

California Health Benefits Review Program

Executive Summary Analysis of Assembly Bill 219: Cancer Treatment

A Report to the 2013-2014 California Legislature

April 4, 2013



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Analysis of Assembly Bill 219 Health Care Coverage: Cancer Treatment

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EXECUTIVE SUMMARY

California Health Benefits Review Program Analysis of Assembly Bill 219

The California Assembly Committee on Health requested on February 5, 2013, 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) 219 (Perea) on oral anticancer medications. In response to this request, CHBRP undertook this analysis pursuant to the provisions of the program's authorizing statute.¹

CHBRP estimates that in 2014 approximately 25.9 million Californians (67%) will have health insurance that may be subject to a health benefit mandate law passed at the state level.² Of the rest of the state's population, a portion will be uninsured (and so has no health insurance subject to any benefit mandate), and another portion will have health insurance subject to other state laws or only to federal laws.

Uniquely, California has a bifurcated system of regulation for health insurance subject to state benefit mandates. The California Department of Managed Health Care (DMHC)³ regulates health care service plans, which offer benefit coverage to their enrollees through health plan contracts. The California Department of Insurance (CDI) regulates health insurers,⁴ which offer benefit coverage to their enrollees through health insurance policies.

All DMHC-regulated plans and/or CDI-regulated policies that provide outpatient prescription drug coverage would be subject to AB 219; therefore, the mandate would affect the health insurance of approximately 25.6 million enrollees (66% of all Californians).

Developing Estimates for 2014 and the Effects of the Affordable Care Act

The Affordable Care Act (ACA)⁵ is expected to dramatically affect health insurance and its regulatory environment in California, with many changes becoming effective in 2014. Beginning in 2014, an expansion of the Medicaid program to cover people up to 133% of the federal poverty level (FPL)⁶ and the availability of subsidized and unsubsidized health insurance coverage purchased through newly established state health insurance exchanges are expected to significantly increase the number of people with health insurance in the United States.

¹ Available at: www.chbrp.org/docs/authorizing_statute.pdf.

² CHBRP's estimates are available at: www.chbrp.org/other_publications/index.php.

³ DMHC was established in 2000 to enforce the Knox-Keene Health Care Service Plan of 1975; see Health and Safety Code (H&SC), Section 1340.

⁴ 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 (IC), Section 106(b) or subdivision (a) of Section 10198.6.

⁵ The federal "Patient Protection and Affordable Care Act" (P.L.111-148) and the "Health Care and Education Reconciliation Act" (P.L. 111-152) were enacted in March 2010. Together, these laws are referred to as the Affordable Care Act (ACA).

⁶ The Medicaid expansion, which California will pursue, is to 133% of the federal poverty level (FPL)—138% with a 5% income disregard.

State exchanges will sell health insurance in the small-group and individual markets⁷ through qualified health plans (QHPs), which will be certified by and sold in a state's exchange. QHPs sold through California's state exchange, Covered California,⁸ will be DMHC-regulated plans or CDI-regulated policies, and as such will be subject to California state benefit mandates.

It is important to note that CHBRP's analysis of proposed benefit mandate bills typically address the marginal effects of the proposed bills—specifically, how the proposed mandate would impact benefit coverage, utilization, costs, and public health, holding all other factors constant. CHBRP's estimates of these marginal effects are presented in this report. Because expanded enrollment will not occur until January 2014, CHBRP relies on projections from the California Simulation of Insurance Markets (CalSIM) model⁹ to help set baseline enrollment for 2014. From this projected baseline, CHBRP estimates the marginal impact of proposed benefit mandates that could be in effect after January 2014. CHBRP's methods for estimating baseline 2014 enrollment from CalSIM projections are provided in further detail in Appendix D.

Bill-Specific Analysis of AB 219

The full text of AB 219 can be found in Appendix A.

AB 219 would prohibit DMHC-regulated plans and CDI-regulated policies that provide coverage for “prescribed, orally administered anticancer medications” from charging more than \$100 per filled prescription. This would apply to any DMHC-regulated plan and CDI-regulated policy issued, amended, or renewed on or after January 1, 2014.

AB 219 does not require DMHC-regulated plans and CDI-regulated policies that do not already provide coverage for oral anticancer medications to provide coverage for this benefit.

