policies may tend to be lower in cost than in-state products because the state of domicile allows for the development, marketing, and modification of products with minimal insurance requirements, regulatory review, or oversight. Still, the deep discounts of the in-state Blues and combined low provider price/high utilization management of Kaiser will continue to provide lower premiums. Out-of-state carriers that currently have a presence in California—meaning they 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

Carriers that are currently domiciled out-of-state *and* do not currently have Knox-Keene licensed plans or CDI-regulated policies would be permitted to sell out-of-state policies in California, under AB 1904. These out-of-state 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 may be able to, especially for managed care products that tend to offer comprehensive benefits with defined provider networks. An out-of-state carrier's ability to negotiate discounts for services would depend on factors such as geography, patient mix, and employer demands for certain providers within networks. For example, a hospital system may be unwilling to enter into contract with an out-of-state carrier for services to enrollees in out-of-state licensed products because (1) the hospital system would want to ensure that the carrier is subject to California oversight, and (2) the hospital system would not want to be saddled with uncompensated care burden that may result from enrollees, or the hospital being liable for uncovered services. But again, if these out-of-state carriers are able to sell products that are not subject to the many California-specific insurance requirements (besides benefit mandates), then they would be expected to market less costly policies that may be attractive—especially to those currently in the small-group or individual markets or those who are uninsured.

The remainder of this report focuses on the effects, under AB 1904, of introducing these products, policies, or plans sold by carriers that are currently domiciled in California but obtain domicile elsewhere *and* those sold by carriers that are currently domiciled out-of-state. (These products that are not regulated under California requirements will henceforth be called "out-of-state policies.") This analysis seeks to examine the following questions:

- To what extent would exempting out-of-state policies from California benefit mandates affect the cost of insurance and the public health?
- To what extent would a decrease in the price of insurance increase the purchase of insurance among those who are currently uninsured?
- To what extent would exempting out-of-state policies from other California health plan and insurance policy requirements affect the health insurance market?
- What would be the effect of unregulated competition on coverage and delivery of health insurance benefits in California?

Analytic Approach

This report varies from previous CHBRP analyses of a specific benefit mandate or repeal, given that AB 1904 is broader in scope and would effectively repeal all California-specific health insurance requirements, oversight, and regulatory authority of the DMHC and the California Department of Insurance (CDI). Because the benefit mandate requirements and their impacts on

the California health insurance market are highly intermingled and interdependent with the other health insurance requirements, this report would be remiss in not pointing out those relevant issues for policymakers. In addition, given the scope of AB 1904 and the highly compressed timeframe for analysis, this report does not address the medical effectiveness, costs, or public health impacts associated with each of the 44 benefit mandates that are currently required under California law.[8]

This analysis and report is organized in two parts. Part I of the report describes the medical effectiveness and public health and cost impacts of allowing out-of-state limited-mandate plans to compete in the California market. Part II of the report describes the potential impacts of allowing out-of-state carriers to compete in the California health insurance market without being subject to the California laws and regulations imposed on in-state carriers.

To assess the medical effectiveness and the likely public health and cost impacts of AB 1904, this report does the following:

- In the *Medical Effectiveness* section, CHBRP examines each of the benefits that may be excluded under AB 1904 to determine whether the mandated benefit is considered to be medically effective based on existing evidence. Conclusions are drawn from the U.S. Preventive Services Task Force (USPSTF) recommendations, Centers for Disease Control (CDC) recommendations, National Institutes of Health (NIH) guidelines, and other authoritative sources. If a CHBRP analysis exists for a current benefit mandate, this report relies on that previous analysis. For example, the medical effectiveness analysis in the CHBRP report on AB 228 (CHBRP, 2005b) was used as evidence on the effectiveness of covering transplantation services for persons with HIV.

- The *Utilization, Cost and Coverage Impact* section addresses the issue of the added cost 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. This analysis draws upon a previous CHBRP report (AB 1214 [CHBRP, 2007b]) that estimated the impact of allowing limited-mandate plans to be marketed in California. AB 1214 modeled the limited-mandate plans to reflect the insurance policies likely to be offered if in-state carriers were allowed to offer scaled-back benefit designs. Details on the designs used to model the cost impact scenarios are presented in Appendix F. Three possible scenarios are presented:

    - **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-

[8] There are 44 benefit mandates to cover or offer coverage under the California Health and Safety Code. There are 34 benefit mandates to cover or offer coverage under the Insurance Code. Under the Health and Safety Code is an expansive benefit mandate to cover "basic health care services," which include a wide range of preventive and medically necessary diagnostic and treatment services provided in the inpatient, outpatient, physician offices and post-acute care settings. Note that these counts include benefit mandate only—not mandates on access to providers or eligibility mandates. (See Appendix C for a list of these mandates.)

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 only have an impact only on the price-sensitive segment of the individual market. However, in constrast to 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 assumes that only 40% of all those insured in this market segment with incomes below 350% of the 2010 FPL ($37,905 for a single person, $77,175 for a family of four) who currently 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 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 should AB 1904 be 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 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 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 will switch to limited-mandate plans. This scenario also falls within the range of possibility should AB 1904 be enacted.

The *Utilization, Cost, and Coverage Impact* section also estimates the short-term impacts on those currently uninsured in California under each of the scenarios described above.
The Public Health Impacts section identifies the population that would be affected by a health condition related to a mandated benefit. The report offers general conclusions regarding the public health impact of waiving a particular benefit mandate based on the findings presented in the Medical Effectiveness section and the number of insured Californians that may be affected by the health condition.

PART I: THE IMPACT OF ALLOWING LIMITED-MANDATE PLANS TO COMPETE IN THE CALIFORNIA MARKET

Part I of this report focuses on the medical effectiveness and the cost and public health impacts of allowing health insurance products that do not include legislatively imposed benefit mandates to be sold to Californians. Because this exemption would apply to products sold by carriers that are currently domiciled in California but obtain domicile elsewhere *and* those sold by carriers that are currently domiciled out-of-state, this part will refer to all limited-mandate policies as "out-of-state" limited-mandate policies.

Medical Effectiveness

Medical Effectiveness of Current Mandates: Summary of Evidence

AB 1904 would permit the waiver of 44 health insurance mandates and mandated offering statutes that address numerous health care services used to screen for, diagnose, treat, and manage a wide range of diseases and conditions.

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.

Nine mandates were not analyzed because they do not require coverage for specific health care services or for specific diseases or conditions. Three mandates that address coverage for pharmaceuticals were not analyzed, because they apply to such a large number of diseases and conditions that the evidence cannot be summarized briefly. As indicated in Table 4, these mandates concern coverage for all drugs that are used off-label, not on health plans' or health insurers' formularies, or were previously prescribed to enrollees to treat any disease or condition. One mandate was not analyzed because it requires coverage for vaccination against a condition for which no vaccine is currently available (i.e., the AIDS virus).

Literature Review Methods

Studies of the medical effectiveness of the mandates and mandated offerings subject to AB 1904 were identified through searches of databases that index peer-reviewed literature on the effectiveness of health care services. Web sites maintained by organizations that produce systematic reviews and evidence-based guidelines regarding health care services were also searched. In addition, previous CHBRP reports on pertinent topics were reviewed. Appendix B presents more detailed information about the literature search methods.

Once the literature search was completed, the most useful sources of evidence were selected for review. 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 and, thus, provide the strongest evidence of effectiveness. Where multiple meta-analyses, systematic reviews, and evidence-based practice guidelines were available, CHBRP focused on the syntheses that were most thorough and which provided the most information about the research designs of the studies synthesized. Most syntheses were published within the past 5 years, although in a few cases, the only syntheses available were published in the late 1980s or 1990s. Individual studies were reviewed only if meta-analyses, systematic reviews, or evidence-based practice guidelines had not been published. If no studies had been published, CHBRP relied on clinical practice guidelines based on expert opinion.

Methodological Considerations

For this analysis, CHBRP took a broad view of the evidence of effectiveness for each mandate. The literature review focused on evidence about the effectiveness of major types of health care services used to screen, diagnose, treat, and manage the diseases and conditions addressed in the mandates and mandated offerings subject to AB 1904. CHBRP chose this broad approach to the literature review because the rapid pace of advances in medical technology leads to frequent changes in state-of-the-art therapy for many conditions. Medications or procedures that are currently the most effective treatments for a disease or condition may soon be supplanted by new and improved alternatives.

This focused approach to the literature review may have led CHBRP staff to inadvertently omit important sources of evidence from the review. Most notably, relying on syntheses may have caused CHBRP to overlook studies published since the syntheses were completed. However, CHBRP believes this approach is appropriate given the large number of health care services for which evidence needed to be assessed in a short period of time. General conclusions about the effectiveness of treatments for which there is a large body of research probably would not change if the latest studies were added.

CHBRP discussed the relative merits of different tests and treatments for a disease or condition only where there was compelling evidence that certain tests or treatments were more effective than others. For example, CHBRP summarized findings regarding three different screening tests for breast cancer (i.e., mammography, clinical breast examination, and self-examination), because there is strong evidence that mammography detects breast cancer more accurately than clinical breast examinations and self-examination. In contrast, CHBRP did not summarize findings from studies that have addressed the relative merits of different drugs used to treat osteoporosis, because all of these drugs have been found to be more effective than placebos.

Outcomes Assessed

The outcomes that are most important for assessing effectiveness differ across the mandates and mandated offerings analyzed. Some of these mandates concern coverage for screening and diagnostic tests. In these cases, CHBRP examined evidence of a test's ability to accurately identify persons with a disease or condition, and evidence of whether the benefits of testing

outweigh the harms. For two mandates that address coverage for immunizations, CHBRP examined evidence regarding the vaccines' ability to prevent illness and evidence that the benefits of vaccines outweigh their side effects. Other mandates concern coverage for treatment and management of illness. In these cases, the pertinent outcomes vary with the nature of the illness addressed. For example, control of blood glucose level is a critical outcome for studies of medication and services used to manage diabetes, because glucose control improves health outcomes for people with diabetes. Conversely, evaluation of breathing outcomes is important in studies of asthma management interventions, because asthma affects a person's ability to breathe and because persons with asthma who have better performance on pulmonary function tests and less frequent symptoms are less likely to use acute care services.

Study Findings

The amount and strength of evidence regarding the medical effectiveness of the services for which coverage is required under the mandates subject to AB 1904 varies. For some mandates, CHBRP could draw upon multiple meta-analyses, systematic reviews, and evidence-based guidelines that synthesized findings from large, well-designed randomized controlled trials (RCTs). In other cases, the only evidence available comes from small, nonrandomized studies that have major methodological flaws. When examining the evidence for each mandate, CHBRP considered both the pattern of findings across studies and the methodological rigor of the studies.

Nevertheless, most 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 evidence of medical effectiveness.

Findings regarding the medical effectiveness of specific health care services addressed by the mandates and mandated offerings that could be excluded under AB 1904 are described below. The mandates are grouped by major categories of diseases, conditions, populations, and types of services. The findings are summarized in Table 4 at the end of this section.

Cancer screening and treatment

Cancer screening tests

- There is clear and convincing evidence[9] that there are accurate screening tests for breast cancer, cervical cancer, and colorectal cancer and that the benefits of routine screening of asymptomatic persons who are at risk for these cancers outweigh the harms, because early diagnosis and treatment of these cancers reduces mortality associated with these cancers (USPSTF, 2009a).[10]

[9] CHBRP characterizes evidence as "clear and convincing" where there are consistent findings from meta-analyses, systematic reviews, and evidence-based guidelines based on well-implemented RCTs or, if syntheses are not available, individual RCTs that are well-implemented. When assessing the strength of RCTs, CHBRP considers sample size, attrition, and equivalence between intervention and control groups. Blinding of health professionals and subjects to the assignment of subjects to the intervention and control groups is also taken into consideration in cases in which blinding is feasible.

[10] The specific groups of persons for whom the benefits of screening outweigh the harms differ for breast, cervical, and colorectal cancers. In addition, recommendations for screening may change over time as new evidence becomes

- There is *insufficient evidence* to recommend for or against routine screening of asymptomatic persons for lung cancer, oral cancer, and skin cancer (USPSTF, 2009a).

- There is a *preponderance of evidence*[11] that screening asymptomatic persons for bladder cancer, ovarian cancer, pancreatic cancer, and testicular cancer is *not effective* because screening tests pose some risks and because early detection and treatment does not improve health outcomes (USPSTF, 2009a).

- Findings from two recently published RCTs suggest that using the prostate specific antigen (PSA) test to screen asymptomatic men for prostate cancer *has no or a very small effect on prostate cancer-specific mortality* (Andriole et al., 2009; Schröder et al., 2009). These are the first RCTs to assess the effectiveness of PSA screening. The benefits of PSA screening, seen only in the European trial, are relatively small, with over 1,000 men needing to be screened to prevent 1 cancer death over 10 years. In addition, 48 men diagnosed with prostate cancer would have to be treated to prevent 1 cancer death. This is balanced against the known long-term harms of prostate cancer treatment, which include incontinence and impotence. The U.S. study did not show a benefit, though the statistical analysis did demonstrate that a small benefit, such as that seen in the European trial, is possible.

Diagnosis and treatment of breast cancer

- There is *clear and convincing evidence* that there *are effective* diagnostic procedures and treatments for breast cancer. Major forms of treatment that have been found to be effective include surgery, radiation, chemotherapy, hormone therapy, and immunotherapy (NCCN, 2009).[12]

- There is *insufficient evidence* to determine whether longer length of inpatient stay is associated with better outcomes for females who have a mastectomy or lymph node dissection (CHBRP, 2005a).

Chronic conditions

Diabetes[13]

- There is *clear and convincing evidence* that self-monitoring of blood glucose and comprehensive, ongoing education regarding diabetes self-management skills and nutrition therapy *improve* the management of Type 1, Type 2, and gestational diabetes.

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available. For example, the USPSTF issued revised guidelines for breast cancer screening in November 2009. The USPSTF now recommends "biennial screening mammography for women aged 50 to 74 years." It also recommends that "the decision to start regular, biennial screening mammography before the age of 50 years should be an individual one and take patient context into account, including the patient's values regarding specific benefits and harms" (USPSTF, 2009b).

[11] CHBRP characterizes the evidence as a "preponderance" if the majority of studies, but not an overwhelming majority, reach the same conclusion. This classification is also used when the evidence is drawn from RCTs with major methodological weaknesses and from nonrandomized studies. Even if the overwhelming majority of these studies report the similar findings, the evidence is not as strong as evidence obtained from well-implemented RCTs.

[12] Findings regarding the effects of performing breast reconstruction surgery in conjunction with mastectomy are discussed below under the heading "Reconstructive Surgery."

[13] Findings regarding the effects of therapeutic shoes on prevention and treatment of diabetic foot ulcers are discussed under the heading "Special Footwear (i.e., therapeutic shoes)."

- There is *clear and convincing evidence* that insulin is an *effective* treatment for persons with Type 1 diabetes and for some persons with Type 2 diabetes whose blood glucose levels are not well-controlled by other treatments.

- There is *clear and convincing evidence* that medications are *effective* treatments for Type 2 diabetes.

- There is a *preponderance of evidence* that insulin pump therapy is an *effective* alternative to multiple insulin injections for persons with diabetes who are unable to achieve glycemic control with multiple daily injections or for whom multiple injections are contraindicated (AACE, 2007; NCCCC, 2009).

Osteoporosis

- There is *clear and convincing evidence* that measurement of bone mineral density with dual-energy X-ray absorptiometry (DEXA) is an *effective* diagnostic test for bone mineral loss or osteopenia.[14]

- There is *clear and convincing evidence* that exercise, calcium, vitamin D, and medications are *effective* treatments for osteoporosis. Most studies of the effectiveness of medications have assessed effects on postmenopausal women (NICE, 2010a, 2010b; SIGN, 2003).

Screening for human immunodeficiency virus (HIV)

- Although no studies have directly assessed whether testing asymptomatic persons for HIV decreases morbidity and mortality, there is substantial indirect evidence that screening for HIV is effective.

- There is a *preponderance of evidence* from multiple studies that tests for HIV are highly accurate (i.e., have high sensitivity and specificity).

- There is *clear and convincing evidence* from multiple controlled studies that highly active antiretroviral therapy (HAART), prophylaxis for opportunistic infection, and vaccination against hepatitis B and influenza reduce the risk of clinical progression of HIV, opportunistic infection, and death.

- There is a *preponderance of evidence* that delivering infants born to HIV-positive mothers by elective cesarean section and feeding them formula instead of breast milk further reduces the risk of HIV transmission from mother to infant above and beyond the reduction in risk achieved through use of HAART.

- There is also evidence from studies of self-reported behavior that persons who are aware that they are HIV-positive are less likely to engage in unprotected intercourse than persons who are not aware of their status (CHBRP, 2008a).

[14] Osteoporosis is the most common type of osteopenia, but osteomalacia from vitamin D deficiency also causes bone mineral loss on DEXA testing.

Transplantation services for persons with HIV

- The available studies of organ transplantation in HIV-positive patients consist primarily of studies of kidney and liver transplantation, with only a few reports of heart transplantation, multiple organ transplantation, and autologous stem cell transplantation for lymphoma after high-dose chemotherapy.

- Evidence from case series and case reports suggests that patients with HIV undergoing kidney transplantation have survival rates *similar* to those of patients without HIV. Evidence from case series and case reports suggests that in persons who do not have hepatitis C, survival rates after liver transplantation are *similar* regardless of HIV status (CHBRP, 2005b).

Phenylketonuria (PKU)[15]

- The *preponderance of evidence* indicates that consuming phenylalanine-free medical formulas, low-protein medical foods, and foods that are naturally low in phenylalanine is *effective* in reducing the severity of mental and behavioral disorders associated with PKU (Fernandes et al., 2006; Nyhan et al., 2005).

Mental illness and substance use disorders

Severe mental illnesses

- The *preponderance of evidence* indicates that medication, psychotherapy, and electroconvulsive therapy (ECT) are *effective* treatments for bipolar disorder, major depression, and schizophrenia.

- The *preponderance of evidence* indicates that treating persons who have bipolar disorder, schizophrenia, or severe or recurrent major depressive disorder with both medication and psychotherapy is more *effective* than treating them with either medication or psychotherapy alone (APA, 2000, 2002, 2004; NCCMH, 2006, 2009a, 2009b).

Alcoholism

- There is *clear and convincing evidence* that pharmaceuticals and certain forms of psychotherapy, including 12-step programs, are *effective* treatments for alcoholism (APA, 2006; Mann et al., 2004; Srisurapanont and Jarusuraisin, 2005).

Illnesses and injuries due to intoxication or consumption of controlled substances

- There is *insufficient evidence* to determine whether prohibiting health insurers from excluding coverage for illnesses and injuries due to intoxication or use of controlled substances (other than those prescribed by a physician) increases the provision of screening and counseling for alcoholism and substance abuse disorders (CHBRP, 2007c).

[15] Phenylketonuria (PKU) is a metabolic disorder. Persons who have PKU cannot properly metabolize phenylalanine, an amino acid found in high concentrations in high-protein foods. Inability to metabolize phenylalanine causes accumulation of phenylalanine and phenylketones in the blood, which can lead to mental retardation, behavioral problems, and other disorders if not treated.

Orthodontic services

Orthodontia for oral clefts

- No studies of the effectiveness of orthodontic services for persons with oral clefts were identified. However, there is consensus among experts that orthodontic services coordinated with reconstructive surgeries performed as a child develops should be part of standard care for oral clefts. (CHBRP, 2008b).

Prostheses, orthoses, and special footwear

Prosthetic devices for amputations and limb deformities

- Use of prosthetic devices has been the standard of care for amputations and congenital limb deformities for so long that their benefits are widely accepted even though there are very few controlled studies of prosthetics versus no treatment.

Orthoses

- There is a *preponderance of evidence* that knee orthoses are *effective* treatments for osteoarthritis of the knee (Brouwer et al., 2005), that foot orthoses are *effective* treatments for rheumatoid arthritis of the foot (Clark et al., 2006; Egan et al., 2001), and that ankle orthoses are *effective* for prevention of ankle sprains (Handoll et al., 2001).

- There is *insufficient evidence* to assess the effectiveness of foot orthoses for treatment of Achilles tendonitis, plantar heel pain, soreness around the kneecap; the effectiveness of knee orthoses for treatment of soreness around the knee; hand and wrist orthoses for treatment of rheumatoid arthritis of the hand and wrist; or the effectiveness of foot and knee orthoses for prevention of sprains, strains, and stress fractures (Crawford and Thomson, 2003; D'Hondt et al., 2002; McLauchlan and Handoll, 2001; Rome et al., 2005; Yeung and Yeung, 2001).

- There is a *preponderance of evidence* that foot orthoses are *not effective* treatments for abnormal deviation of the big toe and bunions (Ferrari et al., 2004).

- Prosthetic devices for persons who have had a laryngectomy

- Evidence from small nonrandomized studies of persons who have had a laryngectomy suggests that tracheoesophageal speech with a voice prosthesis *is more intelligible* than speech produced using esophageal speech and electrolaryngeal speech, and requires less cognitive effort on the part of listeners (Arias et al., 2000; Evitts and Searl, 2006; Globlek et al., 2004; Stajner-Katusic et al., 2006).[16]

[16] Laryngectomies are usually performed to treat cancer of the larynx. They are occasionally performed on persons whose throats have been severely injured. Persons who have a laryngectomy lose the ability to speak normally. The three methods most frequently used to enable persons with laryngectomies to speak are esophageal speech, electrolarygneal speech, and tracheosophageal speech with a voice prosthesis. Esophageal speech involves the use of the esophagus to produce sound in place of the larynx. Electrolaryngeal speech is produced by a battery-operated machine that is held against the neck or placed in a small tube in the corner of the mouth. Speech therapy is needed to successfully use any of these three methods. Tracheoesophageal speech is generated through use of a one-way,

- Evidence of the effectiveness of tracheoesophageal speech with a voice prosthesis relative to esophageal speech and electrolaryngeal speech on self-reported ability to communicate in daily-life situations (e.g., talking on the telephone) is *ambiguous* (Carr et al., 2000; Farrand and Duncan, 2007; Tsai et al., 2003).

- The *preponderance of evidence* from two nonrandomized studies suggests that quality of life *does not differ* among persons with laryngectomies who use tracheoesophageal speech with a voice prosthesis, esophageal speech, or electrolaryngeal speech (Carr et al., 2000; Farrand and Duncan, 2007).

Special footwear (i.e., therapeutic shoes)

- A *preponderance of evidence* suggests that therapeutic shoes are *effective* in improving functioning and reducing pain and inflammation in persons with rheumatoid arthritis (Farrow et al., 2005).

- The evidence of the effectiveness of therapeutic footwear in preventing recurrence of diabetic foot ulcers is *ambiguous* (Bus et al., 2008; Maciejewski et al., 2004; McIntosh et al., 2003).

- There is *insufficient evidence* to determine whether therapeutic footwear prevents amputation among persons with diabetes (Maciejewski et al., 2004; McIntosh et al., 2003).

- Evidence from three small RCTs suggests that therapeutic shoes are *less effective* than total contact casting in facilitating healing of diabetic foot ulcers (Bus et al., 2008; Maciejewski et al., 2004; McIntosh et al., 2003).

Pain management

Acupuncture

- The *preponderance of evidence* suggests that needle acupuncture[17] is an *effective* treatment for some musculoskeletal conditions, chronic headache, and postoperative nausea and vomiting.

