

California Health Benefits Review Program

Executive Summary

Analysis of Assembly Bill 2418:
Prescription Drug Refills

A Report to the 2013-2014 California Legislature

April 25, 2014



KEY FINDINGS

Analysis of California Assembly Bill (AB) 2418: Health Care Coverage: Prescription Drug Refills

SUMMARY TO THE 2013-14 CALIFORNIA LEGISLATURE • APRIL 25, 2014



AT A GLANCE

AB 2418 (as introduced on February 21, 2014) would require state-regulated health plans and insurers that provide prescription drug benefits to comply with three provisions: (1) plans and insurers that impose a mandatory-mail-order requirement for refills would have to implement and maintain an AB 2418–compliant opt-out process; (2) coverage denials for synchronizing refills would be prohibited; and (3) coverage denials for topical ophthalmic products at or after 70% of the prescription’s expected days of use would be prohibited.

- **Enrollees.** CHBRP estimates that in 2015, 23.4 million Californians will be enrolled in state-regulated health insurance and that 23.1 million of these enrollees will have coverage for outpatient prescription drugs and so could be affected by AB 2418. These figures include some Medi-Cal beneficiaries and some enrollees associated with CalPERS.
- **Impact on expenditures.** Total expenditures are estimated to increase by \$3.3 million (0.003%), due to AB 2418.
- **EHBs.** AB 2418 affects terms of benefit coverage and would not exceed California’s definition of essential health benefits (EHBs).
- **Medical effectiveness.** CHBRP evaluated the literature relating to the effect on adherence of AB 2418’s three provisions (mandatory mail opt-out requirement, synchronization denial prohibition, and early topical ophthalmic product refill denial prohibition). CHBRP found *insufficient evidence* to determine the effect these provisions may have on adherence. Please note that the absence of evidence is not evidence of no effect.
- **Benefit coverage.** Postmandate, CHBRP estimates the following changes: 1.07 million enrollees (who had mandatory mail order requirements) would gain an AB 2418–compliant opt-out process for mandatory mail order; 10.28 million enrollees would gain coverage for synchronization refills; 10.43 enrollees (who had coverage for topical ophthalmic product refills at 75-85%) would have coverage for topical ophthalmic product refills at 70% of expected days of use.
- **Utilization.** Postmandate, CHBRP estimates the following changes: retail pharmacy refills would increase by 0.26% (with a commensurate decrease in mandatory mail refills due to switching from mail to retail refills); topical ophthalmic product refills would increase by 0.12%.
- **Public health.** Although AB 2418 would result in a limited increase in filled prescriptions, CHBRP found *insufficient evidence* to estimate any impact on adherence, so AB 2418’s impact on the public’s health is unknown.

BILL SUMMARY

AB 2418 would institute three provisions: one requirement and two prohibitions on DMHC-regulated plans and CDI-regulated insurers — including those enrolling Medi-Cal beneficiaries and enrollees associated with CalPERS, as described below.

Provision 1: AB 2418 would require plans and insurers that both (1) provide a prescription drug benefit and (2) impose a mandatory-mail-order restriction for all or some covered prescription drugs to establish and maintain an AB 2418–compliant opt-out process for mail-order restriction.

Plans and insurers would not be required to initiate the opt-out option process for (1) drugs not available at an in-network retail pharmacy due to manufacturer’s instructions or restriction (2) drugs subject to risk evaluation or management, or strategies approved by the FDA.

Provision 2: AB 2418 would prohibit plans and insurers that provide prescription drug benefits from denying coverage for the refill of an otherwise covered drug when the refill is ordered for the purpose of placing medications on the same schedule for refill.

Provision 3: AB 2418 would prohibit plans and insurers that provide prescription drug benefits from denying coverage for the refill of covered prescription topical ophthalmic products at or after 70% of the predicted days of use.