Analytic Approach and Key Assumptions

This analysis relies on a number of assumptions:

- **Definition of oral anticancer medications:** Because the bill specifies “prescribed, orally administered anticancer medications,” CHBRP assumes it would only affect cost sharing for drugs specific to the treatment of cancer. This analysis therefore assumes that AB 219 would not affect cost sharing for other medications, such as antipain or anti-nausea drugs, that a cancer patient might use during the course of chemotherapy.
- **Coverage of oral anticancer drugs:** Chemotherapy can be covered under the medical benefit—which provides coverage of hospital and physician/provider services—or

⁷ Effective 2017, states may allow large-group purchasing through the exchange, which may make some large-group plans and policies subject to essential health benefits requirements [ACA Section 1312(f)(2)(B)].

⁸ The California Health Benefits Exchange Authorizing Statute is available here: <http://www.healthexchange.ca.gov/Documents/California%20Codes%20Governing%20the%20Health%20Benefit%20Exchange.pdf>.

⁹ CalSIM was developed jointly and is operated by the University of California, Los Angeles, Center for Health Policy Research and the University of California, Berkeley, Center for Labor Research. The model estimates the impact of provisions in the ACA on employer decisions to offer, and individual decisions to obtain, health insurance.

outpatient prescription drug pharmacy benefit of a DMHC-regulated plan or CDI-regulated policy. Because the bill explicitly names “prescribed, orally administered” medications, CHBRP assumes that the bill applies to the outpatient pharmacy benefit portion of the plan or policy.

- **No expansions of coverage:** AB 219 would not require DMHC-regulated plans and CDI-regulated policies that do not already provide coverage for prescription drugs on an outpatient basis to begin covering them, nor would it require DMHC-regulated plans and CDI-regulated policies that cover only generic prescription drugs on an outpatient basis to begin covering nongeneric (brand) drugs.

CHBRP is aware of 21 states¹⁰ and the District of Columbia that have passed legislation to limit cost sharing for oral anticancer medications and/or achieve parity between oral and intravenously injected anticancer medications. In 2013, eight states, including California, have introduced legislation to limit cost sharing for oral anticancer medications.¹¹

Background on Disease or Condition

Nearly one in two Californians born today will develop cancer at some point in his or her lifetime (CCR, 2011). In California, there are an estimated 145,000 cases of cancer diagnosed each year, whereas approximately 1.3 million Californians alive today have a history with the disease (CCR, 2011). It is estimated that 45% of cancer cases occur in the nonelderly population (those younger than 65 years of age)—i.e., the population being impacted by AB 219 (CCR, 2011). In California, cancer is the second leading cause of death, accounting for 24% of all deaths, or approximately 55,000 deaths each year (CCR, 2011). Early diagnoses, through population-based screening, as well as advances in cancer treatment, have greatly improved survival rates of cancer patients (NCI, 2013). In California, the relative 5-year survival rate from all cancers is 63% (CCR, 2011).

The treatment options for cancer depend on the type of cancer, as well as the stage of diagnosis, and include surgical removal, radiation treatment, and medications, including chemotherapy (which may include oral anticancer medications). Medications used for patients undergoing cancer treatment include those specific to the treatment of cancer as well as medications that are used to alleviate pain or reduce the side effects of chemotherapy. Because the bill specifies “prescribed, orally administered anticancer medications,” CHBRP assumes it would only affect drugs specific to the treatment of cancer and not affect other medications, such as antipain or antinausea medications, that a cancer patient might use during the course of chemotherapy.

¹⁰ States with parity for oral anticancer medications include CO, CT, DE, HI, IA, IL, IN, KS, LA, MA, MD, MN, NE, NJ, NM, NY, OR, TX, VA, VT, and WA. Of those states, four states’ laws have passed language similar to what is proposed in AB 219. Those states, Illinois (2011), Maryland (2012), Minnesota (2012), and Virginia (2012), passed legislation to limit cost sharing on oral anticancer medications, but the language did not expand benefit coverage to include oral anticancer medications if health insurance did not already cover it. CHBRP evaluated enrolled or enacted bill language from each state’s legislative website.

¹¹ States that have introduced legislation to limit cost sharing for oral anticancer medications include CA, FL, ME, MO, OK, RI, PA, and UT. Of these states, three—Utah, Missouri, and Pennsylvania—have introduced legislation to limit cost sharing on oral anticancer medications, but do not expand benefit coverage. CHBRP evaluated introduced bill language from each state’s legislative website.