- The *preponderance of evidence* suggests that needle acupuncture is as *effective* as or *more effective* than other nonsurgical treatments for osteoarthritis of the knee, temporomandibular joint (TMJ) disorders, pelvic pain associated with pregnancy, chronic headache, and postoperative nausea and vomiting.

- The *preponderance of evidence* suggests that needle acupuncture is an *effective* adjuvant treatment for chronic low back pain, pelvic pain, stroke, and chemotherapy-induced vomiting (CHBRP, 2007a).

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prosthetic valve that is placed in an incision between the esophagus and the trachea. This prosthesis allows air from the lungs to flow into the esophagus to produce sound.

[17] Needle acupuncture refers to the use of needles to stimulate acupuncture pressure points. Evidence of the effectiveness of other treatments provided by acupuncturists, such as cupping and moxibustion, was not reviewed.

Pain management medication for persons with terminal illnesses

- Most of the research on pain management for persons with life-threatening illness has focused on cancer pain. Some of these studies include both persons whose cancers are terminal and persons who cancers are treatable.

- The *preponderance of evidence* indicates that medications *reduce* pain caused by cancer or cancer treatment (Goudas et al., 2001).

General anesthesia for dental procedures

- The use of general anesthesia and other forms of sedation for dental procedures is based primarily on consensus rather than scientific evidence.

- There is a consensus that general anesthesia is appropriate for persons who have physical or mental disabilities that make it difficult for them to cooperate during dental procedures, persons who cannot be given local anesthesia due to allergy or acute infection, and persons who need extensive dental care or dental surgery.

- There is a consensus that children undergoing dental procedures should receive general anesthesia only if they are unable or unwilling to undergo the procedure using local anesthesia or nitrous oxide (ADA, 2005; AAPD/AAP, 2006).

Pediatric health: Comprehensive preventive services for children and adolescents

- There is *a preponderance of evidence* that the following preventive services for children and adolescents are *effective*:

    - Immunizations recommended by the Centers for Disease Control Advisory Committee on Immunization Practices (ACIP, 2000, 2006; Bilukha et al., 2005; CDC, 1997; CHBRP, 2009; Cortese and Parashar, 2009; Fiore et al., 2009; Kretsinger et al., 2006; Marin et al., 2007; Mast et al., 2005; Prevots et al., 2000; USPSTF, 1996; Watson et al., 1998.)[18]
    - Counseling regarding nutrition and prevention of unintentional injuries (USPSTF, 1996)
    - Screening newborns for metabolic disorders shortly after birth (e.g., congenital hypothyroidism, hemoglobinopathies, PKU, galactosemia) (USPSTF, 1996, 2009a)
    - Screening children younger than 5 years for visual impairment (USPSTF, 2009a)
    - Providing Pap smears to sexually active adolescent females (USPSTF, 2009a)
    - Screening all sexually active adolescent females for chlamydia (USPSTF, 2009a)
    - Screening for gonorrhea, HIV, and syphilis among sexually active adolescents who are at *increased* risk for contracting these diseases (USPSTF, 2009a)
    - Screening newborns for hearing loss (USPSTF, 2009a)

[18] These immunizations include vaccines against diphtheria, tetanus, pertussis, haemophilus influenza type b, hepatitis a, hepatitis b, human papillomavirus, polio, influenza, measles, mumps, rubella, meningococcal disease, pneumococcal infection, rotavirus, and chickenpox.

- There is a *preponderance of evidence* to suggest that screening asymptomatic adolescents for the herpes simplex virus is *not effective* and that the harms of screening may outweigh the benefits (USPSTF, 2009a)

- There is *insufficient evidence* to recommend for or against the following preventive services:
  - Screening asymptomatic children for iron deficiency anemia (USPSTF, 2009a)
  - Counseling children and adolescents regarding nutrition (USPSTF, 2009a)
  - Violence prevention counseling (USPSTF, 1996)

- No meta-analyses, systematic reviews, or evidence-based guidelines could be located for some recommended preventive services for children and adolescents. In these cases, CHBRP relied on expert consensus or opinion. These services include:
  - Physical examinations (AAP, 2000)
  - Measurement of height, weight, head circumference, and blood pressure (Kuczmarski et al., 2000; USPSTF, 1996)
  - Developmental and behavioral assessments (AAP, 2000)
  - Screening children at high risk for iron deficiency (AAP, 2000)
  - Counseling regarding infant sleep position (AAP, 2000)
  - Preventive dental examinations (AAP, 2000)
  - Urinalysis screening of asymptomatic children under age 5 years and sexually active adolescents (AAP, 2000)
  - Pelvic examinations for sexually active adolescent females (AAP, 2000)
  - Tuberculin testing for children and adolescents at high risk for tuberculosis (AAP, 2000)
  - Cholesterol testing for children and adolescents at high risk for high cholesterol (AAP, 2000)

Management of pediatric asthma

- There is *clear and convincing evidence* that asthma self-management education helps children with asthma and their parents learn skills necessary for controlling asthma and improving their health.

- The *preponderance of evidence* suggests that peak flow monitoring is as *effective* as symptom monitoring and is especially useful for persons who have moderate or severe persistent asthma or a history of severe asthma exacerbations.

- The *preponderance of evidence* suggests that nebulizers and metered-dose inhalers (MDIs) are equally *effective* in improving health outcomes and that nebulizers should be used by persons who cannot use an MDI with a spacer or an MDI with both a spacer and face mask, such as infants.

- A *preponderance of evidence* suggests that use of spacers in conjunction with MDIs reduces the risk of local adverse effects, such as oral thrush;[19] they are most likely to benefit persons who are having a severe asthma exacerbation or who cannot use MDIs properly (e.g., young children) (Ahrens et al., 1995; CHBRP, 2004, 2006a; Dolovich et al., 2005; Feddah et al., 2001; NAEP, 2007).[20]

Screening for blood lead level*s*

- There is *insufficient evidence* to recommend for or against routine screening for elevated blood lead levels in asymptomatic children who are at *increased risk* for lead poisoning.

- There is a *preponderance of evidence* to recommend *against* routine screening for elevated blood lead levels in asymptomatic children who are at *average risk* for lead poisoning due to the significant potential harms of treatment (USPSTF, 2009a).[21]

Reproductive health

Contraceptive devices requiring a prescription[22]

- There is *clear and convincing evidence* that sexually active females who use prescription contraceptives are *much less likely* to become pregnant than sexually active females who do not use any type of contraception.

- There is a *preponderance of evidence* that prescription contraceptives are *more effective* than nonprescription contraceptives for preventing pregnancy.[23]

[19] Oral thrush is an oral yeast infection.

[20] Studies of the impact of using spacers with MDIs on inhalation of asthma medications are difficult to generalize, because their features vary and because they have been studied in conjunction with different medications. Findings from laboratory studies suggest that effectiveness varies across medications and across spacers with different features (e.g., integrated with MDI device, contains valved holding chamber, shape of chamber, rigid or flexible chamber). In addition, many studies have sample sizes that limit their ability to detect statistically significant differences in breathing outcomes. Finally, no studies have been published regarding the use of spacers with the new hydrofluoroalkane-propelled MDIs (HFA MDIs). Historically, MDIs have used chlorofluorocarbons (CFCs), a major cause of ozone depletion, to propel medication. The U.S. Food and Drug Administration (FDA) ordered the removal of CFC-based MDIs from the market at the end of 2008. They have been replaced by HFA MDIs.

[21] There is good evidence that chelation treatment in asymptomatic children does not improve neurodevelopmental outcomes and is associated with a slight diminution in cognitive performance. Chelation therapy may result in transient renal, hepatic, and other toxicity, mild gastrointestinal symptoms, sensitivity reactions, and rare life-threatening reactions.

[22] Prescription contraceptives can be divided into three major categories: barrier methods, intrauterine devices, and hormone-based contraceptives. Barrier methods are devices inserted into the vagina that are used in conjunction with a spermicide and removed between episodes of intercourse. They include the cervical cap, the cervical shield, and the diaphragm. Intrauterine devices are small devices composed of copper wire wrapped around a plastic frame that are implanted in the uterus. Hormone-based contraceptives prevent ovulation and change the lining of the uterus and cervical mucus to prevent pregnancy. Multiple methods have been developed to deliver hormone-based contraceptives, including pills, injections, implants, skin patches, and vaginal rings.

[23] However, prescription contraceptives *do not* protect against HIV. Condoms are the only form of contraception that prevents transmission of HIV.

- There is *clear and convincing evidence* that hormone-based contraceptives and IUDs are *more effective* than barrier methods for preventing pregnancy (WHO, 2009).

Infertility

- There is a *preponderance of evidence* that there are *effective* tests for ascertaining whether female infertility is due to lack of ovulation, tubal occlusion, endometriosis, or chlamydia.

- There is a *preponderance of evidence* that medication and surgery are *effective* treatments for certain disorders that cause infertility in males and females, and that tubal flushing is an *effective* treatment for other causes of female infertility.

- There is *clear and convincing evidence* that intrauterine insemination *increases* the likelihood of pregnancy in couples with mild male factor fertility problems or unexplained fertility problems, or where a female partner has minimal to mild endometriosis (Attia et al, 2007; Luttjeboer et al., 2007; NCCWCH, 2004).

Prenatal diagnosis of genetic disorders

- There is a *preponderance of evidence* that there are *accurate* tests for identifying fetuses with certain genetic disorders, such as Down syndrome, spina bifida, and anencephaly (ACOG, 2007; Alfirevic et al., 2003; NCCWCH, 2008; Wald et al., 2008).

Expanded alpha-fetoprotein screening

- There is a *preponderance of evidence* that expanded alpha-fetoprotein screening tests *accurately* detect likely cases of Down syndrome. Performing this test reduces the number of women with healthy fetuses, who will undergo diagnostic tests that have a small risk of miscarriage (ACOG, 2007; NCCWCH, 2008).

Surgical procedures

Jawbone and associated bone disorders

- TMJ disorders were the only disorder of the jawbone and associated bone joints for which evidence could be located.

- A *preponderance of evidence* suggests that surgical treatments for TMJ disorders are *effective* at reducing pain among persons who do not respond to nonsurgical treatments (Reston and Turkelson, 2003).

Reconstructive surgery

- Clubfoot, craniofacial abnormalities, and breast reconstruction following mastectomy are the only indications for reconstructive surgery for which evidence could be located.

- Evidence of the impact of breast reconstruction following mastectomy on psychosocial outcomes is *ambiguous* (Fung et al., 2001; Holly et al., 2003; Janz et al., 2005; Nano et al.,

2005; Nissen et al., 2001; Pusic et al., 1999; Rowland et al., 2000; Rubino et al., 2007; Yurek et al., 2000).[24]

- There is *insufficient evidence* to ascertain the effects of reconstructive surgery on physical and psychosocial outcomes for persons with clubfoot or craniofacial abnormalities (Endriga and Kapp-Simon, 1999; Marcusson et al., 2001, 2002; Roye et al., 2001; Sarwer et al., 1999; Vitale et al., 2005).

Hospice and home health care

Hospice care[25]

- Studies of hospice care vary widely with regard to research design, study population, characteristics of the hospice intervention,[26] and outcomes assessed.

- Most studies of hospice care that have strong research designs were published in the 1980s. Pain control medication and standards of care for pain control may have changed since these studies were conducted.

- Most studies have evaluated the impact of hospice care on persons with terminal cancers.

- The *preponderance of evidence* suggests that hospice care *reduces* some symptoms associated with terminal illness, such as anxiety, diarrhea, and nausea.

- The evidence of the effects of hospice care on the duration, frequency, and severity of pain is *ambiguous*.

- The evidence of the effects of hospice care on hospital use and quality of life is *ambiguous* (Harding et al., 2005; Higginson et al., 2003; NICE, 2004; Zimmermann et al., 2008).

Home care

- Studies of home care vary widely with regard to study populations, characteristics of home care interventions, comparison groups,[27] and outcomes assessed.

[24] Women who have a mastectomy can elect to have breast reconstruction surgery or use a breast prosthesis. For most women with stage I or stage II breast cancer, mastectomy and breast-conserving therapy (lumpectomy with levels I and II axillary node dissection, plus radiotherapy) are equally effective treatments. Mastectomy and chemotherapy and hormone treatment are the most effective treatments for stage III and stage IV cancers.

[25] Hospice care encompasses care and services provided to persons in the late stages of terminal illnesses to relieve pain and suffering and maximize quality of life prior to death, and services provided to families to help them cope with a loved one's illness and their own bereavement.

[26] Some studies have assessed the delivery of hospice care in patients' homes, and some have examined inpatient hospice units in hospitals. Others have evaluated interventions that combined home-based and inpatient hospice services.

[27] Some studies compare persons receiving home care to persons who receive "usual care," an undefined set of services typically available to persons in the communities in which the studies are undertaken. Other studies compare persons who receive rehabilitative services (e.g., physical therapy) in their homes to persons who receive similar services in inpatient settings.

- Most studies have evaluated the impact of home care on elderly persons and many were conducted outside the United States.

- There is *clear and convincing evidence* that home care is associated with statistically significant *reductions* in days of hospitalization and nursing home use and with a nonsignificant decrease in mortality relative to usual care (Hedrick et al., 1989; Hughes et al., 1997; Parker et al., 2002).

- There is *clear and convincing evidence* that home-based rehabilitation is associated with *fewer* days of hospitalization than inpatient rehabilitation (Cunliffe et al., 2004; Shepperd et al., 2009). The *preponderance of evidence* suggests that persons with stroke or hip fracture who receive home-based rehabilitation have *better* physical functioning than persons who receive inpatient rehabilitation (Crotty et al., 2002; Early Supported Discharge Trialists, 2005; Giusti et al., 2006; Kuisma, 2002; Langhorne and Widen-Holmqvist, 2007).

- The *preponderance of evidence* indicates that home-based rehabilitation and inpatient rehabilitation have *similar effects* on mortality, psychological functioning, quality of life, hospital readmission, and caregiver burden (Cunliffe et al., 2004; Early Supported Discharge Trialists, 2005; Langhorne and Widen-Holmqvist, 2007; Shepperd et al., 2009).

- There is *insufficient evidence* to determine whether home care improves physical or mental health outcomes for children with very low birth weight, genetic disorders, or chronic conditions (Parker et al., 2002).

Table 4. Mandates Addressed in AB 1904, by Strength of Evidence

Description	**Clear and Convincing Evidence that Test(s) and/or Treatment(s) *Are* Effective**	**Preponderance of Evidence that Test(s) and/or Treatment(s) *Are* Effective**	**Evidence of the Effectiveness of Test(s) and/or Treatment(s) Is Ambiguous**	**Insufficient Evidence to Determine whether Test(s) and/or Treatment(s) *Are* Effective**	**Preponderance of Evidence that Test(s) and/or Treatment(s) *Are Not* Effective**
Cancer Screening and Treatment					
Cancer screening tests	X, colorectal, breast, and cervical cancer screening			X, lung, oral, and skin cancer screening	X, bladder, ovarian, pancreatic, prostate, and testicular cancer screening
Prostate cancer screening and diagnosis					X
Cervical cancer screening	X				
Breast cancer screening, diagnosis and treatment	X				
Breast cancer screening with mammography	X				
Mastectomy and lymph node dissection: length of stay				X	
Chronic Conditions					
Diabetes management	X, except for special footwear				
Osteoporosis diagnosis, treatment, and management	X				
Human immunodeficiency virus screening	X				

Table 4. Mandates Addressed in AB 1904, by Strength of Evidence (cont'd.)

Description	Clear and Convincing Evidence that Test(s) and/or Treatment(s) *Are* Effective	Preponderance of Evidence that Test(s) and/or Treatment(s) *Are* Effective	Evidence of the Effectiveness of Test(s) and/or Treatment(s) Is Ambiguous	Insufficient Evidence to Determine whether Test(s) and/or Treatment(s) *Are* Effective	Preponderance of Evidence that Test(s) and/or Treatment(s) *Are Not* Effective
Chronic Conditions (cont'd.)					
Transplantation services for persons with HIV		X[28]			
Phenylketonuria, medical formulas and medical foods		X			
Mental Illness and Substance Use Disorders					
Parity in coverage for severe mental illness	X[29]				
Coverage for mental and nervous disorders	X				
Alcoholism	X				

[28] Most evidence regarding organ transplantation in persons with HIV comes from studies of persons receiving kidney or liver transplants. There is insufficient evidence to determine whether findings generalize to transplantation of other organs.

[29] The review of evidence regarding treatments for mental illness was limited to three severe mental illnesses: bipolar disorder, major depressive disorder, and schizophrenia.

Table 4. Mandates Addressed in AB 1904, by Strength of Evidence (cont'd.)

Description	Clear and Convincing Evidence that Test(s) and/or Treatment(s) *Are* Effective	Preponderance of Evidence that Test(s) and/or Treatment(s) *Are* Effective	Evidence of the Effectiveness of Test(s) and/or Treatment(s) Is Ambiguous	Insufficient Evidence to Determine whether Test(s) and/or Treatment(s) *Are* Effective	Preponderance of Evidence that Test(s) and/or Treatment(s) *Are Not* Effective
Mental Illness and Substance Use Disorders (cont'd.)					
Prohibition on exclusion of coverage for illnesses or injuries associated with intoxication or consumption of controlled substances not prescribed by a physician				X	
Orthodontic Services					
Orthodontic services for persons with oral clefts				X	
Prostheses, Orthoses, and Footwear					
Orthotic and prosthetic devices		X, prostheses and some orthoses[30]		X, some orthoses[31]	X, foot orthoses for deviated big toe
Prosthetic devices for laryngectomy			X[32]		

[30] There is a preponderance of evidence that knee orthoses are effective treatments for osteoarthritis of the knee and that foot orthoses are effective treatments for rheumatoid arthritis of the foot. There is also a preponderance of evidence that ankle orthoses are effective for prevention of ankle sprains.

[31] There is insufficient evidence to assess the effectiveness of foot orthoses for treatment of Achilles tendonitis, plantar heel pain, and soreness around the kneecap, and the effectiveness of knee orthoses for treatment of soreness around the kneecap. There is also insufficient evidence to determine the effectiveness of hand and wrist orthoses for treatment of rheumatoid arthritis, and the effectiveness of foot and knee orthoses for prevention of strains, sprains, and stress fractures.

[32] Findings from acoustical analyses differ from findings from studies of the self-reported ability to communicate in everyday situations.

Table 4. Mandates Addressed in AB 1904, by Strength of Evidence (cont'd.)

Description	Clear and Convincing Evidence that Test(s) and/or Treatment(s) *Are* Effective	Preponderance of Evidence that Test(s) and/or Treatment(s) *Are* Effective	Evidence of the Effectiveness of Test(s) and/or Treatment(s) Is Ambiguous	Insufficient Evidence to Determine whether Test(s) and/or Treatment(s) *Are* Effective	Preponderance of Evidence that Test(s) and/or Treatment(s) *Are Not* Effective
Prostheses, Orthoses, and Footwear (cont'd.)					
Special footwear for persons with foot disfigurement		X, rheumatoid arthritis[33]	X, diabetes		
Pain Management					
Acupuncture		X[34]			
Pain management medication for persons with terminal illnesses		X cancer [35]			
General anesthesia for dental procedures performed in hospitals				X[36]	

[33] The only literature located on special footwear concerned special footwear for persons with diabetes or rheumatoid arthritis. Findings from these studies may not generalize to persons with foot disfigurement due to other diseases or conditions.
[34] Evidence of effectiveness varies across the many diseases and conditions that are treated with acupuncture. The literature review was limited to studies of the use of acupuncture needles to stimulate acupressure points; other services provided by acupuncturists, such as cupping and moxibustion, were not assessed.
[35] Most studies of the impact of pain management medication on persons with terminal illnesses have assessed persons with terminal cancers. Their findings may not generalize to persons in the terminal phases of other diseases or conditions.
[36] No studies of the effectiveness of general anesthesia for dental procedures were located. However, there is a consensus among experts that use of general anesthesia is appropriate for young children, children who are extremely anxious or fearful about dental procedures, persons with mental or physical disabilities that impede their ability to cooperate during dental procedures, persons for whom local anesthesia cannot be used due to allergy or acute infection, and persons who require extensive dental care or dental surgery.

Table 4. Mandates Addressed in AB 1904, by Strength of Evidence (cont'd.)

Description	Clear and Convincing Evidence that Test(s) and/or Treatment(s) *Are* Effective	Preponderance of Evidence that Test(s) and/or Treatment(s) *Are* Effective	Evidence of the Effectiveness of Test(s) and/or Treatment(s) Is Ambiguous	Insufficient Evidence to Determine whether Test(s) and/or Treatment(s) *Are* Effective	Preponderance of Evidence that Test(s) and/or Treatment(s) *Are Not* Effective
Pediatric Health					
Comprehensive preventive services for children aged 16 years or younger		X, some recommended services[37]		X, some recommended services[38,39]	
Comprehensive preventive care for children aged 17 or 18 years		X, some recommended services		X, some recommended services	
Asthma management		X, peak flow monitors, nebulizers, education	X, spacers		

[37] The mandates regarding comprehensive preventive services for children and adolescents require health plans to cover services recommended by the American Academy of Pediatrics (AAP) and the Recommended Childhood Immunization Schedule issued jointly by AAP, the American Academy of Family Physicians, and the Centers for Disease Control's Advisory Committee on Immunization Practices. Recommended services that *a preponderance of evidence indicates are effective* include immunizations, vision screening for children younger than five years, screening newborns for metabolic disorders, Pap smears for sexually active adolescent females, sexually transmitted disease screening for sexually active adolescents, and counseling parents and children about nutrition and prevention of unintentional injury.

[38] Recommended preventive services for children and adolescents for which *evidence of effectiveness is insufficient* include screening newborns for hearing loss, screening asymptomatic children for iron deficiency, screening asymptomatic adolescents for the herpes simplex virus, nutrition counseling, and violence prevention counseling.

[39] No meta-analyses, systematic reviews, or evidence-based guidelines could be located for some recommended preventive services for children and adolescents. For these services, the only evidence reviewed by CHBRP is based on expert consensus or opinion. These preventive services include physical examinations; measurement of height, weight, head circumference, and blood pressure; developmental and behavioral assessments; screening high risk children for iron deficiency; urinalysis screening of asymptomatic children under age 5 and sexually active adolescents; pelvic exams for sexually active adolescent females; tuberculin testing for children and adolescents at high risk for tuberculosis; cholesterol testing for children and adolescents at high risk for high cholesterol; counseling regarding infant sleep position; and preventive dental examinations.

Table 4. Mandates Addressed in AB 1904, by Strength of Evidence (cont'd)

Description	Clear and Convincing Evidence that Test(s) and/or Treatment(s) *Are* Effective	Preponderance of Evidence that Test(s) and/or Treatment(s) *Are* Effective	Evidence of the Effectiveness of Test(s) and/or Treatment(s) Is Ambiguous	Insufficient Evidence to Determine whether Test(s) and/or Treatment(s) *Are* Effective	Preponderance of Evidence that Test(s) and/or Treatment(s) *Are Not* Effective
Pediatric Health (cont'd.)					
Screening children for blood lead levels				X, children at increased risk	X, children at average risk
Reproductive Health					
Contraceptive devices requiring a prescription	X				
Infertility: diagnosis and treatment	X				
Prenatal diagnosis of genetic disorders		X			
Expanded alpha-fetoprotein screening		X			
Surgical Procedures					
Jawbone and associated bone joints		X[40]			
Reconstructive surgery			X, mastectomy with breast reconstruction[41]	X, clubfoot and craniofacial abnormalities	

[40] TMJ disorders were the only indication for jaw surgery for which evidence of effectiveness could be located.
[41] Evidence was located for only three indications for reconstructive surgery: breast reconstructive following mastectomy, clubfoot, and craniofacial abnormalities.