CHBRP KEY FINDINGS: INCREMENTAL IMPACT OF AB 2418

CHBRP is aware that many factors may influence implementation and details of the terms of benefit coverage addressed by AB 2418. In this report, the *Medical Effectiveness* section focuses on medication adherence and the *Benefits Coverage, Utilization, and Cost Impacts* section focuses on cost.

Medical Effectiveness

Prescription drugs are used to treat a wide variety of diseases and conditions. CHBRP did not examine the effectiveness of prescription drugs in treating the many conditions for which they are prescribed. For the purposes of this review, CHBRP assumed Food and Drug Administration (FDA)-approved drugs are effective when used as directed.

Topical ophthalmic products are also used to treat a variety of illnesses, including glaucoma, uveitis allergic conjunctivitis, and chronic dry eye disease. Topical ophthalmic products may prevent vision loss (including blindness) and may prevent pain, inflammation, and other symptoms. For the purposes of this review, CHBRP assumed that FDA-approved topical ophthalmic products are effective when used as directed.

For all three terms of benefit coverage AB 2418 would affect, CHBRP assessed the quality of the evidence as *insufficient* to determine an effect on adherence. The lack of evidence is not evidence of no effect.

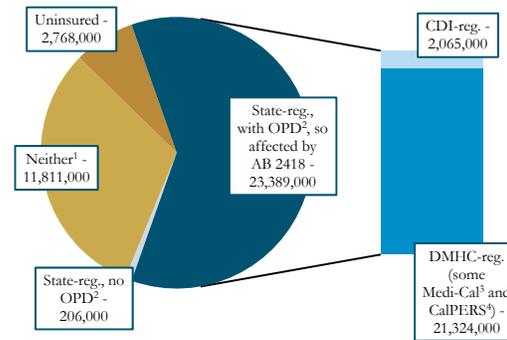
Public Health

Although some additional prescriptions would be filled, because there is insufficient evidence to determine the impact of AB 2418's provisions on adherence, the public health impact is unknown.

Benefit Coverage, Utilization and Cost

As illustrated in Table 1, of the 23.4 million enrollees in DMHC-regulated plans and CDI-regulated policies subject to state mandates, 23.1 million enrollees have an outpatient drug benefit that could be affected by AB 2418. These figures include some Medi-Cal beneficiaries and some enrollees associated with CalPERS.

Figure 1. AB 2418 and California Health Insurance – by Number of Persons/Enrollees



Source: California Health Benefits Review Program, 2014

Notes: 1. Neither = Federally regulated health insurance, such as Medicare, veterans, or self-insured plans. 2. Outpatient Prescription Drug benefit. 3. Many, but not all, Medi-Cal beneficiaries are enrolled in DMHC-regulated plans. 4. Some, but not all, enrollees affiliated with the California Public Employees Retirement System are in DMHC-regulated plans.

Benefit coverage impacts: Estimates of baseline and postmandate benefit coverage figures follow:

- At baseline, 1.07 million enrollees have benefit coverage that includes a mandatory-mail-order refill requirement. Opt-out processes that are not compliant with AB 2418 are in place for these enrollees. Postmandate, all of these enrollees would have an AB 2418-compliant opt-out process.
- At baseline, 10.28 million enrollees could have a refill coverage denial when synchronizing prescriptions. Postmandate, no enrollees could see such a denial.
- At baseline, 10.43 million enrollees could have a topical ophthalmic product refill coverage denial when the predicted use period is at or at or after 75% to 85%. Postmandate, no enrollee could see a denial at or after 70% of predicted use.

Utilization impacts: Postmandate, CHBRP estimates the following changes: retail pharmacy refills would increase by 0.26% (with a commensurate decrease in mandatory-mail-order refills) and topical ophthalmic product refills would increase by 0.12%.

Cost impacts: Postmandate, CHBRP projects an increase of \$3.3 million (0.003%) in terms of total expenditures (premiums and enrollee expenses) as a result of AB 2418.