Traditionally, anticancer medications were delivered either through intravenous (IV) fluid or through injection in a physician's office or hospital. Oral anticancer medications have also been used in cancer treatment as an adjunct to IV therapy, or as an alternative to IV therapy. Over the past decade, oral anticancer medications have been prescribed more frequently for cancer treatment, which may be due in part to the approval of new oral anticancer medications by the U.S. Food and Drug Administration (FDA) (DeMario and Ratain, 1998; O'Neill and Twelves, 2002). An estimated 25% of anticancer agents currently in development are planned to be administered orally (Weingart et al., 2008). Studies estimate that a majority of patients (up to 89%) prefer oral anticancer medications to traditional IV fluid or injection therapies (Verbrugghe et al., 2013). Many of the most prevalent cancers in California, including breast and colorectal cancer, may be treated with regimens that include oral anticancer medications (CCR, 2011).

Medical Effectiveness

AB 219 would apply to such a large number of oral anticancer medications for such a wide range of cancers that a systematic review of the literature on the effectiveness of all of them was not feasible during the 60 days within which CHBRP must complete its reports. Instead, CHBRP summarized general, descriptive information about these medications.

- All oral anticancer medications must be approved by the U.S. Food and Drug Administration (FDA) before they can be marketed or sold in the United States.
- To date, the FDA has approved 54 oral anticancer medications that are used to treat more than 50 different types of cancer.
- The number of oral anticancer medications has grown by 108% over the past decade. The FDA approved 28 new oral anticancer medications between 2003 and early 2013.
- Approximately 100 oral anticancer medications are currently under development.
- Only 9 of the 54 oral anticancer medications approved by the FDA have intravenous or injected equivalents (either intravenous/injected versions of the same drug or therapeutic equivalents).¹²
- Only 11 of the 54 brand-name oral anticancer medications approved by the FDA have generic equivalents.
- Oral anticancer medications are used alone or in combination with other oral, intravenously administered, or injected anticancer medications, depending on the cancer they are being used to treat and the stage at which the cancer is diagnosed.
- The roles of oral anticancer medications in cancer treatment vary and include:
 - Presurgical treatment
 - Postsurgical treatment
 - Concurrent treatment with radiation
 - First-line treatment to kill or retard the growth of cancer cells

¹² Personal communication, Betty Chan, PharmD, March 6, 2013.

- Second-line treatment of cancers that do not respond to first-line treatments
- Treatment of early stage cancers
- Treatment of advanced or metastatic cancers
- Treatment of recurrent cancers
- Treatment of cancers that cannot be surgically removed
- Prevention of cancer recurrence in persons treated for early stage disease
- The outcome of cancer treatment varies with the stage at which cancer is diagnosed and the type of cancer.
 - For some types of early-stage cancers, use of oral anticancer agents and other treatments may enable a person to live cancer-free for many years.
 - For advanced and metastatic cancers, treatment often cannot reverse the disease and may only prolong life for a few months.
- When compared to intravenous and injectable anticancer medications, oral anticancer medications have both advantages and disadvantages. Advantages are that oral anticancer medications may allow administration of the medication on a daily basis, may be more convenient for patients, and may reduce the risk of infection or other complications. Disadvantages include less certainty in patient adherence to treatment regimens and a reduction in interaction between patients and their health care providers to manage complications of treatment. There may also be higher risks of drug-food and drug-drug interactions relative to intravenous and injectable anticancer medications.
- The preponderance of evidence from studies of the effects of cost sharing on use of anticancer medications suggests that cost sharing has at most a small effect on use of specialty oral anticancer medications. Cost sharing has a larger effect on adherence and persistence with aromatase inhibitors for breast cancer, perhaps because these medications are used primarily to prevent recurrence of cancer and are taken over long periods of time regardless of whether patients have symptoms.

Benefit Coverage, Utilization, and Cost Impacts

To perform the analysis, CHBRP measured current cost sharing (as a percentage of the cost of the medication) for oral anticancer medications. CHBRP modeled compliance with the mandate as resulting in the prohibition of charging more than \$100 per filled prescription being applied to oral anticancer medications.

Table 1 summarizes the estimated utilization, cost, and benefit coverage impacts of AB 219.

Benefit coverage impacts

- Although AB 219 would not be expected to expand benefit coverage, CHBRP estimates that almost all enrollees with health insurance subject to the mandate have at least some coverage for anticancer medications.
- AB 219 would affect the health insurance of the 25.6 million enrollees with health insurance whose insurance provides an outpatient prescription drug benefit, out of the 25.9 million enrollees in DMHC-regulated plans and CDI-regulated policies subject to state mandates.
 - Outpatient prescription drug benefits cover oral anticancer medications, though coverage of specific anticancer medications may vary by health plan or insurer.