Table 4. Mandates Addressed in AB 1904, by Strength of Evidence (cont'd)

Description	Clear and Convincing Evidence that Test(s) and/or Treatment(s) *Are* Effective	Preponderance of Evidence that Test(s) and/or Treatment(s) *Are* Effective	Evidence of the Effectiveness of Test(s) and/or Treatment(s) Is Ambiguous	Insufficient Evidence to Determine whether Test(s) and/or Treatment(s) *Are* Effective	Preponderance of Evidence that Test(s) and/or Treatment(s) *Are Not* Effective
Home Health Care and Hospice Care					
Home health care	X, elderly and disabled adults			X, children	
Hospice care			X		

Sources: AACE, 2007; AAP, 2000; ACOG, 2007; Ahrens et al., 1995; Alfirevic et al., 2003; Andriole et al., 2009; APA, 2000, 2002, 2004, 2006; Arias et al., 2000; Attia et al, 2007; Brouwer et al., 2005; Bus et al., 2008; Carr et al., 2000; CHBRP, 2004, 2005a, 2005b, 2006a, 2007a, 2007c , 2008a, 2008b; Crawford and Thomson, 2003; Crotty et al., 2002; Cunliffe et al., 2004; D'Hondt et al., 2002; Dolovich et al., 2005; Early Supported Discharge Trialists, 2005; Endriga and Kapp-Simon, 1999; Evitts and Searl, 2006; Farrand and Duncan, 2007; Farrow et al., 2005; Feddah et al., 2001; Fernandes et al., 2006; Ferrari et al., 2004; Fung et al., 2001; Giusti et al., 2006; Globlek et al., 2004; Goudas et al., 2001;Handoll et al., 2001; Harding et al., 2005; Hedrick et al., 1989; Higginson et al., 2003; Holly et al., 2003; Hughes et al., 1997; Janz et al., 2005; Kuczmarski et al., 2000; Kuisma, 2002; Langhorne and Widen-Holmqvist, 2007; Luttjeboer et al., 2007; Maciejewski et al., 2004; Mann et al., 2004; Marcusson et al., 2001, 2002; McIntosh et al., 2003;McLauchlan and Handoll, 2001; NAEP, 2007; Nano et al., 2005; NCCCC, 2009; NCCMH, 2006, 2009a, 2009b; NCCN, 2009; NCCWCH, 2004, 2008; NICE, 2004, 2010a, 2010b; Nissen et al., 2001; Nyhan et al., 2005; Parker et al., 2002; Pusic et al., 1999; Reston and Turkelson, 2003; Rome et al., 2005; Rowland et al., 2000; Roye et al., 2001; Rubino et al., 2007; Sarwer et al., 1999; Schröder et al., 2009; Shepperd et al., 2009;SIGN, 2003; Srisurapanont and Jarusuraisin, 2005; Stajner-Katusic et al., 2006; Tsai et al., 2003; USPSTF, 2009a; Vitale et al., 2005; Wald et al., 2008; WHO, 2009; and Yeung, 2001; Yurek et al., 2000; Zimmermann et al., 2008;

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Utilization, Cost, and Coverage Impacts

AB 1904 would allow a carrier domiciled in another state to offer, sell, or renew a health care service plan contract or a health insurance policy in this state without holding a license issued by the California Department of Managed Health Care or a certificate of authority issued by the California 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.

The carrier's plan or policy would be exempt from all Knox-Keene licensing requirements and requirements under the California Insurance Code as long as the plan or policy is lawfully authorized and complies with the domiciliary state's requirements. Included in the exemptions are all existing benefit mandates.

The intent of AB 1904 is to allow for the development, marketing, and purchasing of health insurance products in California that are more affordable and thereby expand coverage to the uninsured, especially for those that would purchase coverage in the small-group or individual markets ("limited-mandate products"). The bill seeks to do this by allowing these products to:

- No longer be subjected to California health benefit mandates, and
- No longer be subjected to premium requirements, patient protection requirements, fiduciary and financial requirements, and provider access mandates.

Because there are currently 44 health insurance benefit mandates under California law, the number of possible combinations of these 44 benefits that might be offered if they were no longer mandated is virtually limitless (more than 17 quadrillion). Since it is not possible to predict which of these will be offered by out-of-state carriers, CHBRP neither attempted to analyze any particular limited-mandate combination of benefits, nor did it attempt to predict the offer rates of employers or the take-up rates of individuals in the group market or individual market to a limited-mandate combination of benefits. Instead, CHBRP employed a scenario analysis approach to the assessment of the impact of AB 1904, under simplifying assumptions regarding health insurance product design, as is described later in this section. Details on the designs used to model the cost impact scenarios are presented in Appendix F.

This section first provides a brief summary of the existing literature on the cost of insurance mandates in order to put the possible effects of AB 1904 on health care premiums into context. *For further details on the underlying data sources and methods, please see Appendix D at the end of this document.* Further discussion on the cost and availability of health insurance is presented in Part II of this document. The section then presents the scenarios used to analyze the possible projected impact of AB 1904, the assumptions used to model each scenario, and their potential cost impacts.

Cost of Insurance Mandates: Summary of the Literature

The financial cost of mandated health insurance benefits can be defined either as the full cost of the service or as the marginal or additional cost of the mandate. The marginal cost equals the full cost of the service minus the cost of the services that would be covered in the absence of the legal requirement imposed by the mandate. The cumulative cost of the mandated benefits depends also on the number of mandated benefits. Two sources thus may contribute to the potential lower premium of a limited-mandate plan: lower cost for each limited mandate, and a lower number of benefits. In Texas, for example, carriers are allowed to offer Consumer Choice Health Benefits plans that do not include all the required mandates.

Estimates for the cumulative cost of the mandated benefits vary. Recent studies estimate the cumulative cost range from 5% to 19% of premium. An evaluation of the Federal legislative proposal to allow carriers to sell insurance across state lines found that in the small-group market, the elimination of benefit mandates that were not in effect in at least 45 states would lead to a premium reduction of 5% (CBO, 2006a, 2006b). For its 2007 analysis of SB 365, CHBRP estimated that allowing out-of-state carriers to compete in the California market without providing coverage for the 44 state-mandated benefits or the Knox-Keene Act benefits would produce a decrease of 10% in total health care expenditures, roughly proportional to a 10% decrease in premiums (CHBRP, 2007d). However, in preparing for the analysis of AB 1904, CHBRP consulted with content experts who indicated that in-state carriers in California are able to obtain discounts of 10% to 15% and more from provider networks compared to out-of-state carriers 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 economies of scale in administraion of arrangements between health plans and provider networks. This cost advantage was not factored into CHBRP's previous analysis of SB 365. In analyzing a related piece of legislation (AB 1214), CHBRP estimated that eliminating all 44 of California's mandates for in-state carriers, while maintaining the Knox-Keene Act benefits, would reduce premiums by about 4.8% (CHBRP, 2007b).

The premiums savings for other states vary. The Texas Department of Insurance has been collecting mandated benefit cost and experience data from their largest carriers since 1992. For the most recent study period—October 2004 to September 2005 data—they estimate that for individual (non-group) benefit plans, mandated benefit costs 3.10% of total premiums and 3.90% of total premiums for group plans. Their review of the data for each mandated benefit shows that each benefit accounted for less than 1% of total claim costs. Claims paid for diabetes education and supplies represented the highest percentage of claims at 0.74%. Reconstructive breast surgery following a mastectomy accounted for the next highest percentage of costs at 0.66% of total claims, followed by claims paid for serious mental illness (0.54%), colorectal cancer testing (0.47%), and hearing screening for children (0.44%). The least costly benefits were nutritional supplements for PKU (phenylketonuria) and other inheritable diseases (rare), and telemedicine services; both benefits had claims totaling less than 0.01% of total claims (TDI, 2005).

A Massachusetts study estimated total spending associated with the state's 26 mandated benefit laws was 12% of premiums for the study period: July 1, 2004, through June 30, 2005. Five mandates—maternity, mental health, home health, preventive care for children, and infertility

services—accounted for 80% of the total cost of the mandated benefits, or 10% of premiums. This study estimated the marginal cost of the health insurance mandates ranged from 1.2% of the average premium to 6.4%, with an average between 3% and 4% of premium (Bachman et al., 2008).

A Maryland study (MHCC, 2008) that estimated the cost of their 42 mandates found that the mandates represent 15.4% of a typical group premium and 18.6% of premium for the individual market. The two most expensive mandates were coverage for mental health and substance use benefits at roughly 5% of premium, and hospitalization benefits for childbirth and length of stay for mothers of newborns at 3% of premium, when including the mandate on minimum length of stay. The Maryland study estimated the marginal costs of all its mandates at 2.2% of premium. The two most expensive were for in vitro fertilization with a marginal cost equal to 0.6% of premium and mental illness and substance abuse with a marginal cost equal to 0.5% of premium. (MHCC, 2008)

LaPierre et al. (2009) used Community Tracking Survey data from 1997-2003 to examine the impact of mandates on premiums for indemnity and HMO products in the individual market, with mixed results: They found that although the total number of mandates in a state had no significant effect on premiums, some mandates were cost saving, whereas others resulted in higher premiums. Selected services (or benefit) mandates and provider mandates tended to reduce HMO family premiums, whereas coverage mandates (e.g. mandates requiring coverage of dependents) had the opposite effect.

Cost Impact of Allowing Limited-Mandate Policies to Be Offered in the Group and Individual Markets

The impact of allowing out-of-state carriers to offer limited-mandate insurance products in California could result in lower premiums for Californians in all segments of the insurance market. In a previous analysis of AB 1214, which also would have allowed carriers to offer limited-mandate policies, CHBRP estimated that premium reductions of up to 4% or 5% could be achieved statewide. However, these estimates assumed that the carriers offering these limited-mandate benefits were existing carriers in the California market. An analysis of the across-state-lines proposal that was the basis of Senator McCain's proposal for health reform during his 2008 presidential campaign concluded that it would not necessarily lower premiums because of the large discounts available to large in-state insurers (Bertko et al., 2008). It is not clear how quickly California's largest insurers, which are for-profit (with the exception of Kaiser and Blue Shield of California), might establish out-of-state domiciles in order to offer limited-mandate policies in California. Or, whether other insurers from outside the state would be able to compete effectively with insurers currently licensed in California, which would be able to establish out-of-state domiciles to protect their market share. Because of this uncertainty, CHBRP's analysis of the potential cost impacts of AB 1904 includes three scenarios, representing hypothetical range between maximum and low-impact estimates.

Potential market response by carriers to exemption from licensure in California

In-state carriers

In-state carriers may move their base or "domicile" to another state if they considered it advantageous to compete with other carriers that offer products not subject to California regulations in all markets.

These carriers would not be expected to stop developing, marketing, or selling health insurance products subject to state regulation. Carriers licensed by DMHC would be expected to continue to offer Knox-Keene controlled managed care products, especially to large- or mid-sized groups that may demand a state-regulated product that comes with a comprehensive set of benefits and predictable provider network. Carriers who hold a certificate of authority from the CDI would continue to offer leaner policies since CDI projects are not subject to the mandate to cover maternity costs or hospitalization.

Out-of-state carriers currently licensed in California

Carriers currently domiciled and licensed in another state (out-of-state carriers) would be allowed to offer, sell, or renew a health insurance policy in California. These carriers would be likely to sell products in California that would be most competitive in the small employer group market and the individual market. These out-of-state policies may tend to be lower in cost than those sold by in-state carriers because the state of domicile allows for the development, marketing, and modification of products with minimal insurance requirements, regulatory review, or oversight. Still, the deep discounts of the in-state Blues and combined low provider price/high utilization management of Kaiser will continue to provide lower premiums. Out-of-state carriers that currently have a presence in California—meaning they 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

Out-of-state carriers not currently licensed in California would be permitted to sell out-of-state policies in California. 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. Carriers currently licensed in California 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. In this analysis, Scenario 1 assumes that out-of-state carriers would have an immediate impact on all market segments, whereas the other Scenarios assume that out-of-state carriers would have a more limited impact on the individual market only.

Market share, offer rates, scope of benefits offered, and take-up rates

The ultimate cost impact of AB 1904 would depend on how large a market share the new limited-mandate plans capture, as well as the average premium savings that can be achieved by these plans. Because AB 1904 is likely to increase the availability of health insurance products

with lower premiums relative to the current market, economic theory and research evidence predict that some portion of the currently insured market would switch to these lower-cost plans (known as a substitution effect). Economic theory and evidence also indicate that some individuals who are currently uninsured would be able to purchase insurance because it is now more affordable (known as an income effect). In the group market, the impact of AB 1904 would depend on the market share achieved by these limited-mandate plans, which in turn depends on the proportion of employers that offer these plans (i.e., the offer rate) and the proportion of employees who enroll in these plans when offered (i.e., the take-up rate). In the individual market, the impact of AB 1904 on the market share of limited-mandate plans would depend solely on the take-up rate of individuals.

Evidence suggests that large-group employers who purchase health insurance also generally offer fairly generous benefit packages. For example, based on CHBRP's survey of the largest health insurers in California, 99.50% of covered lives in the large-group market have comprehensive benefit packages (i.e., those with deductibles lower than $1,100 per individual per year). In the small-group market (i.e., employers with 2 to 50 employees), the vast majority (77.67%) of employees have comprehensive benefit packages; although in the CDI-regulated small-group market, about 60% of employees have HDHPs.

HDHPs, which represent a less comprehensive benefit package because of high deductibles and copayments, have a considerable market share in the individual market in California. About 45.03% of covered enrollees in the DMHC-regulated individual market and about 64.16% in the CDI-regulated individual market in California have HDHPs. The large market share of HDHPs in the individual market suggests that purchasers in this market segment are responsive to the lower premiums associated with HDHPs. This is not surprising, given the fact that these purchasers do not receive an employer contribution toward their premium.

Description of scenario analysis

In its analysis of AB 1904, CHBRP does not attempt to predict the offer rates of employers or the take-up rates of individuals in the group market or individual market. Instead, the maximum-impact hypothetical scenario (Scenario 1), and the two low-income impact hypothetical scenarios (Scenarios 2 and 3) make assumptions about the potential impact of AB 1904 if limited-mandate plans replaced full-mandate plans in some or all the segments of the insurance market, with one exception. Beneficiaries of public insurance programs for the low-income and uninsured were assumed to be exempt from AB 1904 because the administering state agencies require participating contractors to follow the scope of benefits in the DMHC-regulated plans. CHBRP also assumes that under all the scenarios, the currently uninsured who would purchase insurance, following passage of AB 1904, are assumed to purchase the cheapest available plans.

Specifically, in Scenario 1, CHBRP assumes that limited-mandate plans would replace full-mandate plans in each of the major market segments (DMHC-regulated group and CDI-regulated group—for both large and small groups, DMHC-regulated individual, and CDI-regulated individual), and for both HDHP and non-HDHP policies within those market segments. This hypothetical scenario is a high-impact estimate because it assumes a 100% offer rate of limited-mandate HDHP and non-HDHP policies and 100% take-up by all individuals in the group and individual markets. In other words, limited-mandate plans would completely displace full-mandate (comprehensive) plans in every market segment, but there would be no switching

between HDHP and non-HDHP policies within market segments. This scenario assumes that current preferences for HDHP and non-HDHP remain constant, and that everyone switches to a limited-mandate version of their current policy in response to the lower premium. This scenario assumes that all California insurance carriers would become domiciled in another state, such as Idaho, whose small number of mandates would allow carriers licensed there to offer the CHBRP prototype limited-mandate policies in all California market segments. This scenario thus represents a maximum hypothetical impact of AB 1904, because there is no reason to believe that every insured Californian would switch to a limited-mandate version of his/her current insurance policy.

CHBRP estimates that Scenario 1 has a low probability of materializing, and particularly so because Kaiser and the two Blue plans are about 65% of the insured market, and Blue plans cannot create a new plan in another state and compete with local Blue plans. Further, the "deep discount" contracts of the Blue plans would not be transferable to non-Blue subsidiary. Thus, an out-of-state Blue subsidiary would have to re-contract with nearly all providers, may not be able to provide the same level of discounting, or provide limited-mandate alternative plans. 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.

The two low income impact hypothetical scenarios (Scenarios 2 and 3) assume that limited-mandate plans would only become widespread for DMHC and CDI-regulated small-group and individual insurance markets. These hypothetical scenarios assume that limited-mandate policies would only have an impact on the most price-sensitive segment of the market – the low income (up to 350% of the FPL in Scenario 2, and up to 200% FPL in Scenario 3) insured in the small-group and individual insurance markets. As for the large-group market, both the DMHC- and the CDI-regulated in-state insurers could prevent effective competition from out-of-state carriers because of the in-state discounts they have negotiated with provider networks and the resulting generous benefits (Marquis et al., 2006), and thus there would be no incentive to offer limited-mandate policies in the large-group market. Furthermore, the large-group market currently has a very low penetration rate by HDHPs, so this market segment is assumed to be less price sensitive.

These scenarios provide low-impact estimates, because they assume that only individuals who have demonstrated a willingness to purchase lower-cost, less comprehensive insurance plans would switch to even lower-cost, limited-mandate plans. Furthermore, in Scenario 1 it is assumed that the take-up rate is 100%, so that all the insured will switch to limited-mandate plans. In Scenarios 2 and 3, in contrast, the take-up rate is limited to 20% for individuals with low-income (with different levels in Scenarios 2 and 3) in the small-group segment, and to 40% in the individual insurance segment.

There are two differences between Scenarios 2 and 3. In Scenario 2, only those with income up to 350% FPL in the individual insurance market segment are assumed to possibly switch. In Scenario 3, individuals in both the small-group and the individual insurance market segment are assumed to possibly switch, but only if their income is very low – up to 200% of FPL.

These scenarios were developed based on CHBRP analysis of the research literature, market trends, and lessons from other states that have attempted to make health insurance more affordable by allowing insurance policies that are exempt from benefit mandates. For example, the research literature and experts generally report that self-insured employers, who are exempt from state benefit mandates, typically offer generous benefit packages (CHCF, 2006). Therefore, CHBRP's analysis assumes that self-insured employers would remain self-insured under AB 1904.

Price of Prototype Benefit Packages That Would Become Available in the DMHC- and CDI-Regulated Markets

The following three tables, one per scenario, strictly price out the premium difference in the benefit packages. The second column shows the baseline premiums in each market segment; these are the baseline estimates CHBRP uses in all of its analyses. The third column shows the reduction in per member per month (PMPM) premium costs associated with the exclusion of currently mandated benefits. Finally, the fourth column shows the percent reduction in premiums that would result from the limited-mandate plans.

Table 5A presents the estimated reduction in premiums associated with the prototype plans developed for Scenario 1. Scenario 1 applies to all market segments in this table. In other words, it assumes that the entire insured population would enroll in limited-mandate plans following enactment of AB 1904. See Appendix F for more details regarding the prototype plans used in this analysis.

Table 5A. Scenario 1: Comparison of Comprehensive-Mandate Plans and AB 1904 Limited-Mandate Plans, by Market Segment

Market Segment	Premiums For Comprehensive Mandate Plans (Baseline) (a) (PMPM)	Reduction due to Limited-Mandate Plans (PMPM)	Reduction due to Limited-Mandate Plans (%)
Large group not HDHP, CDI	$461.00	$24.92	5.4%
Small group not HDHP, CDI	$382.48	$17.12	4.5%
Individual not HDHP, CDI	$187.14	$13.91	7.4%
Large group not HDHP, DMHC	$363.28	$18.30	5.0%
Small group not HDHP, DMHC	$332.94	$14.90	4.5%
Individual not HDHP, DMHC	$418.30	$16.42	3.9%
Large group HDHP, CDI	$407.62	$22.17	5.4%
Small group HDHP, CDI	$282.98	$12.63	4.5%
Individual HDHP, CDI	$178.09	$12.41	7.0%
Large group HDHP, DMHC	$303.90	$12.96	4.3%
Small group HDHP, DMHC	$214.00	$7.59	3.5%
Individual HDHP, DMHC	$321.98	$9.41	2.9%

Source: California Health Benefits Review Program, 2010.
Notes: (a) Baseline benefit premiums are those included in CHBRP's 2009 Cost Model and include coverage of benefits typical of DMHC- and CDI-regulated plans in the current market.
Key: CDI=California Department of Insurance; DMHC=Department of Managed Health Care; HDHP=high-deductible health plan; PMPM=per member per month.

Table 5B presents the estimated reduction in premiums associated with the prototype plans developed for Scenario 2. Scenario 2 applies only to the individual market segment, but only to those earning up to 350% of the FPL. Scenario 2 further assumes that 40% of those people will purchase limited-mandate plans.

Table 5B. Scenario 2: Comparison of Comprehensive-Mandate Plans and AB 1904 Limited-Mandate Plans, by Market Segment

Market Segment	Premiums For Comprehensive Mandate Plans (Baseline) (1) (PMPM)	Reduction Due to Limited-Mandate Plans (PMPM)	Reduction Due to Limited-Mandate Plans (%)
Large group not HDHP, CDI	$461.00	$0.00	0.0%
Small group not HDHP, CDI	$382.48	$0.00	0.0%
Individual not HDHP, CDI	$187.14	$13.91	7.4%
Large group not HDHP, DMHC	$363.28	$0.00	0.0%
Small group not HDHP, DMHC	$332.94	$0.00	0.0%
Individual not HDHP, DMHC	$418.30	$16.42	3.9%
Large group HDHP, CDI	$407.62	$0.00	0.0%
Small group HDHP, CDI	$282.98	$0.00	0.0%
Individual HDHP, CDI	$178.09	$12.41	7.0%
Large group HDHP, DMHC	$303.90	$0.00	0.0%
Small group HDHP, DMHC	$214.00	$0.00	0.0%
Individual HDHP, DMHC	$321.98	$9.41	2.9%

Source: California Health Benefits Review Program, 2010.
Notes: See notes to Table 5A.
Key: See key to Table 5A.

Table 5C presents the estimated reduction in premiums associated with the prototype plans developed for Scenario 3. Scenario 3 applies only to the small groups and individual market segments, but only to those earning up to 200% of the FPL. Scenario 3 further assumes that 40% of those with individual insurance plans, and 20% of those insured in small groups, will purchase limited-mandate plans.

Table 5C. Scenario 3: Comparison of Comprehensive-Mandate Plans and AB 1904 Limited-Mandate Plans, by Market Segment

Market Segment	Premiums For Comprehensive Mandate Plans (Baseline) (1) (PMPM)	Reduction Due to Limited-Mandate Plans (PMPM)	Reduction Due to Limited-Mandate Plans (%)
Large group not HDHP, CDI	$461.00	$0.00	0.0%
Small group not HDHP, CDI	$382.48	$17.12	4.5%
Individual not HDHP, CDI	$187.14	$13.91	7.4%
Large group not HDHP, DMHC	$363.28	$0.00	0.0%
Small group not HDHP, DMHC	$332.94	$14.90	4.5%
Individual not HDHP, DMHC	$418.30	$16.42	3.9%
Large group HDHP, CDI	$407.62	$0.00	0.0%
Small group HDHP, CDI	$282.98	$12.63	4.5%
Individual HDHP, CDI	$178.09	$12.41	7.0%
Large group HDHP, DMHC	$303.90	$0.00	0.0%
Small group HDHP, DMHC	$214.00	$7.59	3.5%
Individual HDHP, DMHC	$321.98	$9.41	2.9%

Source: California Health Benefits Review Program, 2010.
Notes: See notes to Table 5A.
Key: See key to Table 5A.