Utilization impacts

- CHBRP estimates that 0.54% of enrollees with privately purchased health insurance subject to the mandate would use oral anticancer medications during the year following implementation.
- CHBRP does not estimate a measurable increase in the number of enrollees who will require oral anticancer medications nor a measurable increase in the number of prescriptions per enrollee because:
 - The bill does not extend benefit coverage for oral anticancer medications to enrollees currently without coverage. It only affects cost sharing for those enrollees who already have benefit coverage for anticancer medications.
 - The price elasticity of demand¹³—the degree to which utilization will change when the price changes—for anticancer medications is relatively small in comparison to the price elasticity for many other medications. Cancer is a life-threatening illness; consequently, patients will generally comply with prescribed treatment regimens.
 - Few oral anticancer medications have injected or intravenously administered substitutes, and clinical indications may differ between administration forms. A limited number of enrollees have a type and stage of cancer that would allow substitution of an oral anticancer medication for an intravenous or injected anticancer medication. Some portion of these may opt for intravenous or injected medications premandate due to cost considerations. This dynamic cannot be quantified due to the complex clinical factors that are involved when considering potential substitutions.

¹³ Price elasticity of demand shows how the quantity demanded or supplied will change when the price changes. Price elasticity tends to be smaller when a good/service is a necessity.

Cost impacts

- AB 219 would shift some oral anticancer medication costs from enrollees to health plans and insurers through reduced cost sharing. In total, enrollees would see a reduction in out-of-pocket costs of an estimated \$2,539,000 due to lesser cost-sharing requirements.
 - On average, the amount of the annual shift is estimated to be \$25.63 per enrollee requiring anticancer medications.
 - Postmandate amounts shifted from users to plans and insurers would range from \$0 to \$58,744 annually for enrollees requiring anticancer medications. The wide variation is related to the price of particular oral anticancer medications, the utilization of a particular enrollee, and the cost-sharing provisions of any one enrollee's contract or policy.
- Total net annual expenditures are estimated to increase by \$454,000, or 0.0003%, mainly due to the administrative costs associated with the implementation of AB 219.
- The mandate is estimated to increase premiums by about \$2,993,000 (0.0023%). The distribution of the impact on premiums is as follows:
 - Total premiums for private employers are estimated to increase by \$1,969,000, or 0.0025%.
 - Enrollee contributions toward premiums for group insurance are estimated to increase by \$519,000, or 0.0024%.
 - Total premiums for those with individually purchased insurance are estimated to increase by \$505,000, or 0.0037%.
- Increases in insurance premiums vary by privately purchased market segment, ranging from approximately 0.0025% (DMHC-regulated large-group plans) to 0.0047% (CDI-regulated individual policies). Increases as measured by per member per month (PMPM) payments are estimated to be approximately \$0.01 for both DMHC-regulated large-group plans and CDI-regulated small-group policies.
- AB 219 would apply to Medi-Cal Managed Care. However, the California Department of Health Care Services (DHCS), which administers Medi-Cal, would not be expected to face measurable expenditure or premium increases as these plans currently cover oral anticancer medication benefits with minimal or no cost-sharing requirements.
- The estimated premium increases would not have a measurable impact on number of persons who are uninsured.

Public Health Impacts

- CHBRP does not project a measurable increase in utilization of oral anticancer medications as a result of AB 219. Therefore, the only potential public health impact resulting from AB 219 would be a reduction in out-of-pocket costs for oral anticancer medications. This could reduce the financial burden and related health consequences faced by cancer patients.

- Breast cancer is the most prevalent cancer in California, almost exclusively affecting women. Approximately 53.2% of oral anticancer medication prescriptions are for three drugs used to treat breast cancer, corresponding to 2.8% of the total cost for all oral nongeneric anticancer medications. Therefore, to the extent that AB 219 reduces out-of-pocket costs for patients, there is a potential to reduce the financial burden faced by women undergoing treatment for breast cancer.
- After breast cancer, the next three most common cancers in California are colorectal, prostate, and lung cancer. Non-Hispanic blacks in California have higher rates of diagnoses of all three of these cancers compared to all other racial and ethnic groups. These three cancers may all be treated using oral anticancer medications; therefore, to the extent that AB 219 reduces out-of-pocket costs for oral anticancer medications, non-Hispanic black cancer patients could experience a greater reduction in financial burden compared to other ethnic and racial groups.
- There is no projected measurable change in utilization resulting from AB 219. Therefore, there is no expected reduction in premature death or economic loss as a result of passage of this mandate.