Estimated Impacts of AB 1904: Using the Hypothetical Scenario Analysis

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

Scenario 1 Findings: All Currently Insured Switch Their Current Insurance to a Limited-Mandate Version of the Same Plan or Policy (see Tables 6A and 6B)

- Under this scenario, 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 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 therefore 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 Tables 7A and 7B)

- 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 in Small Groups, with Incomes Below 200% FPL, Switch to Limited-Mandate Policies (see Tables 8A and 8B)

- 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%.

Table 6A. Scenario 1: Per Member Per Month Premium and Expenditures Before Enactment of AB 1904, by Market Segment, California, 2010

	DMHC-Regulated							CDI-Regulated			Total Insured	Un-insured	Total Insured and Uninsured
	Large Group	Small Group	Indi-vidual	CalPERS HMO (b)	Medi-Cal Managed Care ≥65 Years (c)	Medi-Cal Managed Care <65 Years (c)	Healthy Families Managed Care	Large Group	Small Group	Indi-vidual	(Annual Cost)		(Annual Cost)
Total Enrollees with Health Insurance Subject to State Regulation (a)	9,445,000	2,394,000	785,000	820,000	175,000	2,616,000	814,000	324,000	935,000	1,179,000	19,487,000	6,624,000	26,111,000
Total Enrollees with Health Insurance Subject to State Regulation Subject to AB 1904	9,445,000	2,394,000	785,000	820,000	0	0	0	324,000	935,000	1,179,000	15,882,000	6,624,000	22,506,000
Average portion of premium paid by employer	$290.96	$223.84	$0.00	$332.10	$223.00	$113.00	$93.19	$346.40	$246.40	$0.00	$51,713,067,000	$0.00	$51,713,067,000
Average portion of premium paid by employee	$72.11	$92.31	$364.68	$58.61	$0.00	$0.00	$11.78	$105.37	$79.68	$180.77	$18,813,408,000	$0.00	$18,813,408,000
Total Premium	$363.07	$316.14	$364.68	$390.70	$223.00	$113.00	$104.97	$451.77	$326.08	$180.77	$70,526,476,000	$0.00	70,526,476,000
Member expenses for covered benefits (deductibles, copays, etc.)	$19.77	$25.74	$64.43	$20.15	$0.00	$0.00	$1.52	$58.78	$116.51	$44.19	$5,961,186,000	$0.00	$5,961,186,000
Member expenses for benefits not covered	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$157.52	$12,521,086,000
Total Expenditures	$382.84	$341.88	$429.11	$410.85	$223.00	$113.00	$106.50	$510.56	$442.59	$224.96	$76,487,662,000	$157.52	$89,008,748,000

Source: California Health Benefits Review Program, 2010.

Notes: (a) The population includes individuals and dependents in California who have private insurance (group and individual) or are enrolled in CalPERS HMO. All population figures include enrollees aged 0 to 64 years and enrollees 65 years or older covered by employment-based coverage.

(b) Of these CalPERS members, about 59% are state employees.

(c) Medi-Cal state expenditures for members under 65 years of age include expenditures for the Major Risk Medical Insurance Program (MRMIP) and the Access for Infants and Mothers (AIM) program. Medi-Cal expenditures for members over 65 years of age include those with Medicare coverage.

(d) Total expenditures by the uninsured are assumed to be equal to what the insured population expends for health care services *not* covered by insurance plus 50% of what the insured population expends for health care services that *are* covered by insurance.

Key: CalPERS=California Public Employees' Retirement System; CDI=California Department of Insurance; DMHC=California Department of Managed Care; HMO=health maintenance organization and point of service plans.

Table 6B. Scenario 1: Impacts of AB 1904 on Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2010

	DMHC-Regulated							CDI-Regulated			Total Insured	Un-insured	Total Insured and Uninsured
	Large Group	Small Group	Indi-vidual	CalPERS HMO (b)	Medi-Cal Managed Care ≥65 Years (c)	Medi-Cal Managed Care <65 Years (c)	Healthy Families Managed Care	Large Group	Small Group	Indi-vidual	(Annual Cost)	Pre- and Post-AB 1904	(Annual Cost)
Total Enrollees with Health Insurance Subject to State Regulation (a)	9,445,000	2,394,000	785,000	820,000	175,000	2,616,000	814,000	324,000	935,000	1,179,000	19,487,000	6,624,000	26,111,000
Total Enrollees with Health Insurance Subject to State Regulation Subject to AB 1904	9,445,000	2,394,000	785,000	820,000	0	0	0	324,000	935,000	1,179,000	15,882,000	6,624,000	22,506,000
Average portion of premium paid by employer	−$14.6465	−$9.8035	$0.0000	−$16.7247	$0.0000	$0.0000	$0.0000	−$18.7429	−$11.0961	$0.0000	−$2,303,607,000	$0.00	−$2,303,607,000
Average portion of premium paid by employee	−$3.6301	−$4.0626	−$12.5157	−$2.9514	$0.0000	$0.0000	$0.0000	−$5.7013	−$3.5889	−$12.8570	−$919,420,000	$0.00	−$919,420,000
Total Premium	−$18.2765	−$13.8661	−$12.5157	−$19.6761	$0.0000	$0.0000	$0.0000	−$24.4442	−$14.6850	−$12.8570	−$3,223,026,000	$0.00	−$3,223,026,000
Member expenses for covered benefits (deductibles, copays, etc.)	−$0.9931	−$1.0921	−$2.0275	−$1.0147	$0.0000	$0.0000	$0.0000	−$3.1827	−$5.2245	−$3.1431	−$288,477,000	$0.00	−$288,477,000
Member expenses for benefits not covered	$8.5829	$6.1377	$5.2896	$8.8697	$0.0000	$0.0000	$0.0000	$11.9610	$8.2669	$5.8555	$1,508,319,000	$0.00	$1,508,319,000
Total Expenditures	−$10.6867	−$8.8205	−$9.2537	−$11.8212	$0.0000	$0.0000	$0.0000	−$15.6659	−$11.6426	−$10.1446	−$2,003,185,000	$0.00	−$2,003,185,000
Percentage Impact of Mandate													
Insured premiums	−5.0338%	−4.3860%	−3.4320%	−5.0361%	0.0000%	0.0000%	0.0000%	−5.4107%	−4.5035%	−7.1125%	−4.5700%	$0.00	−4.5700%
Total Expenditures	−2.7914%	−2.5800%	−2.1565%	−2.8772%	0.0000%	0.0000%	0.0000%	−3.0684%	−2.6306%	−4.5096%	−2.6190%	$0.00	−2.2502%

Source: California Health Benefits Review Program, 2010.
Notes: See notes to Table 6A.
Key: See key to Table 6A.

Table 7A. Scenario 2: Per Member Per Month Premium and Expenditures Before Enactment of AB 1904, by Market Segment, California, 2010

	DMHC-Regulated							CDI-Regulated			Total Insured	Uninsured	Total Insured and Uninsured
	Large Group	Small Group	Individual	CalPERS HMO (b)	Medi-Cal Managed Care ≥65 Years (c)	Medi-Cal Managed Care <65 Years (c)	Healthy Families Managed Care	Large Group	Small Group	Individual	(Annual Cost)		(Annual Cost)
Total Enrollees with Health Insurance Subject to State Regulation (a)	9,445,000	2,394,000	785,000	820,000	175,000	2,616,000	814,000	324,000	935,000	1,179,000	19,487,000	6,624,000	26,111,000
Total Enrollees with Health Insurance Subject to State Regulation Subject to AB 1904	9,445,000	2,394,000	785,000	820,000	0	0	0	324,000	935,000	1,179,000	15,882,000	6,624,000	22,506,000
Average portion of premium paid by employer	$290.96	$223.84	$0.00	$332.10	$223.00	$113.00	$93.19	$346.40	$246.40	$0.00	$51,713,067,000	$0.00	$51,713,067,000
Average portion of premium paid by employee	$72.11	$92.31	$364.68	$58.61	$0.00	$0.00	$11.78	$105.37	$79.68	$180.77	$18,813,408,000	$0.00	$18,813,408,000
Total Premium	$363.07	$316.14	$364.68	$390.70	$223.00	$113.00	$104.97	$451.77	$326.08	$180.77	$70,526,476,000	$0.00	$70,526,476,000
Member expenses for covered benefits (deductibles, copays, etc.)	$19.77	$25.74	$64.43	$20.15	$0.00	$0.00	$1.52	$58.78	$116.51	$44.19	$5,961,186,000	$0.00	$5,961,186,000
Member expenses for benefits not covered	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$157.52	$12,521,086,000
Total Expenditures	$382.84	$341.88	$429.11	$410.85	$223.00	$113.00	$106.50	$510.56	$442.59	$224.96	$76,487,662,000	$157.52	$89,008,748,000

Source: California Health Benefits Review Program, 2010.
Notes: See notes to Table 6A.
Key: See key to Table 6A.

Table 7B. Scenario 2: Impacts of AB 1904 on Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2010

	DMHC-Regulated							CDI-Regulated			Total Insured	Uninsured	Total Insured and Uninsured
	Large Group	Small Group	Individual	CalPERS HMO (b)	Medi-Cal Managed Care ≥65 Years (c)	Medi-Cal Managed Care <65 Years (c)	Healthy Families Managed Care	Large Group	Small Group	Individual	(Annual Cost)	Pre- and Post-mandate	(Annual Cost)
Total Population in Plans Subject to State Regulation (a)	9,445,000	2,394,000	785,000	820,000	175,000	2,616,000	814,000	324,000	935,000	1,179,000	19,487,000	6,624,000	26,111,000
Total Enrollees with Health Insurance Subject to State Regulation Subject to AB 1904	9,445,000	2,394,000	785,000	820,000	0	0	0	324,000	935,000	1,179,000	15,882,000	6,624,000	22,506,000
Average portion of premium paid by employer	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0.00	$0.00	$0.00
Average portion of premium paid by employee	$0.0000	$0.0000	−$1.8997	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	−$1.9515	−$45,506,000	$0.00	−$45,506,000
Total Premium	$0.0000	$0.0000	−$1.8997	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	−$1.9515	−$45,506,000	$0.00	−$45,506,000
Member expenses for covered benefits (deductibles, co-pays)	$0.0000	$0.0000	−$0.3078	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	−$0.4771	−$9,649,000	$0.00	−$9,649,000
Member expenses for benefits not covered	$0.0000	$0.0000	$0.8029	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0.8888	$20,138,000	$0.00	$20,138,000
Total Expenditures	$0.0000	$0.0000	−$1.4046	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	−$1.5398	−$35,017,000	$0.00	−$35,017,000
Percentage Impact of Mandate													
Insured premiums	0.0000%	0.0000%	−0.5209%	0.0000%	0.0000%	0.0000%	0.0000%	0.0000%	0.0000%	−1.0796%	−0.0645%	$0.00	−0.0645%
Total Expenditures	0.0000%	0.0000%	−0.3273%	0.0000%	0.0000%	0.0000%	0.0000%	0.0000%	0.0000%	−0.6845%	−0.0458%	$0.00	−0.0393%

Source: California Health Benefits Review Program, 2010.
Notes: See notes to Table 6A. *Key:* See key to Table 6A.

Table 8A. Scenario 3: Per Member Per Month Premium and Expenditures Before Enactment of AB 1904, by Market Segment, California, 2010

	DMHC-Regulated							CDI-Regulated			Total Insured	Uninsured	Total Insured and Uninsured
	Large Group	Small Group	Individual	CalPERS HMO (b)	Medi-Cal Managed Care ≥65 Years (c)	Medi-Cal Managed Care <65 Years (c)	Healthy Families Managed Care	Large Group	Small Group	Individual	(Annual Cost)		(Annual Cost)
Total Population in Plans Subject to State Regulation (a)	9,445,000	2,394,000	785,000	820,000	175,000	2,616,000	814,000	324,000	935,000	1,179,000	19,487,000	6,624,000	26,111,000
Total Population in Plans Subject to AB 1904	9,445,000	2,394,000	785,000	820,000	0	0	0	324,000	935,000	1,179,000	15,882,000	6,624,000	22,506,000
Average portion of premium paid by employer	$290.96	$223.84	$0.00	$332.10	$223.00	$113.00	$93.19	$346.40	$246.40	$0.00	$51,713,067,000	$0.00	$51,713,067,000
Average portion of premium paid by employee	$72.11	$92.31	$364.68	$58.61	$0.00	$0.00	$11.78	$105.37	$79.68	$180.77	$18,813,408,000	$0.00	$18,813,408,000
Total Premium	$363.07	$316.14	$364.68	$390.70	$223.00	$113.00	$104.97	$451.77	$326.08	$180.77	$70,526,476,000	$0.00	$70,526,476,000
Member expenses for covered benefits (deductibles, copays, etc.)	$19.77	$25.74	$64.43	$20.15	$0.00	$0.00	$1.52	$58.78	$116.51	$44.19	$5,961,186,000	$0.00	$5,961,186,000
Member expenses for benefits not covered	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$157.52	$12,521,086,000
Total Expenditures	$382.84	$341.88	$429.11	$410.85	$223.00	$113.00	$106.50	$510.56	$442.59	$224.96	$76,487,662,000	$157.52	$89,008,748,000

Source: California Health Benefits Review Program, 2010.
Notes: See notes to Table 6A.
Key: See key to Table 6A.

Table 8B. Scenario 3: Impacts of AB 1904 on Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2010

	DMHC-Regulated							CDI-Regulated			Total Insured	Uninsured	Total Insured and Uninsured
	Large Group	Small Group	Individual	CalPERS HMO (b)	Medi-Cal Managed Care ≥65 Years (c)	Medi-Cal Managed Care <65 Years (c)	Healthy Families Managed Care	Large Group	Small Group	Individual	(Annual Cost)	Pre- and Post-AB 1904	(Annual Cost)
Total Population in Plans Subject to State Regulation (a)	9,445,000	2,394,000	785,000	820,000	175,000	2,616,000	814,000	324,000	935,000	1,179,000	19,487,000	6,624,000	26,111,000
Total Population in Plans Subject to AB 1904	9,445,000	2,394,000	785,000	820,000	0	0	0	324,000	935,000	1,179,000	15,882,000	6,624,000	22,506,000
Average portion of premium paid by employer	$0.0000	−$0.3257	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	−$0.3686	$0.0000	−$13,492,000	$0.00	−$13,492,000
Average portion of premium paid by employee	$0.0000	−$0.1350	−$0.9889	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	−$0.1192	−$1.0159	−$28,903,000	$0.00	−$28,903,000
Total Premium	$0.0000	−$0.4606	−$0.9889	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	−$0.4878	−$1.0159	−$42,394,000	$0.00	−$42,394,000
Member expenses for covered benefits (deductibles, copays, etc.)	$0.0000	−$0.0363	−$0.1602	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	−$0.1736	−$0.2483	−$8,012,000	$0.00	−$8,012,000
Member expenses for benefits not covered	$0.0000	$0.2039	$0.4179	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0.2746	$0.4627	$19,421,000	$0.00	$19,421,000
Total Expenditures	$0.0000	−$0.2930	−$0.7312	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	−$0.3868	−$0.8015	−$30,985,000	$0.00	−$30,985,000
Percentage Impact of Mandate													
Insured premiums	0.0000%	−0.1457%	−0.2712%	0.0000%	0.0000%	0.0000%	0.0000%	0.0000%	−0.1496%	−0.5620%	−0.0601%	$0.00	−0.0601%
Total Expenditures	0.0000%	−0.0857%	−0.1704%	0.0000%	0.0000%	0.0000%	0.0000%	0.0000%	−0.0874%	−0.3563%	−0.0405%	$0.00	−0.0348%

Source: California Health Benefits Review Program, 2010.
Notes: See notes to Table 6A.
Key: See key to Table 6A.

Public Health Impacts

AB 1904 would likely result in both health benefits and harms to the California population. The primary benefit would be the expansion of the insured population, while potential harm could result from underinsurance by persons moving from more comprehensive to less comprehensive health plans and not getting services that are effective in promoting and maintaining their health.

Potential Health Benefits for Newly Insured

The most recent evidence suggests that nearly one-quarter of Californians under the age of 65 are currently uninsured (Lavarreda et al., 2010). Research has shown that having health insurance is associated with increased health care consumption and better health. 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 worse self-reported health (Freeman et al., 2008; Hadley, 2003). One study found that children without health insurance had a significantly increased risk of in-hospital mortality compared to children with insurance (Abdullah et al., 2009). However, Levy and Metzler (2008) caution that there is not sufficient evidence to claim a causal link between health insurance status and health for the general population. A recent systematic review reported that the health benefits of health insurance coverage have been robustly demonstrated for those with acute or chronic illnesses such as hypertension, coronary heart disease, congestive heart failure, cerebrovascular disease, diabetes, HIV infection, depressive symptoms, acute myocardial infarction, and acute respiratory conditions (McWilliams, 2009).

According to the California Health Interview Survey, in California, individuals who are currently insured are statistically significantly more likely to be in good health compared to those who are not insured (CHIS, 2007). Table 9 details general reported health status by insurance status. However, the uninsured are also more likely to experience many other determinants of poor health in addition to lack of health insurance.

Table 9. Health Status and Insurance Status of Californians

Health Status	Currently Insured	Not Currently Insured
Excellent/very good/good (95% confidence interval)	85.2% (84.8–85.6)	74.4% (73.0–75.8)
Fair/poor (95% confidence interval)	14.8% (14.4–15.2)	25.6% (24.4–27.0)

Source: CHIS, 2007.

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 (Lave et al., 1998). As a result, the estimated 12,000 to 28,000 persons who are expected to no longer be uninsured due to AB 1904 could realize improved health outcomes and reduced financial burden for medical expenses.

Potential Health Harms for Underinsured

Although the benefits of having health insurance are clear, having less comprehensive health insurance due to fewer coverage requirements for health insurers exposes individuals to the financial and health risks of becoming *underinsured* if insurers drop coverage for effective health services currently mandated in California. There are different definitions of what it means to be underinsured; one of the most common is that a high proportion of individuals' annual income is spent on health insurance. Underinsurance has been increasing in the United States, and researchers have found that being underinsured (having high out-of-pocket medical expenses even though one is insured) is associated with having unmet health care needs and not complying with recommended treatments (Schoen et al., 2008). Additionally, recent research has indicated that persons insured through smaller employers are more likely to be underinsured (Abraham et al., 2010)

In California, 12.4% of insured nonelderly individuals spent more than 10% of their annual income on health expenditures in year 2004-2006, compared with 15.7% nationwide (Cunningham, 2010). Although California performed better on this measure than other states, many insured individuals in California forego or delay necessary medical care because of financial and insurance-related reasons. In 2001, approximately 18% of insured individuals, who reported that they delayed or did not get needed medical care, stated financial and insurance-related reasons (CHIS, 2001). Additionally, approximately 23% reported delaying or not filling a prescription due to financial and insurance coverage reasons (CHIS, 2001).

Using the projections from the hypothetical scenarios, 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 potentially increasing an estimated $19.4 million to $20.1 million, these insured have an increased risk of foregoing necessary treatments no longer covered under limited-mandate plans. 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 increased benefits, should they want to do so.

Health Impacts Associated with California's Mandated Benefits

In order to assess the public health impact of dropping coverage for a specific mandated benefit, three criteria were used. First, the medical effectiveness findings were used to determine whether the benefit was effective. Benefits with "clear and convincing" evidence or a "preponderance" of evidence of their medical effectiveness were considered to be effective. For those benefits where there was evidence of "no impact," a conclusion of *no impact on public health* was drawn. For benefits where there was either "insufficient" or "ambiguous" medical effectiveness evidence or no prevalence data, a conclusion of *unknown* impact on public health was drawn.

The second criterion examined is the scope of the public health problem associated with the benefit. Public health scope was assessed using prevalence data and three categories are reported: *broad* public health scope for conditions affecting a large segment of the population (1 or more in 20 persons), *moderate* public health scope (affecting between 1 in 2,000 persons and 1 in 20

persons), and *limited* public health scope affecting a smaller segment of the population (1 or fewer in 2,000 persons). The third criterion is the type of public health impact, defined in terms of a *mortality* or *morbidity* impact. Mortality (rates of death within a population) and morbidity (rates of the incidence and prevalence of disease within a population) are commonly used measures for health status in a community.

Table 2 details the current California mandates that have expected public health impacts if coverage for mandated benefits was dropped from health insurance plans.

One mandate with evidence of *no impact on public health* if coverage is dropped is screening the blood lead levels of children at average risk for lead poisoning. 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,[42] 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,[43] and orthodontic services for persons with oral clefts.[44] It is important to note that insufficient evidence of an effect is not the same as evidence of no effect.

When reviewing the estimated public health impact of California's mandated benefits, another important issue to consider is the likelihood that health insurance products would drop coverage for a particular benefit under AB 1904. Appendix F details the expected limited-mandate plans that would be offered by insurance carriers if AB 1904 were to be enacted. Comparing Appendix F to the mandates in Table 2, Table 10 details the medically effective benefits (based on medical effectiveness review) most likely to be dropped from coverage in health plans under AB 1904. The mandated benefits likely to be dropped with the broadest public health impact related to mortality are alcoholism treatments and parity in coverage for severe mental illness/coverage for mental and nervous disorders. Other mandates likely to have mortality impacts if they are dropped include phenylketonuria (PKU) treatment with medical formula and foods and expanded alpha-fetoprotein screening (AFP). Dropping mandated coverage for prescription contraceptive devices would have morbidity impacts of *broad public health scope*. Mandates that, if dropped, would have morbidity impacts of *moderate public health scope* include acupuncture, infertility treatments, jawbone or associated bone joint surgery, and orthotics and prosthetics, and special footwear for persons with rheumatoid arthritis. The mandate for home care services for elderly and disabled adults would have a morbidity impact of *limited public health scope* if it were dropped.

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

[43] Although the medical effectiveness review found insufficient evidence regarding general anesthesia for dental procedures, professional consensus is that the use of general anesthesia is effective for young children, people with anxiety, or those with mental or physical limitations, and those needing extensive dental care.

[44] Although the medical effectiveness review found insufficient evidence regarding orthodontic services for persons with oral clefts, professional opinions suggest that this mandate may reduce complications associated with delays in orthodontic services for oral clefts.

Table 10. Public Health Impact for Benefits Most Likely to Be Dropped From Health Plans Under AB 1904

Benefit	Medical Effectiveness Conclusion	Public Health Scope	Premature Death/ Mortality Outcomes	Potential Public Health Impact if Dropped
Alcoholism treatments	*Clear and convincing evidence* that pharmacological and psychosocial treatments are effective in treating alcohol dependence	7.8% of Californians report alcohol abuse or dependence in the past year (SAMHSA, 2005)	There are an estimated 9,765 annual alcohol-related deaths in California (CDC, 2004)	Mortality impact of broad public health scope
Parity in coverage for severe mental illness; Coverage for mental and nervous disorders	*Clear and convincing evidence* that medications and psychotherapy are effective in treating mental illness	6.35% of non-institutionalized population (over 2 million Californians) (DMH, 2004)	There are approximately 3,000 suicides 16,000 hospitalized suicide attempts each year in California (SPRC, 2008)	Mortality impact of broad public health scope
Phenylketonuria treatment with medical formula and foods	*Preponderance of evidence* that screening and treatment are effective in identifying children with PKU and reducing the severity of the associated mental and behavioral disorders	The prevalence of classic PKU is one in 27,000 births – this translates into 15-18 PKU births each year (CNSP, 2004)	Women with PKU who become pregnant are at higher risk of having a child with birth defects (including those resulting in premature death) if their PKU is not well managed (Matalon et al., 2003)	Mortality impact of limited public health scope
Expanded alpha-fetoprotein screening (AFP)	*Preponderance of evidence* that AFP tests detect likelihood of fetal Down syndrome at a rate of 70% to 80%	Down syndrome occurs at a rate of 1.51 per 1,000 births which translates into approximately 830 cases/year in California (CBDMP, n.d.)	10% of babies born with Down syndrome die before age 1 (CBDMP, n.d.)	Mortality impact of limited public health scope
Prescription contraceptive devices	*Clear and convincing evidence* that prescription contraceptives are more effective than nonprescription contraceptives for preventing pregnancy	Nearly 1 million insured females of reproductive age in California use prescription contraceptives (OWH, 2006)	Premature death is not an outcome typically associated with prescription contraceptive devices	Morbidity impact of broad public health scope

Table 10. Public Health Impact for Benefits Most Likely to Be Dropped From Health Plans Under AB 1904 (Cont'd)

Benefit	Medical Effectiveness Conclusion	Public Health Scope	Premature Death/ Mortality Outcomes	Potential Public Health Impact if Dropped
Acupuncture	*Preponderance of evidence* suggests that acupuncture is effective in reducing pain and functioning in persons with a variety of conditions	In California, it is estimated that 2.4% of insured adults have used acupuncture in the past year (CHBRP, 2007a)	Premature death is not an outcome associated with the conditions for which people get acupuncture	Morbidity impact of moderate public health scope
Infertility treatments	*Clear and convincing evidence* that diagnosis and treatment of male and female infertility are effective in improving pregnancy rates	15.1% of married females aged 15 to 44 years have impaired fecundity (i.e., ability to get pregnant or carry a baby to term), half of which (7.4%) are classified as infertile (not pregnant within 12 months) (Chandra et al., 2005)	Premature death is not an outcome associated with infertility treatments	Morbidity impact of moderate public health scope
Jawbone or associated bone joints – surgery	*Preponderance of evidence* suggests that surgical treatment for TMJ results in reduced pain	It is estimated that more than 1 million people in California have TMJ disorders, however, a small percentage receive treatment.[45]	Premature death is not an outcome associated with jawbone or associated bone joint pain	Morbidity impact of moderate public health scope
Orthotic and prosthetic devices and services	*Preponderance of evidence* that orthoses and prostheses are effective for some conditions	O&P devices were used by the insured population nationally in 2004, for a utilization rate of 40.4 procedures per 1,000 persons (CHBRP, 2006b)	Premature death is not an outcome typically associated with the utilization of O&P devices	Morbidity impact of moderate public health scope

[45] Estimated based on 10 million estimated cases of TMJ (NIDCR, 2006) and proportion of population residing in California (US Census Bureau, 2008).

Table 10. Public Health Impact for Benefits Most Likely to Be Dropped From Health Plans Under AB 1904 (Cont'd)

Benefit	Medical Effectiveness Conclusion	Public Health Scope	Premature Death/ Mortality Outcomes	Potential Public Health Impact if Dropped
Special footwear for persons suffering from foot disfigurement	*Preponderance of evidence* that special footwear is effective for persons with rheumatoid arthritis	Approximately 0.49% of the insured population under age 65 have been diagnosed with rheumatoid arthritis (CHBRP, 2005c) Special footwear is used by 30% to 60% of persons with this condition (Vidigal et al, 1975).	The extent to which the utilization of special footwear for persons suffering from foot disfigurement reduces premature death is unknown	Morbidity impact of moderate public health scope for persons with rheumatoid arthritis
Home health care	*Clear and convincing evidence* that home health care leads to better outcomes for elderly and disabled patients	The rate of current home health care use in the under 65 population across the U.S. is 16.4 per 100,000; this represents 29.5% of home health care patients (NHHCS, 2004)	Overall, home health care resulted in a non-significant decrease in mortality relative to usual care	Morbidity impact of limited public health scope

Gender, Racial, and Ethnic Disparities

A number of mandates are associated with benefits primarily for females (e.g., breast/cervical cancer, maternity care-related mandates, and prescription contraceptives). Of the estimated 266,000 to 298,000 previously insured persons expected to move from a plan with mandated benefits to one where coverage of mandated benefits is no longer required. Females would be at greater risk for moving to a plan without mandated services in comparison to males.

In California, racial and ethnic minorities are more likely to be low income and more likely to be uninsured compared to whites (CHIS, 2007). As a result, among the 12,000 to 28,000 estimated newly insured, a larger proportion of minorities compared to whites could change from being uninsured to insured in a plan that provides limited benefits 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.

PART II: POTENTIAL IMPACTS OF EXEMPTING OUT-OF-STATE CARRIERS FROM CALIFORNIA LAWS AND REGULATIONS

AB 1904 would allow a carrier domiciled in another state to offer, sell, or renew a health plan or insurance policy in California without holding a license issued by the DMHC or without a certificate of authority issued by the CDI. Under this proposal, an insurer would have to follow the laws and regulations in the state where it is based or "domiciled"—not the rules of California where the consumer or policyholder lives.

This section describes the potential impacts of exempting carriers from California health insurance rules, specifically those rules related to consumer protections (such as provider access standards, independent external reviews), financial solvency, and cost and availability (such as small-group guaranteed issue and restrictions on medical underwriting).
Not only would the carriers' health insurance products be allowed to exclude legislatively imposed benefit mandates (as discussed in Part I of this report), but the carrier's themselves would be exempt from the laws and regulations imposed on "in-state carriers" codified in the statute or regulation.

The intent of AB 1904 is to allow for the development, marketing, and purchasing of health insurance products licensed outside of California, thereby sparking innovation and competition among carriers, driving down the cost of available products, and expanding coverage to those who are currently uninsured—especially for those in the small-group or individual markets.

Proponents of similar bills at the Federal level argue that allowing for the development of plans exempt from state mandates would encourage the market to develop lower-priced products, giving employers and individuals more health plan choices, and forcing state-regulated plans to compete with lower-priced policies (Parente et al., 2008).

The bill seeks to meet these various policy objectives by effectively repealing all California-specific health insurance requirements, oversight, and regulatory authority of the DMHC and the CDI. The remainder of this report describes the impact of repealing these requirements on the health insurance market in California.

Background and Discussion on Carriers' Domicile

To be "domiciled" in a state means that the insurance company must be headquartered in that state. Currently about two thirds of Californians with privately purchased health insurance are in state-regulated health plans or insurance policies offered by an entity domiciled in California ("in-state carrier"). About one third of California insured are covered by a carrier domiciled in another state ("out-of-state carrier"). Four of the seven major carriers are currently domiciled outside California. See Table 11 for a summary of where these carriers are currently domiciled and the corresponding share of the California market.

Table 11. California Market Share for Private Health Insurance by Insurer and State of Domicile

Insurer/CA Affiliate	Domicile (Headquarters) of Insurer	States in Which Insurer Is Licensed	CA Market Share (CDI)	CA Market Share (DMHC)	Combined
Kaiser Permanente/Kaiser Foundation Health Plan, Inc.	Oakland, CA	9 states, including California and the District of Columbia	0%	40%	33%
Blue Shield of California/Blue Shield of California and Blue Shield of California Life & Health Insurance Company	San Francisco, CA	California	16%	20%	19%
Wellpoint, Inc./Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company	Indianapolis, IN	14 states, including California	43%	19%	23%
Heath Net, Inc./Health Net of California and Health Net Life Insurance Company	Woodland Hills, CA	Subsidiaries licensed in 50 states and the District of Columbia	8%	8%	8%
United HealthGroup, Inc./PacifiCare of California, PacifiCare Life and Health Insurance Company, and United HealthCare Insurance Company	Minnetonka, MN	Subsidiaries licensed in 50 states and the District of Columbia	8%	6%	6%
Aetna, Inc./Aetna Health of California and Aetna Life Insurance Company	Hartford, CT	Subsidiaries licensed in 50 states and the District of Columbia	12%	4%	5%
CIGNA Corporation/Cigna Healthcare of California	Philadelphia, PA	Subsidiaries licensed in 50 states and the District of Columbia	3%	2%	2%

Source: California Health Benefits Review Program analysis of data from Hoovers Inc. Available at www.hoovers.com. Accessed April 6, 2010; DMHC enrollment data as of December, 2009; CDI Covered Lives Data Call for expense reimbursement Health Insurance products, December 31, 2008.

DMHC and CDI Regulatory Authority

States are the primary regulators of health insurance companies and health insurance products. California has several laws in place that relate to availability of coverage, consumer protections, access to providers, financial solvency, and risk distribution. This section will summarize these requirements and qualitatively discuss the potential impacts of removing or relaxing these requirements, using the literature on group purchasing arrangements such as Association health Plans (AHPs), Multiple Employer Welfare Arrangements (MEWAs), and similar proposals that allow for interstate sale of health insurance at the federal level. This literature is instructive because these products or proposals are similar to AB 1904 in that they allow for (1) the development of health insurance products that can be sold across state lines, and (2) a certain level of exemptions from state-specific regulations. This section will also discuss the potential implications of removing health insurance oversight and enforcement authority from California to outside of the state.

During initial licensure and ongoing operations, California regulatory agencies monitor and take corrective action to ensure plans and insurers comply with their requirements related to consumer protections and financial solvency. Exempting insurers from requirements to obtain a Knox-Keene license from the DMHC or a certificate of authority from the CDI would limit the authority of the state in oversight of consumer protection and financial solvency.

The majority of California's health plans are regulated by either the DMHC or CDI. The DMHC regulates HMOs and certain preferred provider organizations (PPOs) (i.e., Anthem Blue Cross or Blue Shield of California) subject to the Knox-Keene Health Care Service Plan Act of 1975, as amended. Health plans apply for and obtain a Knox-Keene license prior to operating in California.

In applying for licensure, a DMHC-regulated health care service plan must submit for review and approval all of the types of plan contracts (policies) it will offer, standard provider contracts and payment methods, proposed advertising and marketing materials, audited financial statements, administrative structure, projections of financial viability, actuarial analyses, and specific proposed service areas.

The CDI regulates point-of-service health plans and certain PPO plans underwritten by disability insurers who sell health insurance products. Disability insurers obtain a certificate of authority from the CDI for the specific line(s) of business they intend to offer prior to conducting insurance business in this state.

The CDI certificate of authority review process involves a detailed operational and financial review. The application process includes review of the company's financial stability, available capital and assets, competency and integrity of ownership and management, claims payment procedures, actuarial certifications, and financial projections.[46]

[46] Insurance Code § 717. CDI requirements to apply for certification of authority are available at www.insurance.ca.gov/0250-insurers/0300-insurers/0100-applications/certificate-of-authority/cert-of-authority-instructions/ca-specific-instruc.cfm.

Neither the DMHC nor the CDI regulates self-insured employer-sponsored plans that cover about 21% of enrollees in privately purchased insurance in California (CHBRP, 2010). All employer-sponsored health plans fall under the jurisdiction of the Employee Retirement Income Security Act (ERISA). ERISA is a federal law that is enforced by the U.S. Department of Labor, Employee Benefits Security Administration (DOL-EBSA). Under ERISA, employer-sponsored plans are subject to minimum standards related to reporting and disclosure, claims processing, and fiduciary duty (Butler and Polzer, 2002). In addition, most states have further consumer protection requirements on employer-sponsored plans that are not self-insured, whereas self-insured employer-sponsored plans are exempt from most state requirements.[47]

California's Consumer Protection Requirements

California currently has a number of patient and consumer protection requirements. Some of these requirements include disclosures, access to services, internal and external grievance review processes, quality assurance, benefit design requirements, and fair claims handling.

Consumer disclosure and marketing requirements: Both the DMHC and the CDI require plans and carriers to disclose information regarding the benefits, services, and terms of the plan contract to provide enrollees with a full and fair disclosure of the provisions of the plan in readily understood language and a clearly organized manner.[48]

Access to services: DMHC monitors and reviews specific guidelines for availability and accessibility of providers (e.g., one primary care physician for every 2,000 enrollees, primary care provider within 30 minutes or 15 miles of residence or work).[49] Plans are required to receive prior approval of networks in each geographic region. The CDI has accessibility regulations for exclusive provider organizations (EPOs).[50]

Coverage for categories of enrollees that could be discriminated against: California has certain laws forbidding health insurers from denying coverage to certain types of enrollees. Plans and insurers cannot deny coverage to persons who are physically or mentally impaired. Additionally, DMHC-regulated plans cannot deny coverage for individuals who are blind or partially blind.

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[47] A self-insured plan is a health plan in which a group—usually a large employer, labor union, or group of employers—assumes financial responsibility for the health care expenses of its enrollees rather than purchasing health insurance through an insurance company. However, such a group may contract with an insurance or other company (as a third-party administrator) for claims processing and other administrative services and may purchase stop-loss to limit its liability for medical claims (sometimes incorrectly called "reinsurance"). The DOL does not regulate self-insured health plans that are sponsored through school districts, other municipalities, and churches. The CDI does not regulate self-insured health plans. Consumers who are members of this type of plan may seek a legal remedy through a court of law. (The CDI's lack of jurisdiction over these products is described at www.insurance.ca.gov/0100-consumers/0060-information-guides/0050-health/health-insurance.cfm#hippa).

[48] Health and Safety Code §1363(a); Insurance Code §§10603 and 10604

[49] California Code of Regulations, Title 28, Section 1300.51

[50] Health and Safety Code § 1351(k) and 1367(e); Insurance Code § 10133.5. EPOs are similar to HMOs except they are regulated by the CDI. EPOs require use of their network providers for coverage of services.

Nondiscrimination in rating: CDI and DMHC-regulated health plans are prohibited from refusing to enter into or renew a contract, as well as from setting differential benefit terms or charges ("rating"), on the basis of the race, color, national origin, ancestry, religion, marital status, or sexual orientation of a person expected to benefit from the contract.[51] Additionally, all health plan contracts and health insurance policies issued, amended, or renewed on or after January 1, 2011, will be prohibited from discriminating in these manners on the basis of gender (Section 1365.5 of the Health and Safety Code and Section 10140.2 to the Insurance Code).

Internal grievance review processes: DMHC-regulated plans are required to maintain an internal plan grievance system to respond to consumer complaints. The DMHC reviews a plan's internal grievance and complaint-handling procedures, including type, frequency, and resolution of complaints during its on-site survey[52] of health plans under its regulatory purview. The Department conducts a routine medical survey of each licensed health care service plan at least once every three years in order to evaluate the plan's compliance with the Knox-Keene Act.[53] In addition, the DMHC operates the "HMO Help Center," a toll-free consumer complaint hotline, 24 hours a day, 7 days per week. An after-hours answering service can page DMHC health professionals. The CDI does not require insurers to maintain an internal grievance or complaint system. The CDI operates a consumer complaint line for all lines of insurance (e.g., life or auto) weekdays during business hours.

External grievance review processes: Effective January 2001, both DMHC and CDI were legislatively mandated to administer an Independent Medical Review (IMR) program for external independent medical review of plan coverage decisions.[54] The IMR program allows enrollees to appeal denied claims and seek expedited review of denials for particular service (e.g., access to specialty care or a procedure). This process occurs after any internal reviews within the plan have been exhausted. This legislation was motivated by people who felt that HMOs might be approving or denying treatment due to concerns about cost to insurers rather than based on medical appropriateness (IMQ, 2002).

Quality assurance: The DMHC reviews internal procedures of plans to review quality of medical care and performance of providers. The DMHC also conducts onsite medical surveys at least once every three years. Both the DMHC and the CDI have standards for utilization review and disclosure requirements.[55]

Covered benefits and benefit design: As discussed in the first part of this report, a number of benefits are mandated for DMHC- and CDI-regulated plans. The DMHC also reviews proposed cost-sharing arrangements under various product lines and may require changes to ensure contracts are "fair, reasonable and consistent with the objectives of the chapter." Benefits cannot be subject to "exclusion, exception, reduction, deductible, or copayment that

[51] Health and Safety Code §§ 1365.5
[52] Health and Safety Code §§ 1351(I), 1368, 1370.2, 1380(F)
[53] Information on DMHC's on-site survey may be found at:
http://www.dmhc.ca.gov/library/reports/med_survey/surveys/043full101406.pdf
[54] Health and Safety Code §§ 1374.30; 1370.4; Insurance Code § 10145.3
[55] Health and Safety Code §§ 1370, 1380, 1380.1; Insurance Code §§ 101339(d) and 10123.1135

renders the benefit illusory."[56] For example, for outpatient prescription drug benefits, the DMHC limits cost sharing to 20%. CDI-regulated plans have no such related requirements except that health insurers must cover benefits mandated under the Insurance Code.

Fair claims handling: The DMHC monitors its plans for prompt payment of provider claims. The DMHC has also developed a definition of unfair payment patterns and a system of responding to them (AB 1455, Statutes of 2000). In January 2009, two additional consumer protections took effect. Under AB 1203, noncontracting hospitals are prohibited from billing patients for poststabilization care if the hospital fails to contact the patient's health plan for authorization or give the health plan an opportunity to transfer the patient. On January 8, the California Supreme Court released a unanimous ruling that bars emergency department physicians and hospitals from billing insured patients directly for charges that their health plans refuse to pay. In effect, the ruling bars so-called "balance billing," which typically occurs when insured people seek emergency care from out-of-network physicians and hospitals. Insurers reimburse out-of-network doctors and hospitals at a lower rate, and the health care provider's bill patients for the remainder of the charges in addition to copayments and deductibles. As for CDI-regulated products, the CDI has broad authority to enforce the Insurance Code.[57] As part of their market conduct examinations discussed below, CDI regulators can assess and address the market practices of insurers, including claims handling.[58]

Continuation of coverage: Health plans and insurers are required to permit an individual who was covered under an individual plan contract or health benefit plan that was rescinded, other than the individual whose information led to the rescission, to transfer to any other individual plan contract or health benefit plan offered by that same entity that provides equal or lesser benefits within 60 days without medical underwriting.[59] Rescission is also prohibited on the basis of fraud if a health plan contract or health insurance policy has been in effect for 24 months.[60]

<u>California's Financial Solvency Requirements</u>

Regulatory agencies take a number of steps to protect consumers and health care providers from disruptions caused by insolvencies. The DMHC requires regular financial filings and conducts on-site financial reviews.[61] To ensure that business is conducted in an honest, open, and fair manner, the CDI conducts onsite review and regulatory examination of claims, financial records, and rating and underwriting practices of all licensed insurers. These are called market conduct examinations.[62]

[56] § 1367 CCR Title 28 § 1300.67.4
[57] Insurance Code § 12919-12938
[58] The range of activities that the commissioner may initiate to assess and address the market practices of insurers include underwriting and rating, marketing and sales, complaint handling operations/management, advertising materials, licensing, policyholder services, claims handling, and policy forms and filing.
[59] Health and Safety Code, Section 1389.7-8; and CA Insurance Code, 10119.2-3
[60] Health and Safety Code, Section 1389.21; and CA Insurance Code, Section 10384.17
[61] Health and Safety Code §§ 1376, 1381,1382
[62] www.insurance.ca.gov/0500-about-us/0100-cdi-introduction

To ensure that HMOs have sufficient levels of capital, the DMHC requires that each plan meet tangible net equity requirements. PPOs and POS plans licensed by the DMHC are subject to higher tangible net equity standards due to the increased risk of offering out-of-network services (Butler and Polzer, 2002). CDI-regulated insurers must maintain the greater of either risk-based capital standard or a minimum capital and surplus requirement (Butler and Polzer, 2002). Disability insurers are required to maintain reserve levels at the greater of either (1) a minimum of $5 million or (2) 200% of the Risk-Based Capital standards developed by the National Association of Insurance Commissioners (Roth and Kelch, 2001).

If a health plan becomes insolvent, the DMHC may allocate its enrollees to other plans in the area with sufficient capacity and financial resources. Plans must provide care for transferred members.[63] For carriers that present solvency problems, the CDI has various options, including asking or ordering an insurer to reduce writing new business, reduce operating costs, seek financial support, or consider the use of reinsurance. As a last resort, the CDI will consider taking regulatory control of an insolvent insurer's operations (Butler and Polzer, 2002). In addition, the Insurance Code requires all life and disability insurers to participate in the Life and Health Insurance Guarantee Association, which will assess members to pay the losses (expenses) of people insured by the insolvent insurer.[64]

California has specific requirements prohibiting health plans from engaging in unfair payment practices to providers. Prohibited practices include the failure to process complete and accurate claims, reducing or denying complete and accurate claims, failing to make timely payments for claims, and failing to automatically include interest.[65] This legislation requires health plans to maintain a dispute resolution mechanism for resolving provider claims payment disputes. In 2003, the DMHC introduced regulations, known as the Claims Settlement Practice and Dispute Resolution Mechanism Regulations, to establish specific standards and safeguards for the timely and accurate payment of claims, and for the establishment of a fast, fair, and cost-effective dispute resolution process (DMHC, 2006).

Potential 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 seek redress for denied claims or other disputes. If disputes were to escalate, enrollees would have to seek resolution in an out-of-state court, creating potential barriers and burdens to judicial review and individual rights. 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 tracking compliance and enforcing policies (Kofman et al., 2006). 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

[63] Health and Safety Code § 1394.7
[64] Insurance Code § 1067-1067.18
[65] Health and Safety Code §§ 1371.36-1371.39

example, the Departments of Insurance in South Dakota and Wyoming have budgets of $1.8 million (2009) and $4.5 million (2007-2008), 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 solely marketing 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.

For products that are self-insured, the Department of Labor (DOL) is the regulatory agency with oversight authority and, under ERISA; there are no federal solvency rules. However, 28 states, including California under the CDI, also have licensing requirements for self-insured MEWAs. Under these state rules, MEWAs that self-insure are subject to lower levels of solvency requirements than insured products, and depending on their size and risk pool, are at higher risk of becoming insolvent. From 2001 to 2003, four self-insured MEWAs became insolvent, with 66,000 individuals and small business losing coverage and about $48 million of unpaid claims (Kofman et al., 2006).

Past experience with MEWAs has shown that lack of clear regulatory oversight or inadequate oversight also creates incentives for the rise of fraudulent insurance products (GAO, 1992, 2004; Kofman et al., 2003). In the mid-1980s, the rise of such insurance scams led Congress to amend ERISA to clarify that states had the authority to regulate MEWAs that self-insure or purchase insured products (GAO, 1992). (As mentioned, 28 states have used the authority to establish licensing requirements for self-insured products.) A national study found that about 144 fraudulent entities not authorized to sell insurance were mostly posing as plans exempt from state regulations under ERISA. All together, these entities included coverage for about 15,000 employers and 200,000 policyholders—leaving about $252 million in unpaid medical claims (GAO, 2004). As of November 2009, the DOL had 55 civil and 71 criminal cases related to MEWA enforcement open for investigation, and has initiated 775 civil and 230 criminal investigations. The DOL states that often these group purchasing arrangements "are nothing more than shams to avoid state insurance regulations" (DOL, 2007). Under AB 1904, the current

California laws that require insurance policies to be licensed in state would no longer apply, thus potentially exposing consumers and groups—especially small groups—to greater risk of purchasing fraudulent polices that claim to be licensed out-of-state.