Interaction With the Federal Affordable Care Act

A number of ACA provisions have the potential to or do interact with state benefit mandates. Below is an analysis of how this proposed benefit mandate may interact with requirements in the ACA, including the requirement for certain health insurance to cover “essential health benefits” (EHBs).¹⁴

Essential health benefits

Effective 2014, the ACA requires nongrandfathered small-group and individual market health insurance—including but not limited to QHPs that will be sold in Covered California—to cover 10 specified categories of EHBs.¹⁵ The U.S. Department of Health and Human Services (HHS) has allowed each state to define its own EHBs for 2014 and 2015 by selecting one of a set of specified benchmark plan options.¹⁶ California has selected the Kaiser Foundation Health Plan Small Group Health Maintenance Organization (HMO) 30 plan as its benchmark plan.¹⁷

¹⁴ Resources on EHBs and other ACA impacts are available on the CHBRP website: www.chbrp.org/other_publications/index.php.

¹⁵ The 10 specified categories of essential health benefits (EHBs) are ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. [ACA Section 1302(b)].

¹⁶ CCIIO, Essential Health Benefits Bulletin. Available at: http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf. Accessed December 16, 2011.

¹⁷ Health and Safety Code, Section 1367.005; Insurance Code, Section 10112.27.

The ACA allows a state to “require that a qualified health plan offered in [an exchange] offer benefits in addition to the essential health benefits.”¹⁸ If the state does so, the state must make payments to defray the cost of those additionally mandated benefits, either by paying the purchaser directly or by paying the QHP.

AB 219 and essential health benefits

Changes to cost sharing required by AB 219 do not fall under the ACA’s—and subsequent regulations’—definition of “state-required benefits.”¹⁹ In other words, the state would not be required to defray costs incurred as a result of AB 219 because the mandate would not be considered a benefit expansion that exceeds EHBs.

As previously noted, AB 219 does not mandate additional benefit coverage for oral anticancer medications; it limits cost sharing for oral anticancer medications. Therefore, to the extent that these DMHC-regulated plans’ and CDI-regulated policies’ outpatient pharmacy benefits provide benefit coverage for oral anticancer medications on their formulary, AB 219 would then require them to limit cost-sharing to \$100 per prescription.

The ACA and California’s EHBs, as defined by the Kaiser HMO 30 plan, require coverage for outpatient prescription drugs. Therefore, QHPs offered through Covered California, as well as nongrandfathered small group and individual market plans and policies, will also cover prescription drugs.

¹⁸ ACA Section 1311(d)(3).

¹⁹ The federal Department of Health and Human Services’ proposed rule on essential health benefits, which was made final in February 2013, specified that “... state rules related to ... cost-sharing ... would not fall under our interpretation of state-required benefits. Even though plans must comply with those state requirements, there would be no federal obligation for states to defray the costs associated with those requirements,” Department of Health and Human Services. Patient Protection and Affordable Care Act: Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation. Final Rule. Available at: www.ofr.gov/OFRUpload/OFRData/2013-04084_PL.pdf. Accessed on: February 20, 2013.