Cost and Availability of Health Insurance

AB 1904 would allow out-of-state policies to be exempt from California-specific requirements related to the cost and availability of health insurance. These requirements have been designed to allow purchasers of health care to spread the risk of health insurance-related costs and to allow access to health insurance for those who might otherwise face high and potentially unaffordable premiums. In the small-group market, these requirements were enacted in 1992 (AB 1672, Margolin, Chapter 1128, Statutes of 1992). When AB 1672 was first enacted, one of its goals was to curtail the insurance industry practice of segmenting risk—that is, providing lower rates to consumers and groups perceived as low-risk (low-cost, usually younger and healthier), while not covering or charging higher rates to groups perceived as high-risk. This legislation changed insurance underwriting rules and encouraged greater price competition and more uniform benefits among insurers selling to groups of three to fifty persons. The strict underwriting and price limits were designed to provide affordable insurance to persons in high-risk occupations and to prevent "exorbitant" premium increases or termination of coverage due to serious illness (Oliver and Dowell, 1994). The key provisions included (1) limiting medical underwriting based on occupation, health status, or previous claims experience (allowing full reflection only for adjustments due to age, family size, and geographic area; (2) limiting denial of coverage for a preexisting condition to one six-month period; (3) establishing narrow "rate bands" so that an insurer must offer a premium to any group that is within 20% of its average premium for that plan; and (4) requiring insurers to guarantee issuance and renewal of all plans (Oliver and Dowell, 1994).

Current Coverage and Availability Requirements

In the small-group market, requirements with respect to the cost and availability of health insurance include premium setting, guaranteed issue, guaranteed renewal, limits on coverage based on preexisting conditions, and continuation of coverage (Kelch, 2005). In the individual market, these requirements are related to guaranteed renewal and limiting coverage based on preexisting conditions (Roth, 2003). Under AB 1904, out-of-state policies would remain subject to the Federal Health Insurance Portability and Accountability Act (HIPAA) requirements (discussed below) or those of their domiciled state, if the state sets additional requirements beyond federal floors.

Premium setting

Premium setting requirements place limits on how much carriers may vary rates based on the health status of employees or any other risk factors. The intent of these requirements is to prevent carriers from imposing high, and potentially unaffordable, rates on higher-risk groups, thereby pricing them out of the market. Federal requirements under HIPAA prohibit group health plans (coverage sponsored by employers) from charging different premiums to workers and their dependents based on health-status related factors. Employers may have different premiums based

on other factors such as location and employment status (i.e., full-time or part-time). These HIPAA standards, however, do not address the premium rates that insurers set for an employer group. Therefore, although employers cannot charge sick employees higher rates than healthy ones, insurers can charge the employer group with sicker workers a higher rate than an employer group with healthy workers. Most states have adopted premium restrictions, limiting the differences in rates that insurers charge small businesses (2 to 50 employees). Few states apply such restrictions in the individual markets.

Generally, there are two types of premium-setting requirements: community/adjusted community rating and rate bands. Community rating means that insurers must set prices for a policy based on the collective claims experience of everyone with such a policy in the state. In other words, regardless of one's age, gender, occupation, health needs (past and current), claims history, or employer group size, everyone pays the same rate. Insurers would not be allowed to vary rates based on the health status or prior claims experience of a business or individual. California does not require community rating. In the small-group market, for example, most states, including California, allow for rate bands with limits on how much premiums can range for sicker people compared to healthy ones buying that policy. These restrictions also include renewal rates (BCBSA, 2007; Kofman and Pollitz, 2006). California's rate bands are "tighter" than in other states, however. This means that the variation among sick and healthy is smaller in California than in states allowing insurers to vary rates based on health factors. In California, an insurer must offer a small group a premium that varies no more than 10% above or below the standard rate (Roth, 2003), as established by the Small Group Legislation passed in 1992 (AB 1672, Margolin, Chapter 1128, Statutes of 1992). In the individual market, there is no similar limit on premium variations. California law, however, requires that rate increases are not discriminatory and prohibits carriers from setting different rates based on race, religion, ancestry, genetic characteristics, or sexual orientation. CDI-regulated carriers are also required to apply rate increases consistently to individuals in a specific "class" of insured people, such as those sharing the same age, family size, geographic region, or health status (Kelch, 2005).

In 2009, California enacted a law (Section 1365.5 of the Health and Safety Code and Section 10140.2 to the Insurance Code) prohibiting insurers from gender-rating, or charging differential premiums based on gender for contracts issued, amended, or renewed on or after January 1, 2011. The greatest impact of the gender-rating ban would be expected on premiums of plans that already include maternity services and currently use gender rating. In theory, there is a possibility that low-risk members (e.g., males) currently in gender-rated maternity plans may choose to drop plans effective January 1, 2011, when their premiums increase due to the introduction of gender-neutral rates. To the extent that gender rating of premiums segments the market and leads to the cost of new maternity coverage being borne entirely by female policyholders, AB 1904 with the recently enacted gender-rating ban effective January 1, 2011, might be less able to spread the risk of maternity costs over a broader patient population, if out-of-state carriers were introduced that did not offer maternity coverage. Although these issues are worthy of further, systematic evaluation and research, it is not feasible to assess this for this analysis.

Guaranteed issue (and nondiscrimination)

Guaranteed issue is the right to buy coverage (regardless of industry, health status, age of employees, or any other risk factors). Guaranteed issue laws prohibit insurers from denying coverage to applicants based on health status–related factors. For example, under guaranteed issue requirements, health insurance carriers could not reject small groups applying for coverage because one employee has a costly, chronic medical condition.

Prior to HIPAA, most states required insurers to sell two products on a guaranteed issue basis. HIPAA expanded this to all small-group products. HIPAA's nondiscrimination protections apply to all size employers. These protections ensure that an employee or dependent is not denied access to the group health plan on the basis of a health status related factor, such as claims or current medical needs. It also ensures that people within an employer group are not charged different rates on the basis of health status–related factors. HIPAA also regulates insurers' ability to limit coverage for a condition predating plan enrollment (preexisting conditions).

For access to the individual market, HIPAA provides limited protections that apply only to people leaving job-based coverage and meeting specific qualifications. For people who do not qualify as HIPAA-eligible, federal law does not provide a right to purchase an individual health insurance policy.

California, like most states, does not have guaranteed issue requirements in the individual market for initial coverage—carriers may deny coverage based on an individual's health condition (past or present), health status, or any other risk factors. However, once a carrier offers to cover a person, that carrier is prohibited from excluding coverage for a preexisting condition[66] for more than 12 months. If the subscriber changes carriers, the new carrier is required to credit the time of that coverage toward any preexisting condition exclusion (Pollitz et al., 2006).

Guaranteed renewal

Guaranteed renewal is the right to renew coverage (regardless of changes in employee health status or use of services, or any other risk factors). Without such requirements, carriers could drop a group when one or more employees experience a high-cost medical condition. Guaranteed renewal laws prohibit insurers from canceling coverage on the basis of medical claims or diagnosis of an illness. HIPAA established rules that require all group and individual health insurance policies to be guaranteed renewable.

California law also requires health insurance plans marketing to individuals, which stop selling coverage or stop enrolling new individuals in a particular product, either offer another product with comparable benefits, services, and terms with no additional underwriting or pool the risk for any discontinued products with other, similar products (Kelch, 2005). This requirement aims to protect individuals who cannot switch to other carriers or other products because of their risk profile. Without any legal protection, those enrolled in a "closed block" of business could end up

[66] A preexisting condition is any illness or health condition for which an insured has received medical advice or treatment during the six months prior to obtaining health insurance (Insurance Code § 10198.7).

being clustered in old or discontinued products at more expensive rates (American Academy of Actuaries, 2004; Kelch, 2005).[67]

Continuation of coverage laws

These laws are designed to protect individuals transitioning from group to individual coverage and gaps in coverage when they are changing jobs. Federal requirements under the Consolidated Omnibus Budget Reconciliation Act (COBRA) require groups with 20 or more employees to continue health insurance for employees and their dependents following death of a spouse, loss of a job, reduction in hours worked, or divorce. Under "Cal-COBRA," California expanded COBRA to include firms with 2 to 19 employees. California adopted HIPAA requirements for carriers to offer their two most popular products to individuals who are not eligible for COBRA or who have already exhausted their COBRA coverage. Under California law, people who exhaust their COBRA coverage or lose group coverage can purchase "conversion" coverage through the group's carrier. The group's carrier cannot refuse to cover these individuals because of health status or subject them to preexisting condition exclusions. California law also limits the premiums that can be charged for this type of coverage (Butler and Polzer, 2002).

Potential Impact of Exemption From California's Coverage and Availability Requirements

CHBRP reviewed evidence on group purchasing pools to gauge the potential impact of AB 1904 because certain types of purchasing pools have, at one point, been exempt from state requirements or have been proposed as legislative solutions to reduce premiums and increase choice. The research on group purchasing arrangements is also relevant to AB 1904 because this bill relaxes the requirements for associations to gain the same treatment as "small employers."[68]

Group purchasing arrangements bring different employers or individuals together for the purpose of purchasing health insurance or negotiating provider discounts on behalf of their members. Examples of group purchasing arrangements include purchasing cooperatives and alliances, MEWAs, and AHPs. Such arrangements need to be legally recognized by the state or federal government because, under traditional insurance regulation, multiple employers and individuals are prohibited from forming a group solely for the purpose of buying group insurance.

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[67] It is a commonly observed practice of the current individual health insurance market that an insurer will periodically "close" a block of business (meaning they will no longer issue new business in that pool of policies). There can be many reasons for closing a block of business. Regardless of the reason, that block will typically experience claim costs rising more rapidly than would a block that was still open. More information on the closed block problem is available at www.actuary.org/pdf/health/rate_may04.pdf.

[68] Existing law defines "small employer" to include a guaranteed association that purchases health care coverage for its members. Existing law defines "guaranteed association" to mean a nonprofit organization of individuals or employers that meets certain requirements, including having been in active existence and having included health coverage as a membership benefit for at least 5 years prior to January 1, 1992, and covering at least 1,000 persons in that regard. AB 1904 would delete the requirements for a guaranteed association to have been in active existence and to have included health care coverage as a membership benefit for at least 5 years prior to January 1, 1992. The bill would reduce the required number of persons covered by health coverage provided through the guaranteed association from 1,000 to 100. The bill would also define "small employer" to include an eligible association that purchases health care coverage for its members and would define an eligible association as a community or civic group or a charitable or religious organization.

CHBRP relied on the input of content experts and the literature on group purchasing arrangements such as AHPs, MEWAs, and the development of similar products or proposals at the federal level to summarize the potential impacts of exempting out-of-state policies from California-specific requirements and regulatory oversight by the DMHC and the CDI.

Impacts on coverage levels

With respect to products sold across state lines, there have been four quantitative models used for projecting the coverage impacts of AHPs: (1) developed by the analysts at the Congressional Budget Office (CBO); (2) developed by researchers at the Urban Institute, called the Health Insurance Reform Simulation Model (HIRSM); (3) developed by actuaries at Mercer Oliver Wyman; and (4) developed by consultants at The Lewin Group, called the Health Benefits Simulation Model.

The CBO model was used to examine the effects of the introduction of AHPs on the insurance market and specifically examined proposals that establish federally certified AHPs and HealthMarts that would not be subject to state insurance regulations (Baumgardner and Hagen, 2001).[69] Researchers found that the introduction of AHPs and HealthMarts would lead to a slight increase in health insurance coverage nationally. They estimated that an additional 330,000 would become newly insured.

Blumberg and Shen (2004) used the HIRSM model to estimate the impact of various AHP proposals on the California market. Characteristics of AHP provisions, such as those proposed under U.S. House of Representative bill H.R. 660 (2003) or under the U.S. Senate bill S. 545 (2003), were used in the analysis. These AHPs would have been certified by the DOL and, in general, would have been exempt from state benefit mandates or rules on availability of coverage (e.g., guaranteed renewal). Researchers found that there was a less than a 1% increase in new coverage or "virtually no net change in insurance coverage resulting from the availability of this alternative insurance product" (Blumberg and Shen, 2004).

The Mercer evaluation of the Federal Health Insurance Marketplace Modernization and Affordability Act of 2006 (S. 1955), conducted for the National Small Business Association (NSBA), projected that the introduction of small business health plans (SBHPs) in the market would result in a net increase of 2 million insured in the small-group market. However, they assumed that specific state requirements and new Federal standards would be in place.[70,71] A previous analysis conducted by Mercer of H.R. 660 and S. 545, also conducted for the NSBA,

[69] Other CBO cost estimates on AHP, HealthMarts, and related proposals include CBO, 2000; CBO, 2003; and CBO, 2006a 2006b. The Baumgardner and Hagen (2001) article is summarized here because it includes the most detail regarding the CBO model and discussion on cost and coverage impacts.

[70] Specifically, Mercer assumed that (1) state regulations would remain in place since SBHPs were assumed to be fully insured plans, (2) all SBHPs would be subject to the same premium setting requirements as prescribed under S. 1955, and (3) state-regulated policies would be able to adopt the same federal premiums setting requirements that would apply to the SBHPs. Thus the Mercer evaluation essentially evaluated the effects of eliminating benefit mandates.

[71] Bender K, Fritchen B. Personal communication with Mr. Todd McCracken of the National Small Business Association regarding the Health Insurance Marketplace Modernization and Affordability Act of 2006, dated March 7, 2006.

found that elimination of rate setting requirements under those AHP proposals would actually generate a net increase in the number of uninsured in the small-group market, since some groups would have to drop coverage as soon as an employee became sick (and considered high-risk) and their corresponding premiums increased (Fritchen and Bender, 2003).

The Lewin Group's analysis of S. 1955, conducted for the Coalition to Protect Access to Affordable Health Insurance, specifically analyzed the effects of the bill on states with community rating requirements. Since California does not have community rating requirement, the results are not relevant to this report (Lewin Group, 2006).

Impacts on premiums and risk segmentation

The analyses using the CBO and HIRSM models found that the introduction of AHPs in the market resulted in savings in premiums for those individuals who entered the AHPs and an increase for those policyholders who stayed in the insured, fully regulated market. Blumberg and Shen (2004) found a decrease of 14% of insurance premiums for the AHP policyholders and an increase of 5% for the policyholders in the insured fully regulated market. Baumgardner and Hagen (2001) found a 2% increase for those remaining in the insured, fully regulated market, and a 13% difference between the premiums offered to AHP policyholders versus those in the insured market. The savings in premiums for AHP policyholders is attributed to both regulatory relief from state regulations, as well as selection of better (low-cost) risk. Conversely, increased premiums in the state-regulated market are due to adverse selection of the worst (high-cost) risk with fewer low-cost enrollees to spread the risk. The Mercer evaluation of H.R. 660 and S. 545 concurred, finding that small-group AHPs would reap a 10% decrease in premiums but those decreases primarily resulted from risk selection. By contrast, small-group plans in the state-regulated market would face a 23% increase in premiums (Fritchen and Bender, 2003).

The Health Care Choice Act of 2005 (H.R. 2355) was a federal proposal similar to AB 1904—it would have allowed individuals buying insurance in the individual market to do so from an entity licensed in another state. The out-of-state individual health policy would have been exempt from laws and regulations of the enrollee's residence state, which are related to consumer protections, mandated benefits, and other requirements related to guaranteed issue, renewal, and limits on covering preexisting conditions.[72] CBO estimates showed that the price of individual policies in the resident state would increase as a result of H.R. 2355, since higher-risk individuals would not be offered insurance from out-of-state policies. CBO also projected that small-group markets in resident states would have an incentives to stop offering coverage since more affordable out-of-state products would be available to their low-risk employees in the individual market and the remaining high-risk employees would be too costly to insure. The CBO estimated that this dynamic would lead to about 1 million small-group enrollees losing health insurance coverage. However, low-risk individuals who were uninsured would obtain low-cost, out-of-state individual policies, offsetting those who lost insurance. Although the characteristics of the insured population could change, with low-risk individuals gaining insurance coverage and high-risk individuals losing coverage, the net effect with respect to the number of insured would be insubstantial (CBO, 2005). Kofman and Pollitz (2006) found that H.R. 2355 could leave the carriers operating in states with guaranteed issue requirements with only the sickest enrollees, who would need access to comprehensive coverage. Although

[72] H.R. 2355 would have required minimal capital and surplus levels to ensure solvency.

California does not have guaranteed issue requirements in the individual market, state-regulated policies that are required to provide comprehensive health coverage under Knox-Keene requirements would face adverse selection, driving up the cost of coverage for those left in those individual policies.

Impacts on market stability

If AB 1904 were to pass, large- and mid-sized employer groups would need to evaluate what products would provide them value for the premiums they expend. California is unusual in that a smaller proportion of private sector employer-sponsored health plans choose to self-insure. Instead, most employer-sponsored plans purchase insured plans that are subject to state requirements (31% of employees in California are in self-insured plans versus 57% of employees nationally [NORC/CHCF, 2009]). Employers choose to do so, in part, because managed care penetration in California has kept the cost of purchasing comprehensive health care coverage relatively low (Butler and Polzer, 2002). If fewer California-regulated products are offered in the commercial market, it is expected that over time, more large groups, and perhaps even mid-sized groups, might choose to self-insure rather than purchase an out-of-state policy. This would be likely to occur if the state-regulated purchased products charged higher and higher premiums, due to adverse selection. Out-of-state policies might not be an attractive alternative if they did not have the kind of generous benefit packages that large-groups tend to demand (Jensen and Morrisey, 1999a). It is likely that large, multistate employers that already offer a self-insured product to employees of another state would do so for employees in California, rather than purchase an insured out-of-state product for California residents.

As previously discussed, insurance requirements in the small-group market were intended to spread risk and ensure availability of coverage for otherwise uninsurable populations. AHP and other proposals for the development and marketing of products exempt from state-specific requirement are likely to result in out-of-state policies attracting healthy, low-risk employers and individuals. This favorable selection and risk segmentation could lead to change in the composition of the market. For example, in the small-group market, those with younger and healthier employees may choose more affordable out-of-state products while other small groups may drop coverage altogether (Blumberg and Shen, 2004; Kofman and Pollitz, 2006; Kofman and Polzer, 2004). Small groups may face dramatic variations in premiums when California-specific rate protections do not apply. The CDI calculated projected premium impacts if S 1955 were to pass and found that small-group employees of the same firm could face premium differentials of 67% (versus 22% in current California law) based on less stringent rate band requirements (CDI, 2006). Under AB 1904, out-of-state policies licensed in the District of Columbia, Virginia, Pennsylvania, or Hawaii would have no rate band requirements. Thus, those premium differentials could be higher than estimated by the CDI (BCBSA, 2007; Kofman and Pollitz, 2006).

Other Considerations Related to the Potential Impacts of AB 1904

Potential Impacts of Federal Health Care Reform

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. These major long-term provisions of P.L.111-148 would require that most U.S. citizens and qualified legal resident have health insurance and that large employers offer health insurance coverage or a tax-free credit to their employees. It 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 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 short-term provisions in Federal Health Care Reform 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. For example:

- The provision (Section 2714) that would allow children up to the age of 26 to enroll onto their parent's health plan or policy (effective 6 months following enactment) may decrease the number of uninsured and/or potentially shift those enrolled with individually purchased insurance to group purchased insurance.

- The provision that prohibits children from being denied coverage due to preexisting conditions (effective 6 months following enactment) may decrease the number of uninsured, or shift enrollment in California Children Services or Healthy Families to those with privately purchased health insurance

- Another provision would establish a temporary high-risk pool for those with pre-existing conditions (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.

The longer-term provisions of P.L. 111-148 significantly alters the California health care insurance market, and would change many of the baseline assumptions as well marginal impacts of AB 1904. Some long-term provisions relevant to AB 1904 include:

Public plan option and interstate compacts

P.L. 111-148 creates state-based American Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges, administered by a governmental agency or non-profit organization, through which individuals and small businesses with up to 100 employees can purchase qualified coverage. (Kaiser Family Foundation, 2010) P.L 111-148

permits states to allow businesses with more than 100 employees to purchase coverage in the SHOP Exchange beginning in 2017. States may form regional Exchanges or allow more than one Exchange to operate in a state as long as each Exchange serves a distinct geographic area (Kaiser Family Foundation, 2010).[73] The federal government's Office of Personnel Management (OPM) is required to contract with insurers to offer at least two multistate qualified health plans in each of the state-based Exchanges. Specifically the provisions are as follows: "(Sec. 1334, as added by Sec. 10104), requires the Director of the Office of Personnel Management (OPM) to: (1) enter into contracts with health insurance issuers to offer at least two multistate qualified health plans through each Exchange in each state to provide individual or group coverage; and (2) implement this subsection in a manner similar to the manner in which the Director implements the Federal Employees Health Benefits Program."

The provisions of P.L. 111-148 also allow for the creation of interstate compacts (Sec. 1333, as modified by Sec. 10104). The new federal law requires the Secretary to issue regulations for the creation of health care choice compacts under which two or more states may enter into an agreement that: (1) qualified health plans could be offered in the individual markets in all such states only subject to the laws and regulations of the state in which the plan was written or issued; and (2) the issuer of any qualified health plan to which the compact applies would continue to be subject to certain laws of the state in which the purchaser resides, would be required to be licensed in each state, and must clearly notify consumers that the policy may not be subject to all the laws and regulations of the state in which the purchaser resides.

Consumer protection provisions

P.L. 111-148 provides federal grants towards the establishment of an office of health insurance consumer assistance or an ombudsman program to serve as an advocate for people with private coverage in the individual and small group markets.[74] The law requires that standards must first be developed and within 12 months following enactment; insurer must comply with standards within 24 months following enactment. P.L. 111-148 also requires health plans participating in the Exchanges to meet marketing requirements, have adequate provider networks, and include other consumer-friendly requirements.

Provisions related to benefit coverage

P.L. 111-148 creates four benefit categories plus a separate catastrophic plan to be offered through the Exchanges, and in the individual and small group markets. States will retain primary responsibility of regulating the business of insurance and may define state benefit mandates. However, federal law requires that private health insurance include certain benefits and protections, for services covered by a plan. HIPAA and subsequent amendments require, for example, that group health plans and insurers who cover maternity care also

[73] Funding is available to states to establish Exchanges within 1 year of enactment and until January 1, 2015.
[74] Federal grants available beginning in Fiscal Year 2010.

cover minimum hospital stays for the maternity care, provide parity in annual and lifetime limits for any offered mental health benefits, and offer reconstructive breast surgery if the plan covers mastectomies.

Additionally, P.L. 111-148 broadly defines "essential health benefits", and to meet these requirements: all plans would be required to provide the following set of services: Hospitalization; Outpatient hospital and outpatient clinic services, including emergency department services; Professional services of physicians and other health professionals; Medical and surgical care; Services, equipment, and supplies incident to physician and health professional care in appropriate settings; Prescription drugs; Rehabilitative and habilitative services; Mental health and substance use disorder services, including behavioral health treatment; Preventive services, as specified; Maternity benefits; and Well baby and well child care and oral health, vision, and hearing services, equipment, and supplies for children under 21. The essential benefits package would also be subject to cost-sharing requirements, with no cost-sharing allowed for required preventive items and services.

For emergency care, the plan would be required to provide coverage without prior authorization and without limitation on coverage if the provider does not have a contractual relationship with the plan. Cost-sharing for out-of-network emergency services could not exceed cost-sharing for in-network emergency services.