Table 1. AB 219 Impacts on Benefit Coverage, Utilization, and Cost, 2014

	Before Mandate	After Mandate	Increase/ Decrease	Change After Mandate
Benefit coverage				
Total enrollees with health insurance subject to state-level benefit mandates(a)	25,899,000	25,899,000	0	0.000%
Total enrollees with health insurance subject to AB 219	25,621,000	25,621,000	0	0.000%
Percentage of individuals with coverage for generic and nongeneric oral anticancer medications	100.0%	100.0%	0.0%	0.000%
Number of individuals with coverage for generic and nongeneric oral anticancer medications	25,621,000	25,621,000	0	0.000%
Utilization and cost				
Annual number of scripts per 1,000 members who have outpatient prescription drug coverage for generic and nongeneric oral anticancer medications	27.4	27.4	0.0	0.000%
Average cost per script, paid by health plans and individuals for generic and nongeneric oral anticancer medications	\$855.52	\$855.52	\$0.00	0.000%
Total annual cost of generic and nongeneric oral anticancer medications				
Costs paid by health plans	\$589,884,000	\$592,423,000	\$2,539,000	0.430%
Costs paid by individuals	\$16,115,000	\$13,576,000	-\$2,539,000	-15.761%
Costs paid by health plans and individuals	\$605,999,000	\$605,999,000	\$0	0.000%
Expenditures				
Premium expenditures by private employers for group insurance	\$78,385,161,000	\$78,387,130,000	\$1,969,000	0.0025%
Premium expenditures for individually purchased insurance	\$13,639,719,000	\$13,640,224,000	\$505,000	0.0037%
Premium expenditures by persons with group insurance, CalPERS HMOs, Covered California, and Medi-Cal Managed Care (b)	\$21,272,946,000	\$21,273,465,000	\$519,000	0.0024%
CalPERS HMO employer expenditures (c)	\$4,016,233,000	\$4,016,233,000	\$0	0.0000%
Medi-Cal Managed Care Plan expenditures	\$12,480,492,000	\$12,480,492,000	\$0	0.0000%
Healthy Families Plan expenditures (d)	\$667,300,000	\$667,300,000	\$0	0.0000%
Enrollee out-of-pocket expenses for covered benefits (deductibles, copayments, etc.)	\$14,462,198,000	\$14,459,659,000	-\$2,539,000	-0.0176%
Enrollee expenses for noncovered benefits (e)	\$6,500,000	\$6,500,000	\$0	0%
Total expenditures	\$144,930,549,000	\$144,931,003,000	\$454,000	0.0003%

Source: California Health Benefits Review Program, 2013.

(a) This population includes persons with privately funded and publicly funded (e.g., CalPERS HMOs, Medi-Cal Managed care Plans) health insurance products regulated by DMHC or CDI. Population includes enrollees aged 0 to 64 years and enrollees 65 years or older covered by employment-sponsored insurance.

(b) Premium expenditures by enrollees include employee contributions to employer-sponsored health insurance, health insurance purchased through Covered California, and enrollee contributions for Medi-Cal Managed Care.

(c) Of the increase in CalPERS employer expenditures, about 58% or \$0 would be state expenditures for CalPERS members who are state employees, state retirees, or their dependents. This percentage reflects the share of enrollees in CalPERS HMOs as of September 30, 2012. CHBRP assumes the same ratio in 2014.

(d) Children in Healthy Families, California's Children's Health Insurance Program, will be moved into Medi-Cal Managed Care by January 1, 2014, as part of the 2012–2013 budget.

(e) Includes only those expenses that are paid directly by enrollees to providers for services related to the mandated benefit that are not currently covered by insurance. In addition, this only includes those expenses that will be newly covered, postmandate. Other components of expenditures in this table include all health care services covered by insurance.

ACKNOWLEDGMENTS

This report provides an analysis of the medical, financial, and public health impacts of Assembly Bill 219. In response to a request from the California Assembly Committee on Health on February 5, 2013, the California Health Benefits Review Program (CHBRP) undertook this analysis pursuant to the program's authorizing statute.

Edward Yelin, PhD, Janet Coffman, MPP, PhD, and Gina Evans-Young all of the University of California, San Francisco, prepared the medical effectiveness analysis. Bruce Abbott, MLS, of the University of California, Davis, conducted the literature search. Joy Melnikow, MD, MPH, Stephen McCurdy, MD, MPH, and Meghan Soulsby, MPH, all of the University of California, Davis, prepared the public health impact analysis. Byung-Kwang Yoo, MD, MS, PhD, of the University of California, Davis, prepared the cost impact analysis. Susan Pantely, FSA, MAAA, and Chankyu Lee of Milliman provided actuarial analysis. Content expert Betty Chan, PharmD, BCOP, of the University of Southern California provided technical assistance with the literature review and expert input on the analytic approach. Hanh Quach of CHBRP staff prepared the *Introduction* and synthesized the individual sections into a single report. A subcommittee of CHBRP's National Advisory Council (see final pages of this report) reviewed the analysis for its accuracy, completeness, clarity, and responsiveness to the Legislature's request.

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

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California Health Benefits Review Program Committees and Staff

A group of faculty and staff undertakes most of the analysis that informs reports by the California Health Benefits Review Program (CHBRP). The CHBRP **Faculty Task Force** comprises rotating representatives from six University of California (UC) campuses. 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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