Beginning July 1, 2012, the Secretary of HHS would be required to define and update the categories of covered treatments, items and services within benefit classes no less than annually. The Secretary could not define a package that is more extensive than a typical employer plan as certified by the Centers for Medicare and Medicaid Services, Office of the Actuary. Some flexibility in plan design would be allowed as long as it did not encourage adverse selection. The Secretary would be required to update or modify these definitions to account for changes in medical evidence or scientific advancement or to address any gaps in access or changes in the evidence base.

Each state would be required to ensure that at least one plan offered in the exchange is at least actuarially equivalent to the standard Blue Cross Blue Shield plan offered to Federal employees.

Provisions related to annual and lifetime benefit limits

P.L. 111-148 prohibits individual and group health plans from placing lifetime limits on the dollar value of coverage (effective 6 months after enactment). Additionally, individual and group health plans will be prohibited from placing annual limits on the dollar value of coverage by 2014.[75]

[75] Prior to January 2014, plans may only impose annual limits on coverage as determined by the Secretary of Health & Human Services.

APPENDICES

Appendix A: Text of Bill Analyzed

BILL NUMBER: AB 1904 INTRODUCED

BILL TEXT

INTRODUCED BY Assembly Member Villines

FEBRUARY 16, 2010

An act to add Section 1349.3 to the Health and Safety Code, and to add Section 699.6 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 1904, as introduced, Villines. Out-of-state carriers.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, requires, subject to specified exceptions, that a health care service plan be licensed by the Department of Managed Health Care and provide basic health care services, as defined, unless exempted from that requirement by the director of the department. Existing law also requires, subject to specified exceptions, that an insurer obtain a certificate of authority from the Insurance Commissioner in order to transact business in this state and that the insurer operate in accordance with specified requirements.

This bill would allow a carrier domiciled in another state to offer, sell, or renew a health care service plan or a health insurance policy in this state without holding a license issued by the department or a certificate of authority issued by the commissioner and would exempt the carrier's plan or policy from requirements otherwise applicable to plans and insurers providing health care coverage in this state if the plan or policy complies with the domiciliary state's requirements, and the carrier is lawfully authorized to issue the plan or policy in that state and to transact business there.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 1349.3 is added to the Health and Safety Code, to read:

1349.3. (a) Notwithstanding any other provision of law, a carrier domiciled in another state is exempt from Section 1349, if it meets the following criteria:

(1) It offers, sells, or renews a health care service plan in this state that complies with all of the requirements of the domiciliary state applicable to the plan.

(2) It is authorized to issue the plan in the state where it is domiciled and to transact business there.

(b) Notwithstanding any other provision of law, a health care service plan offered, sold, or renewed in this state by a carrier that satisfies the criteria of subdivision (a) is exempt from all other provisions of this chapter.

SEC. 2. Section 699.6 is added to the Insurance Code, to read:

699.6. (a) Notwithstanding any other provision of law, a carrier domiciled in another state is exempt from Section 700, if it meets the following criteria:

(1) It offers, sells, or renews a health insurance policy in this state that complies with all of the requirements of the domiciliary state applicable to the policy.

(2) It is authorized to issue the policy in the state where it is domiciled and to transact business there.

(b) Notwithstanding any other provision of law, a health insurance policy offered, sold, or renewed in this state by a carrier that satisfies the criteria of subdivision (a) is exempt from all other provisions of this code.

Appendix B: Literature Review Methods

This literature review and summary relied on the published literature in peer-reviewed journals as well as reports found in the grey literature.

Grey literature is defined as "That which is produced on all levels of government, academics, business and industry in print and electronic formats, but which is not controlled by commercial publishers." (The New York Academy of Medicine (http://www.nyam.org/library/greywhat.shtml, accessed October 2006) Grey literature is, thus, valuable for its timeliness relative to scholarly publications and for its documentation of technical information.

CHBRP searched the grey literature and published peer reviewed journals using the following search terms:

- Association Health plan
- Association sponsored health plans or association sponsored health insurance (and variations)
- multiple-employer welfare association (MEWAs)
- Pre-emption or exemptions of state mandates or state insurance regulations (and variations)
- S.1955 (2006)
- Cost of mandated benefits (and variations)
- H.R. 2355 (2005)

The specific search engines and data bases and web sites that were systematically used are:

- PubMed
- Library of Congress:www.loc.gov
- USA.gov
- California's Legislative Analyst's Office: www.lao.ca.gov
- Congressional Research Service: www.opencrs.com
- General Accountability Office: www.gao.gov
- Congressional Budget Office: www.cbo.gov
- ABI/INFORM: http://www.umi.com/products/pt-products-ABI.shtml
- www.econlit.org
- American's Health Insurance Plans:www.ahip.org
- Urban Institute:www.urbaninstitute.org
- Commonwealth Fund:www.cmwf.org
- RAND Health:www.rand.org/health/
- California Health Care Foundation:www.chcf.org/
- Robert Wood Johnson Foundation:www.rwjfo.org/main.html
- National Bureau of Economic Research:www.nber.org
- Heritage Foundation:www.heritage.org
- Cato Institute:www.cato.org
- Pacific Research Institute: www.pacificresearch.org

CHBRP also relied on the input of an additional health policy expert to help identify the relevant literature, provide input on research approach, and review the draft report. This individual included:

H. E. Frech, III, PhD, Professor, Economics, University of California, Santa Barbara

Additionally a subcommittee of the CHBRP's National Advisory Council was selected to review and provide input on the draft report (see final pages of this report).

Appendix C: Cost Impact Analysis: Data Sources, Caveats, and Assumptions

This appendix describes data sources, as well as general and bill-specific caveats and assumptions used in conducting the cost impact analysis. For additional information on the cost model and underlying methodology, please refer to the CHBRP Web site at http://www.chbrp.org/analysis_methodology/cost_impact_analysis.php.

The cost analysis in this report was prepared by the Cost Team, which consists of CHBRP task force members and staff, specifically from the University of California, Los Angeles, and Milliman Inc. (Milliman). Milliman is an actuarial firm that provides data and analyses per the provisions of CHBRP's authorizing legislation.

Data Sources

In preparing cost estimates, the Cost Team relies on a variety of data sources as described below.

Health insurance

1. The latest (2007) California Health Interview Survey (CHIS), which is used to estimate health insurance for California's population and distribution by payer (i.e., employment-based, individually purchased, or publicly financed). The biannual CHIS is the largest state health survey conducted in the United States, collecting information from over approximately 53,000 households. More information on CHIS is available at www.chis.ucla.edu. The population estimates for both adults and children from 2007 were adjusted to reflect the following trends as of 2009 from the data sources listed: 1) the increase in the total non-institutionalized population in California, from the California Department of Finance; 2) the decrease in private market coverage (both group- and individual-level), from the CHBRP Annual Premium and Enrollment Survey, and 3) the increase in all types of public coverage, from enrollment data available from the Centers for Medicare & Medicaid Services, the California Medical Statistics Section, and the Managed Risk Medical Insurance Board. The residual population after accounting for these trends was assumed to be uninsured.
2. The latest (December, 2008) California Employer Health Benefits Survey (CHCF, 2008) is used to estimate:
    - size of firm,
    - percentage of firms that are purchased/underwritten (versus self-insured),
    - premiums for health care service plans regulated by the Department of Managed Health Care (DMHC) (primarily health maintenance organizations [HMOs] and Point of Service Plans [POS]),
    - premiums for health insurance policies regulated by the California Department of Insurance (CDI) (primarily preferred provider organizations [PPOs] and fee-for-service plans [FFS]), and
    - premiums for high deductible health plans (HDHPs) for the California population with employment-based health insurance.
    - This annual survey is currently released by the California Health Care Foundation/National Opinion Research Center (CHCF/NORC) and is similar to the

national employer survey released annually by the Kaiser Family Foundation and the Health Research and Educational Trust. Information on the CHCF/NORC data is available at: www.chcf.org/topics/healthinsurance/index.cfm?itemID=133543.

3. Milliman data sources are relied on to estimate the premium impact of mandates. Milliman's projections derive from the Milliman Health Cost Guidelines (HCGs) (Milliman, 2009). The HCGs are a health care pricing tool used by many of the major health plans in the United States. See www.milliman.com/expertise/healthcare/products-tools/milliman-care-guidelines/index.php. Most of the data sources underlying the HCGs are claims databases from commercial health insurance plans. The data are supplied by health insurance companies, Blues plans, HMOs, self-funded employers, and private data vendors. The data are mostly from loosely managed healthcare plans, generally those characterized as preferred provider plans or PPOs. The HCGs currently include claims drawn from plans covering 4.6 million members. In addition to the Milliman HCGs, CHBRP's utilization and cost estimates draw on other data, including the following:

   - The MarketScan Database, which includes demographic information and claim detail data for approximately 13 million members of self-insured and insured group health plans.
   - An annual survey of HMO and PPO pricing and claim experience. The most recent survey (2008 Group Health Insurance Survey) contains data from seven major California health plans regarding their 2007 experience.
   - Ingenix MDR Charge Payment System, which includes information about professional fees paid for healthcare services, based upon approximately 800 million claims from commercial insurance companies, HMOs, and self-insured health plans.
   - These data are reviewed for applicability by an extended group of experts within Milliman but are not audited externally.

4. An annual survey by CHBRP of the seven largest providers of health insurance in California (Aetna, Anthem Blue Cross of California, Blue Shield of California, CIGNA, Health Net, Kaiser Foundation Health Plan, and PacifiCare) to obtain estimates of baseline enrollment by purchaser (i.e., large and small group and individual), type of plan (i.e., DMHC or CDI-regulated), cost-sharing arrangements with enrollees, and average premiums. Enrollment in plans or policies offered by these seven firms represents 95.9% of the persons with privately funded health insurance subject to state mandates. This figure represents 98.0% of enrollees in full service (non-specialty), privately funded DMHC-regulated health plan contracts and 85.3% of enrollees in full service (non-specialty), privately funded CDI-regulated policies.

Publicly funded insurance subject to state benefit mandates

5. Premiums and enrollment in DMHC-regulated health plans and CDI-regulated policies by self-insured status and firm size are obtained annually from CalPERS for active state and local government public employees and their dependents who receive their benefits through CalPERS. Enrollment information is provided for DMHC-regulated health care service plans covering non-Medicare beneficiaries—about 74% of CalPERS total enrollment. CalPERS

self-funded plans—approximately 26% of enrollment—are not subject to state mandates. In addition, CHBRP obtains information on current scope of benefits from evidence of coverage (EOCs) documents publicly available at www.calpers.ca.gov.

6. Enrollment in Medi-Cal Managed Care (DMHC-regulated health plans) is estimated based on CHIS and data maintained by the Department of Health Care Services (DHCS). DHCS supplies CHBRP with the statewide average premiums negotiated for the Two-Plan Model, as well as generic contracts that summarize the current scope of benefits. CHBRP assesses enrollment information online at http://www.dhcs.ca.gov/dataandstats/statistics/Pages/BeneficiaryDataFiles.aspx.
7. Enrollment data for other public programs—Healthy Families Program (HFP), Access for Infants and Mothers (AIM), and the Major Risk Medical Insurance Program (MRMIP)—are estimated based on CHIS and data maintained by the Managed Risk Medical Insurance Board (MRMIB). The basic minimum scope of benefits offered by participating health plans under these programs must comply with all requirements for DMHC-regulated health plans, and thus these plans are affected by state-level benefit mandates. CHBRP does not include enrollment in the Post-MRMIP Guaranteed-Issue Coverage Products as these persons are already included in the enrollment for individual market health insurance offered by DMHC-regulated plans or CDI-regulated insurers. Enrollment figures for AIM and MRMIP are included with enrollment for Medi-Cal in presentation of premium impacts. Enrollment information is obtained online at www.mrmib.ca.gov/. Average statewide premium information is provided to CHBRP by MRMIB staff.

General Caveats and Assumptions

The projected cost estimates are estimates of the costs that would result if a certain set of assumptions were exactly realized. Actual costs will differ from these estimates for a wide variety of reasons, including:

- Prevalence of mandated benefits before and after the mandate may be different from CHBRP assumptions.
- Utilization of mandated benefits (and, therefore, the services covered by the benefit) before and after the mandate may be different from CHBRP assumptions.
- Random fluctuations in the utilization and cost of health care services may occur.

Additional assumptions that underlie the cost estimates presented in this report are:

- Cost impacts are shown only for those who are currently enrolled in those plans and policies that are subject to state benefit mandate laws.
- Cost impacts are only for the first year after enactment of the proposed legislation
- Employers and employees will share proportionately (on a percentage basis) in premium rate changes resulting from the proposed legislation. In other words, the distribution of

premium paid by the subscriber (or employee) and the employer will be unaffected by the proposed legislation.

- For state-sponsored programs for the uninsured, the state share will continue to be equal to the absolute dollar amount of funds dedicated to the program.
- When cost savings are estimated, they reflect savings realized for one year. Potential long-term cost savings or impacts are estimated if existing data and literature sources are available and provide adequate detail for estimating long-term impacts. For more information on CHBRP's criteria for estimating long-term impacts please see: http://www.chbrp.org/analysis_methodology/cost_impact_analysis.php.
- Several recent studies have examined the effect of private insurance premium increases on the number of uninsured (Chernew et al., 2005; Glied and Jack, 2003; Hadley, 2006). Chernew et al. (2005) estimate that a 10% increase in private premiums results in a 0.74 to 0.92 percentage point decrease in the number of insured, while Hadley (2006) and Glied and Jack (2003) estimate that a 10% increase in private premiums produces a 0.88 and 0.84 percentage point decrease in the number of insured, respectively. The CBO (2009) estimates that a 10 percent decrease in the out-of-pocket cost that enrollees have to pay would generally cause their use of health care to increase by about 1 to 2 percent (CBO, 2009). The price elasticity of demand for insurance, as selected by CHBRP, can be calculated from these studies in the following way. First, take the average percentage point decrease in the number of insured reported in these studies in response to a 1-percent increase in premiums (about -0.088), divided by the average percentage of insured persons (about 80%), multiplied by 100%, i.e., ({[-0.088/80] x 100} = −0.11). This elasticity converts the *percentage point* decrease in the number of insured into a *percentage* decrease in the number of insured persons for every 1% increase in premiums. Because each of these studies reported results for the large-group, small-group, and individual insurance markets combined, CHBRP employs the simplifying assumption that the elasticity is the same across different types of markets. While elasticity is affected by wealth (Abraham, 2006), and Hadley (2006) shows that low income individuals with family income up to 400% of the federal poverty level (FPL) are much more price sensitive than high income individuals, CHBRP employs the simplifying assumption that elasticity is the same across different levels of income. For more information on CHBRP's criteria for estimating impacts on the uninsured please see: http://www.chbrp.org/analysis_methodology/cost_impact_analysis.php.
- Price elasticity may be different for premium increases and premium decreased (Glied and Jack, 2003). CHBRP, as noted in http://www.chbrp.org/analysis_methodology/cost_impact_analysis.php, employs the simplifying assumption that the elasticity is symmetrical, and the same calculation given above is effective to both premium increases and premium decreases. Price elasticity was also linked to other factors, such as education level (Glied and Jack, 2003), health status (Auerbach and Ohri, 2006), marital status (Abraham, 2006; Marquis and Buntin, 2006. Since detailed information on these factors is not readily available, CHBRP employs the simplifying assumption that elasticity is only affected by premium increases and decreases.

There are other variables that may affect costs, but which CHBRP did not consider in the cost projections presented in this report. Such variables include, but are not limited to:

- Adverse selection: Theoretically, individuals or employer groups who had previously foregone health insurance may now elect to enroll in a health plan or policy, following enactment of the legislation, because they perceive that it is to their economic benefit to do so.
- Geographic and delivery systems variation: Variation in existing utilization and costs, and in the impact of the mandate, by geographic area and delivery system models: Even within the health insurance types CHBRP modeled (HMO—including HMO and point of service (POS) plans—and non-HMO—including PPO and fee for service (FFS) policies), there are likely variations in utilization and costs by type. Utilization also differs within California due to differences in the health status of the local population, provider practice patterns, and the level of managed care available in each community. The average cost per service would also vary due to different underlying cost levels experienced by providers throughout California and the market dynamic in negotiations between providers and health plans or insurers. Both the baseline costs prior to the mandate and the estimated cost impact of the mandate could vary within the state due to geographic and delivery system differences. For purposes of this analysis, however, CHBRP has estimated the impact on a statewide level.

Caveats and Assumptions

CHBRP's analysis of AB 1904 is based on several key assumptions, some of which apply to all the scenarios presented in this report, and others that are unique to each of the scenarios. These assumptions are:

Key assumptions common to the three scenarios:

- Because it is impossible to determine exactly which combinations of current mandated benefits would be offered under AB 1904, CHBRP assumed that the currently mandated benefits will continue to be offered to groups and individuals to be purchased, in addition to any limited mandate plans and benefits.
- The uninsured rate among adults aged 18 to 64 years and children aged 0 to 17 years who are not eligible for public programs would decline by 1.1% for every 10% drop in premiums in each market segment. For more information on CHBRP's criteria for estimating impacts on the uninsured please see the discussion above under general caveats, and http://www.chbrp.org/analysis_methodology/cost_impact_analysis.php. The overall price change estimated by CHBRP for all limited-mandate plans would be applied to the estimated 4.848 million uninsured adults and children not eligible for public programs. The number of uninsured was obtained from CHIS 2007. CHBRP was not able to stratify the uninsured who are employed by size of firm. There is some evidence in the research literature that reducing the number of mandated benefits does have a positive impact on the number of insured individuals (Sloan and Conover, 1998; Jensen and Morrisey, 1999b).

- The newly insured would be distributed according to the same proportions as in the baseline period. The cost of the uninsured in the baseline period would be about 50% of spending in the post-AB 1904 period for the newly insured, based on estimates from the RAND Health Insurance Experiment data about the impact on expenditures of moving from high-deductible coverage to comprehensive coverage with limited cost sharing (Newhouse et al., 1993).
- The administrative expenses and profit margins are assumed to be the same for comprehensive, full benefit plans as they are for limited-mandate plans, HDHPs and limited-mandate HDHP plans.

Key assumptions under scenario 1 (high impact):

- This scenario assumes all insurers would offer limited-mandate plans in every market, and all currently insured Californians would purchase the limited-mandate plans instead of their current health insurance products. The purpose of this scenario is to illustrate the maximum savings possible from removing the requirement for mandated benefits in the short term.
- Because premiums for all segments of the market (large-group, small-group, and individual sectors, and DMHC-regulated vs. CDI-regulated) would be lower, CHBRP assumes that the market share of low- and zero-deductible plans relative to HDHPs remains the same within each market segment, even though the price reductions are not exactly the same in each market. This simplifying assumption is supported by evidence from Marquis et al. (2006) that overall demand for insurance is not sensitive to changes in the benefits offered.

Key assumptions under scenario 2 (low income impact):

- This scenario assumes that only those who currently have the lowest-premium plans individual plans would be interested in purchasing health insurance products with limited mandates, and that 40% of those currently with DMHC and CDI-regulated individual policies and with incomes up to 350% FPL, would purchase a less-expensive policy with limited mandates.
- The reduction in the number of uninsured will be estimated in the same way as above under scenario 1, but all newly insured will be concentrated in the DMHC and CDI-regulated individual market only.

- *Key assumptions under scenario 3 (very low income impact):*
- This scenario assumes that only those who currently have the lowest-premium plans in the small-group and individual market segment would be interested in purchasing health insurance products with limited mandates, and that 40% of those currently with DMHC and CDI-regulated individual policies and 20% of those currently with small-group plans, and with income up to 200% FPL, would purchase a less-expensive policy with limited mandates.
- The reduction in the number of uninsured will be estimated in the same way as above under scenario 1, but all newly insured will be concentrated in the small-group and individual market segments.

- These scenarios may overstate the impact of AB 1904, because not everyone would switch from their current plans to limited-mandate plans. Therefore, these scenarios should be thought of as hypothetical maximum and low-impact scenarios in the short term rather than actual estimates of how the market might respond to AB 1904. They are useful because they show *at most* the short-term savings that might be possible if there was broad acceptance of these policies.

Appendix D: Information Submitted by Outside Parties

In accordance with CHBRP policy to analyze information submitted by outside parties during the first two weeks of the CHBRP review, the following parties chose to submit information.

No information was submitted directly by interested parties for this analysis.

For information on the processes for submitting information to CHBRP for review and consideration please visit: http://www.chbrp.org/recent_requests/index.php.

Appendix E: Limited-Mandate Plan Designs Used to Model Cost Impact Scenarios

This appendix presents possible prototypes for the limited-mandate plans that are used to model the hypothetical cost impact scenarios presented in this report. For more information regarding the underlying assumption of which benefit *mandates* are included or excluded, please refer to Table F-4. Treatment of Mandates in Current Law for Each of the CDI-Regulated Limited-Mandate Plan Prototypes, and Table F-5. Treatment of Mandates in Current Law for Each of the DMHC Limited-Mandate Plan Prototypes.

The limited-mandate plans designs, and underlying assumptions as to which benefit mandates are included, were based on a review of "summary of benefits" documents or disclosure forms for carriers that offered limited-mandate or limited-benefit plans in other states that have laws permitting the development of these plans[76]. Typically these limited-mandate plans may waive or be exempt from all or a subset of benefit mandates in law in those particular states. In addition to these publicly available marketing sources, the grey literature was also consulted. Note that these prototypes do not include cost-sharing information such as the deductible, copayments, and out-of-pocket maximums. This is not specified because this cost impact analysis did not make any assumptions with respect to cost sharing as a result of AB 1904, since the bill does not address the related requirements, even though some out-of-state carriers may change cost sharing in order to reduce the premiums of the limited-mandate plans.

Group CDI-Regulated Limited-Mandate Policies

The proposed design for a large-group CDI limited-mandate plan could be one that a carrier can present as a lower-premium option to large-group purchasers. Large-group purchasers who offer this policy to their employees would do so in conjunction with another, more comprehensive HMO or PPO policy. The policy is designed to provide large-group employees the option of purchasing a bare bones policy at the lowest cost. The design for a small-group CDI limited-mandate plan is identical to that of the large-group market. It is also designed for small-group purchasers who would want to make available a bare bones policy at the lowest cost. This could be also be used by some small groups to attract better risk. If there is enough premium savings associated with this plan, smaller groups who do not currently offer health insurance may offer this policy. This plan design could also be appropriate for groups that would not offer coverage for dependants.

[76] Quotes for individual insurance policies by gender and age were searched on eHealthInsurance.com in the states of Idaho, North Dakota, and Wyoming on March 15, 2010.

Table E-1. Large-Group and Small-Group CDI Limited-Mandate Plan

Benefit	Included/Excluded
Professional Services (Doctor Office Visits)	
Primary and specialty care visits (includes routine and urgent care appointments)	Included
Preventive screening	Included
Well-child preventive care visits (0-23 months)	Included
Family planning visits	Excluded
Scheduled prenatal care and first postpartum visit	Included
Eye exams	Excluded
Hearing tests	Excluded
Physical, occupational, and speech therapy visits	Included
Outpatient Services	
Outpatient surgery	Included
Vaccines (immunizations)	Included
X-rays and lab tests	Included
Health education	Excluded
Hospitalization Services	
Room and board, surgery, anesthesia, X-rays, lab tests, and drugs	Included
Labor & Delivery	Included
Emergency Department visits	Included
Ambulance Services	Included
Prescription Drug Coverage	
Generic	Included
Brand name	Excluded
Contraception drugs and devices	Excluded
Durable Medical Equipment	Excluded
Prosthetics and Orthotics	Excluded
Mental Health Services	
Inpatient psychiatric care	Excluded
Outpatient visits	Excluded
Chemical Dependency Services	
Inpatient detoxification	Excluded
Outpatient visits	Excluded
Home Health Services	Excluded
Noncustodial Skilled Nursing Facility Care	Included
Hospice Care	Excluded
Infertility Services	Excluded
Acupuncture	Excluded
Chiropractic	Excluded
Other (dental procedures, TMJ, experimental or investigational treatment, cosmetic surgery, food and dietary supplements, hearing aid, over-the-counter drugs or devices, weight reduction, sexual reassignment surgery)	Excluded

Individual CDI-Regulated Limited-Mandate Plan

This plan is designed for young, healthy adults who cannot necessarily afford a comprehensive HMO or PPO option. It would provide catastrophic coverage and provide only those preventive services recommended for adults. It is not designed to carry children as dependants. Note that the main difference between this individual plan design and the plan design for CDI large and small groups is its lack of maternity coverage.

Table E-2. Individual CDI Limited-Mandate Plan

Benefit	Included/Excluded
Professional Services (Doctor Office Visits)	
Primary and specialty care visits (includes routine and Urgent Care appointments)	Included
Preventive screening	Included
Well-child preventive care visits (0-23 months)	Excluded
Family planning visits	Excluded
Scheduled prenatal care and first postpartum visit	Excluded
Eye exams	Excluded
Hearing tests	Excluded
Physical, occupational, and speech therapy visits	Included
Outpatient Services	
Outpatient surgery	Included
Vaccines (immunizations)	Included
X-rays and lab tests	Included
Health education	Excluded
Hospitalization Services	
Room and board, surgery, anesthesia, X-rays, lab tests, and drugs	Included
Labor & Delivery	Excluded
Emergency Department visits	Included
Ambulance Services	Included
Prescription Drug Coverage	
Generic	Included
Brand name	Excluded
Contraception drugs and devices	Excluded
Durable Medical Equipment	Excluded
Prosthetics and Orthotics	Excluded
Mental Health Services	
Inpatient psychiatric care	Excluded
Outpatient visits	Excluded
Chemical Dependency Services	
Inpatient detoxification	Excluded
Outpatient visits	Excluded
Home Health Services	Excluded
Noncustodial Skilled Nursing Facility Care	Included
Hospice Care	Excluded
Infertility Services	Excluded
Acupuncture	Excluded
Chiropractic	Excluded
Other (dental procedures, TMJ, experimental or investigational treatment, cosmetic surgery, food and dietary supplements, hearing aid, over-the-counter drugs or devices, weight reduction, sexual reassignment surgery)	Excluded

DMHC Limited-Mandate Plan

This plan is designed to provide large- and small-group employees and individuals the option of purchasing a bare bones policy at the lowest cost and for those groups who may otherwise not offer coverage for dependants. This could be attractive to those who would prefer an HMO option.

Table E-3. Group and Individual DMHC Limited-Mandate Plan

Benefit	Included/Excluded
Professional Services (Doctor Office Visits)	
Primary and specialty care visits (includes routine and Urgent Care appointments)	Included
Preventive screening	Included
Well-child preventive care visits (0-23 months)	Included
Family planning visits	Excluded
Scheduled prenatal care and first postpartum visit	Included
Eye exams	Excluded
Hearing tests	Excluded
Physical, occupational, and speech therapy visits	Included
Outpatient Services	
Outpatient surgery	Included
Vaccines (immunizations)	Included
X-rays and lab tests	Included
Health education	Excluded
Hospitalization Services	
Room and board, surgery, anesthesia, X-rays, lab tests, and drugs	Included
Labor & Delivery	Included
Emergency Department visits	Included
Ambulance Services	Included
Prescription Drug Coverage	
Generic	Included
Brand name	Included
Contraception drugs and devices	Excluded
Durable Medical Equipment	Excluded
Prosthetics and Orthotics	Excluded
Mental Health Services	
Inpatient psychiatric care	Included
Outpatient visits	Included
Chemical Dependency Services	
Inpatient detoxification	Excluded
Outpatient visits	Excluded
Home Health Services	Included
Noncustodial skilled nursing facility care	Included
Hospice care	Included
Infertility services	Excluded
Acupuncture	Excluded
Chiropractic	Excluded
Other (dental procedures, TMJ, experimental or investigational treatment, cosmetic surgery, food and dietary supplements, hearing aid, over-the-counter drugs or devices, weight reduction, sexual reassignment surgery)	Excluded

Table E-4. Treatment of Mandates in Current Law for Each of the CDI-Regulated Limited-Mandate Plan Prototypes

Part A. Cancer Screening & Treatment

Description of Benefit	Health & Safety Code Section	California Insurance Code Section	Type of Requirement Mandate or Mandated Offering	Markets Affected	CDI Individual N/A=mandate doesn't apply	CDI Group N/A=mandate doesn't apply
Cancer screening tests	1367.665	10123.2	Mandate	Individual and group	Included as part of preventive services	Included as part of preventive services
Prostate cancer screening and diagnosis	1367.64	10123.83	Mandate	Individual and group	Included as part of preventive services	Included as part of preventive services
Cervical cancer screening	1367.66	10123.18	Mandate	Individual and group	Included as part of preventive services	Included as part of preventive services
Breast cancer screening, diagnosis, and treatment	1367.6	10123.8	Mandate	No mention	Included	Included
Breast cancer screening with Mammography	1367.65	10123.81	Mandate	No mention	Included as part of preventive services	Included as part of preventive services
Mastectomy and lymph node dissection – length of stay	1367.635	10123.86	Mandate	Individual and group	Included under ambulatory care or inpatient services	Included under ambulatory or inpatient services
Patient care related to clinical trials for cancer	1370.6	N/A	Mandate	No mention	N/A	N/A

Part B. Chronic Conditions

Description of Benefit	Health & Safety Code Section	California Insurance Code Section	Type of Requirement Mandate or Mandated Offering	Markets Affected	CDI Individual N/A=mandate doesn't apply	CDI Group N/A=mandate doesn't apply
Diabetes management and treatment	1367.51	10176.61	Mandate	No mention	Included	Included
Osteoporosis diagnosis, treatment and management	1367.67	10123.185	Mandate	No mention	Included	Included

Part B. Chronic Conditions (Cont'd)

Description of Benefit	Health & Safety Code Section	California Insurance Code Section	Type of Requirement Mandate or Mandated Offering	Markets Affected	CDI Individual N/A=mandate doesn't apply	CDI Group N/A=mandate doesn't apply
Transplantation services for persons with HIV	1374.17	10123.21	Mandate	No mention	Included under inpatient services	Included under inpatient services
AIDS vaccine	1367.45	10145.2	Mandate	Individual and group	Excluded	Excluded
HIV/AIDS, HIV Testing	1367.46	10123.91	Mandate	Individual and group	Excluded	Included
Phenylketonuria	1374.56	10123.89	Mandate	No mention	Excluded as part of maternity services	Included as part of maternity services

Part C. Mental Illness

Description of Benefit	Health & Safety Code Section	California Insurance Code Section	Type of Requirement Mandate or Mandated Offering	Markets Affected	CDI Individual N/A=mandate doesn't apply	CDI Group N/A=mandate doesn't apply
Coverage for mental and nervous disorders	N/A	10125	Mandated offering	Group	N/A	Excluded
Coverage and premiums for persons with physical or mental impairment	1367.8	10122.1	Mandate	Individual and group	Excluded under mental health services	Excluded under mental health services
Parity in coverage for severe mental illness	1374.72	10123.15 (10144.5)	Mandate	Group	N/A	Excluded under mental health services
Alcoholism treatment	1367.2	10123.6	Mandated offering	Group	N/A	Excluded under chemical dependency services
Alcohol and drug exclusion	N/A	10369.12	Mandate	Group	N/A	Excluded

Part D. Orthotics and Prosthetics

Description of Benefit	Health & Safety Code Section	California Insurance Code Section	Type of Requirement Mandate or Mandated Offering	Markets Affected	CDI Individual N/A=mandate doesn't apply	CDI Group N/A=mandate doesn't apply
Orthotic and prosthetic devices and services	1367.18	10123.7	Mandated offering	Group	N/A	Excluded
Prosthetic devices for laryngectomy	1367.61	10123.82	Mandate	No mention	Excluded	Excluded
Special footwear for persons suffering from foot disfigurement	1367.19	10123.141	Mandated offering	No mention	Excluded as orthotic and prosthetic items and devices	Excluded as orthotic and prosthetic items and devices

Part E. Pain Management

Description of Benefit	Health & Safety Code Section	California Insurance Code Section	Type of Requirement Mandate or Mandated Offering	Markets Affected	CDI Individual N/A=mandate doesn't apply	CDI Group N/A=mandate doesn't apply
Acupuncture	N/A	10127.3	Mandated offering	Group	N/A	Excluded
Pain management medication for terminally ill	1367.215	N/A	Mandate	No mention	N/A	N/A
General anesthesia for dental procedures	1367.71	10119.9	Mandate	No mention	Excluded	Excluded

Part F. Pediatric Health

Description of Benefit	Health & Safety Code Section	California Insurance Code Section	Type of Requirement Mandate or Mandated Offering	Markets Affected	CDI Individual N/A=mandate doesn't apply	CDI Group N/A=mandate doesn't apply
Comprehensive preventive care for children aged 16 years or younger	1367.3	10123.55	Mandated offering	Group	N/A (excluded under preventive services)	Included as part of preventive services
Comprehensive preventive care for children aged 17 or 18 years	1367.3	10123.55	Mandated offering	Group	N/A (excluded under preventive services)	Included as part of preventive services
Asthma management	1367.06	N/A	Mandate	No mention	N/A	N/A
Screening children for blood lead levels	1367.3 (b)(2)(D)	10119.8	Mandate	Individual and group	Excluded under preventive services	Included as part of preventive services

Table E-5. Treatment of Mandates in Current Law for Each of the DMHC Limited-Mandate Plan Prototypes

Part A. Cancer Screening & Treatment

Description of Benefit	Health & Safety Code Section	California Insurance Code Section	Type of Requirement Mandate or Mandated Offering	Markets Affected	DMHC Individual N/A=mandate doesn't apply	DMHC Small and Large Group N/A=mandate doesn't apply
Cancer screening tests	1367.665	10123.2	Mandate	Individual and group	Included as part of preventive services	Included as part of preventive services
Prostate cancer screening and diagnosis	1367.64	10123.83	Mandate	Individual and group	Included as part of preventive services	Included as part of preventive services
Cervical cancer screening	1367.66	10123.18	Mandate	Individual and group	Included as part of preventive services	Included as part of preventive services
Breast cancer screening, diagnosis, and treatment	1367.6	10123.8	Mandate	No mention	Included	Included
Breast cancer screening with Mammography	1367.65	10123.81	Mandate	No mention	Included as part of preventive services	Included as part of preventive services

Part A. Cancer Screening & Treatment (Cont'd)

Description of Benefit	Health & Safety Code Section	California Insurance Code Section	Type of Requirement Mandate or Mandated Offering	Markets Affected	CDI Individual N/A=mandate doesn't apply	CDI Group N/A=mandate doesn't apply
Mastectomy and lymph node dissection – length of stay	1367.635	10123.86	Mandate	Individual and group	Included under ambulatory care or inpatient services	Included under ambulatory or inpatient services
Patient care related to clinical trials for cancer	1370.6	N/A	Mandate	No mention	Excluded	Excluded

Part B. Chronic Conditions

Description of Benefit	Health & Safety Code Section	California Insurance Code Section	Type of Requirement Mandate or Mandated Offering	Markets Affected	DMHC Individual N/A=mandate doesn't apply	DMHC Small and Large Group N/A=mandate doesn't apply
Diabetes management and treatment	1367.51	10176.61	Mandate	No mention	Included	Included
Osteoporosis diagnosis treatment and management	1367.67	10123.185	Mandate	No mention	Included	Included
Transplantation services for persons with HIV	1374.17	10123.21	Mandate	No mention	Included under inpatient services	Included under inpatient services
AIDS vaccine	1367.45	10145.2	Mandate	Individual and group	Excluded	Excluded
HIV/AIDS, HIV testing	1367.46	10123.91	Mandate	Individual and group	Excluded	Included
Phenylketonuria	1374.56	10123.89	Mandate	No mention	Included as part of maternity services	Included as part of maternity services

Part C. Mental Illness

Description of Benefit	Health & Safety Code Section	California Insurance Code Section	Type of Requirement Mandate or Mandated Offering	Markets Affected	DMHC Individual N/A=mandate doesn't apply	DMHC Small and Large Group N/A=mandate doesn't apply
Coverage for mental and nervous disorders	N/A	10125	Mandated offering	Group	N/A	N/A
Coverage and premiums for persons with physical or mental impairment	1367.8	10122.1	Mandate	Individual and group	Included under mental health services (SMI only with limits)	Included under mental health services (SMI only with limits)
Parity in coverage for severe mental illness	1374.72	10123.15 (10144.5)	Mandate	Group	Included under mental health services (SMI only with limits)	Included under mental health services (SMI only with limits)
Alcoholism treatment	1367.2	10123.6	Mandated offering	Group	N/A	Excluded under chemical dependency services
Alcohol and drug exclusion	N/A	10369.12	Mandate	Group	N/A	Excluded

Part D. Orthotics and Prosthetics

Description of Benefit	Health & Safety Code Section	California Insurance Code Section	Type of Requirement Mandate or Mandated Offering	Markets Affected	DMHC Individual N/A=mandate doesn't apply	DMHC Small and Large Group N/A=mandate doesn't apply
Orthotic and prosthetic devices and services	1367.18	10123.7	Mandated offering	Group	N/A	Excluded
Prosthetic devices for laryngectomy	1367.61	10123.82	Mandate	No mention	Excluded	Included
Special footwear for persons suffering from foot disfigurement	1367.19	10123.141	Mandated offering	No mention	Excluded as orthotic and prosthetic items and devices	Excluded as orthotic and prosthetic items and devices

Part E. Pain Management

Description of Benefit	Health & Safety Code Section	California Insurance Code Section	Type of Requirement Mandate or Mandated Offering	Markets Affected	DMHC Individual N/A=mandate doesn't apply	DMHC Small and Large Group N/A=mandate doesn't apply
Acupuncture	N/A	10127.3	Mandated offering	Group	N/A	Excluded
Pain management medication for terminally ill	1367.215	N/A	Mandate	No mention	Included	Included
General anesthesia for dental procedures	1367.71	10119.9	Mandate	No mention	Excluded	Included

Part F. Pediatric Health

Description of Benefit	Health & Safety Code Section	California Insurance Code Section	Type of Requirement Mandate or Mandated Offering	Markets Affected	DMHC Individual N/A=mandate doesn't apply	DMHC Small and Large Group N/A=mandate doesn't apply
Comprehensive preventive care for children aged 16 years or younger	1367.35	10123.5	Mandate	Group	N/A	Included
Comprehensive preventive care for children aged 17 or 18 years	1367.3	10123.55	Mandated offering	Group	N/A	Included
Asthma management	1367.06	N/A[77]	Mandate	No mention	Included	Included
Screening children for blood lead levels	1367.3(b)(2)(D)	10119.8	Mandate	Individual and group	Included	Included

[77] An N/A in either the Health & Safety Code column or the California Insurance Code column indicates that a mandate does not apply to plans covered under that code.

Part G. Reproductive

Description of Benefit	Health & Safety Code Section	California Insurance Code Section	Type of Requirement Mandate or Mandated Offering	Markets Affected	DMHC Individual N/A=mandate doesn't apply	DMHC Small and Large Group N/A=mandate doesn't apply
Contraceptive devices requiring a prescription	1367.25	10123.196	Mandate	No mention	Excluded	Excluded
Infertility treatments	1374.55	10119.6	Mandated offering	Group	N/A	Excluded
Conditions associated with exposure to diethylstilbestrol	1367.9	10119.7	Mandate	No mention	Excluded	Excluded
Prenatal diagnosis of genetic disorders	1367.7	10123.9	Mandated offering	Group	N/A	Included under maternity services
Expanded alpha-fetoprotein	1367.54	10123.184	Mandate	Individual and group	Included as part of maternity services	Included as part of maternity services
Maternity benefits—minimum length of stay[78]	1367.62	10123.87	Mandate	Individual and group	Included under maternity services	Included under maternity services
Maternity coverage—amount of copayment or deductible for inpatient services	1373.4	N/A	Mandate	No mention	Included (plan prototypes did not vary cost sharing_	Included (plan prototypes did not vary cost sharing)

[78] The federal Newborns' and Mothers' Health Protection Act of 1996 requires coverage for a minimum length of stay following delivery *if* the plan covers maternity service.

Part H. Mandates Related to Surgery

Description of Benefit	Health & Safety Code Section	California Insurance Code Section	Type of Requirement Mandate or Mandated Offering	Markets Affected	DMHC Individual N/A=mandate doesn't apply	DMHC Small and Large Group N/A=mandate doesn't apply
Jawbone or associated bone joints	1367.68	10123.21	Mandate	No mention	Excluded under TMJ and dental disorders	Excluded under TMJ and dental disorders
Reconstructive surgery[79]	1367.63	10123.88	Mandate	Individual and group	Included (federal)	Included (federal)

Part I. Hospice and Home Health Care Benefit Mandates

Description of Benefit	Health & Safety Code Section	California Insurance Code Section	Type of Requirement Mandate or Mandated Offering	Markets Affected	DMHC Individual N/A=mandate doesn't apply	DMHC Small and Large Group N/A=mandate doesn't apply
Hospice care	1368.2	N/A	Mandate	Group	N/A	Included
Home health care	N/A	10123.10	Mandated offering	Group	N/A	N/A

[79] The federal Women's Health and Cancer Rights Act requires coverage for postmastectomy reconstructive surgery so that service would still have to be covered, even if this mandate were to be waived.

Part J. Other Mandates Regarding Terms and Conditions of Coverage

Description of Benefit	Health & Safety Code Section	California Insurance Code Section	Type of Requirement Mandate or Mandated Offering	Markets Affected	DMHC Individual N/A=mandate doesn't apply	DMHC Small and Large Group N/A=mandate doesn't apply
Prescription drugs: coverage of "off-label" use	1367.21	10123.195	Mandate	No mention	Included	Included
Prescription drugs: coverage for previously prescribed drugs	1367.22	N/A	Mandate	No mention	Excluded	Included
Authorization for nonformulary prescription drugs	1367.24	N/A	Mandate	No mention	Excluded	Included
Coverage for persons with blindness or partial blindness	1367.4	N/A	Mandate	Individual and group	Included	Included

Part K. Other Provider Mandates

Description of Benefit	Health & Safety Code Section	California Insurance Code Section	Type of Requirement Mandate or Mandated Offering	Markets Affected	DMHC Individual N/A=mandate doesn't apply	DMHC Small and Large Group N/A=mandate doesn't apply
Medical transportation services—direct reimbursement	1367.11	10126.6	Mandate	No mention	Included under ambulance services	Included under ambulance services
OB-GYNs as primary care providers	1367.69	10123.83	Mandate	No mention	Included	Included
Pharmacists—compensation for services within their scope of practice	1368.5	N/A	Mandate	No mention	Included	Included

Part L. Reproductive

Description of Benefit	Health & Safety Code Section	California Insurance Code Section	Type of Requirement Mandate or Mandated Offering	Markets Affected	CDI Individual N/A=mandate doesn't apply	CDI Group N/A=mandate doesn't apply
Contraceptive devices requiring a prescription	1367.25	10123.196	Mandate	No mention	Excluded	Excluded
Infertility treatments	1374.55	10119.6	Mandated offering	Group	N/A	Excluded
Conditions associated with exposure to diethylstilbestrol	1367.9	10119.7	Mandate	No mention	Excluded	Excluded
Prenatal diagnosis of genetic disorders	1367.7	10123.9	Mandated offering	Group	N/A	Included under maternity services
Expanded alpha—fetoprotein	1367.54	10123.184	Mandate	Individual and group	Excluded	Included as part of maternity services

Part L. Reproductive (con't)

Description of Benefit	Health & Safety Code Section	California Insurance Code Section	Type of Requirement Mandate or Mandated Offering	Markets Affected	CDI Individual N/A=mandate doesn't apply	CDI Group N/A=mandate doesn't apply
Maternity benefits—minimum length of stay[80]	1367.62	10123.87	Mandate	Individual and group	Excluded	Included under maternity services
Maternity coverage—amount of copayment or deductible for inpatient services	1373.4	N/A	Mandate	No mention	N/A	N/A

Part M. Mandates related to Surgery

Description of Benefit	Health & Safety Code Section	California Insurance Code Section	Type of Requirement Mandate or Mandated Offering	Markets Affected	CDI Individual N/A=mandate doesn't apply	CDI Group N/A=mandate doesn't apply
Jawbone or associated bone joints	1367.68	10123.21	Mandate	No mention	Excluded under TMJ and dental disorders	Excluded under TMJ and dental disorders
Reconstructive surgery[81]	1367.63	10123.88	Mandate	Individual and group	Included (federal)	Included (federal)

Part N. Hospice and Home Health Care Benefit Mandates

Description of Benefit	Health & Safety Code Section	California Insurance Code Section	Type of Requirement (Mandate or Mandated Offering)	Markets Affected	CDI Individual N/A=mandate doesn't apply	CDI Small Group N/A=mandate doesn't apply
Hospice care	1368.2	N/A	Mandate	Group	N/A	N/A
Home health care	N/A	10123.10	Mandated offering	Group	N/A	Excluded

[80] The federal Newborns' and Mothers' Health Protection Act of 1996 requires coverage for a minimum length of stay following delivery *if* the plan covers maternity service.

[81] The federal Women's Health and Cancer Rights Act requires coverage for postmastectomy reconstructive surgery so that service would still have to be covered, even if this mandate were to be waived.

Part O. Other Mandates Regarding Terms and Conditions of Coverage

Description of Benefit	Health & Safety Code Section	California Insurance Code Section	Type of Requirement (Mandate or Mandated Offering)	Markets Affected	CDI Individual N/A=mandate doesn't apply	CDI Small Group N/A=mandate doesn't apply
Prescription drugs: coverage of "off-label" use	1367.21	10123.195	Mandate	No mention	Excluded	Excluded
Prescription drugs: coverage for previously prescribed drugs	1367.22	N/A	Mandate	No mention	N/A	N/A
Authorization for nonformulary prescription drugs	1367.24	N/A	Mandate	No mention	N/A	N/A
Coverage for persons with blindness or partial blindness	1367.4	N/A	Mandate	Individual and group	N/A	N/A

Part P. Other Provider Mandates

Description of Benefit	Health & Safety Code Section	California Insurance Code Section	Type of Requirement (Mandate or Mandated Offering)	Markets Affected	CDI Individual N/A=mandate doesn't apply	CDI Small Group N/A=mandate doesn't apply
Medical transportation services—direct reimbursement	1367.11	10126.6	Mandate	No mention	Included under ambulance services	Included under ambulance services
OB-GYNs as primary care providers	1367.69	10123.83	Mandate	No mention	Included	Included
Pharmacists – compensation for services within their scope of practice	1368.5	N/A	Mandate	No mention	N/A	N/A

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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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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, MD, Senior Vice President–Health Sciences and Services.