A Report to the 2013–2014 California State Legislature

**Analysis of Assembly Bill 2418
Prescription Drug Refills**

April 25, 2014

**California Health Benefits Review Program
1111 Franklin Street, 11th Floor
Oakland, CA 94607
Tel: 510-287-3876
Fax: 510-763-4253
www.chbrp.org**

Additional free copies of this and other CHBRP bill analyses and publications may be obtained by visiting the CHBRP website at www.chbrp.org.

EXECUTIVE SUMMARY

California Health Benefits Review Program Analysis of Assembly Bill 2418

The California Assembly Committee on Health requested on February 25, 2014, 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) 2418, Prescription Drug Refills. In response to this request, CHBRP undertook this analysis pursuant to the provisions of the program's authorizing statute,¹ which allows for the review of benefit mandates affecting health insurance regulated by the state.

State benefit mandates apply to a subset of health insurance in California, those regulated by one of California's two health insurance regulators:² the California Department of Managed Health Care (DMHC)³ and the California Department of Insurance (CDI).⁴ In 2015, CHBRP estimates that approximately 23.4 million Californians (60%) will have health insurance that may be subject to any state health benefit mandate law.⁵ Of the rest of the state's population, a portion will be uninsured (and therefore will have 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.

The mandate would affect the health insurance of approximately 23.4 million enrollees (60% of all Californians). Specifically, DMHC-regulated plans and/or CDI-regulated policies, would be subject to AB 2418.

Developing Estimates for 2015 and the Effects of the Affordable Care Act

The Affordable Care Act (ACA)⁶ is substantially affecting health insurance and its regulatory environment in California. It is important to note that CHBRP's analysis of proposed benefit mandate bills typically address the incremental 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 incremental effects are presented in this report. In order to accommodate continuing changes in health insurance enrollment, CHBRP is relying on projections from the California Simulation of Insurance Markets (CalSIM)

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

² California has a bifurcated system of regulation for health insurance. The Department of Managed Health Care (DMHC) 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, which offer benefit coverage to their enrollees through health insurance policies.

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

⁶ 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).

model⁷ to help estimate baseline enrollment for 2015. From this projected baseline, CHBRP estimates the incremental impact of proposed benefit mandates that could be in effect after January 2015.

Bill-Specific Analysis of AB 2418

AB 2418 would institute three provisions: one requirement and two prohibitions on DMHC-regulated plans and CDI-regulated insurers, as described below.

Provision 1 (requirement): AB 2418 would require plans and insurers that both (1) provide a prescription drug benefit and (2) impose a mandatory-mail-order restriction for all or some covered prescription drugs, to establish and maintain an opt-out process for mail-order restrictions.

An AB 2418-compliant opt-out process:

- Would not impose conditions, including but not limited to requiring prescriber approval or submission of documentation by the enrollee or prescriber.
- Would allow the enrollee to opt out or revoke an opt-out at any time.
- Would make the enrollee's choice to opt out (or not) valid throughout the enrollee's enrollment.
- Would provide enrollees with written notice of the mandatory-mail-order restriction for each drug subject to the restriction. The written notices:
 - Would be provided within 30 days prior to the restriction for a particular drug taking effect.
 - Would be in addition to any evidence of coverage (EOC) or evidence of benefits document.
 - Would inform the enrollee of the right to opt out of the restriction and how to do so.
 - Would include carrier contact information for use by the enrollee initiating the opt-out, and would include toll-free numbers if the carrier suggests phone or fax communication.
- Plans and insurers would not be required to initiate the opt-out process for:
 - Drugs not available at an in-network retail pharmacy due to manufacturer's instructions or restrictions.
 - Drugs subject to risk evaluation or management, or strategies approved by the federal Food and Drug Administration (FDA).

⁷ 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.

Provision 2 (prohibition): AB 2418 would prohibit plans and insurers that provide prescription drug benefits from denying coverage for the refill of an otherwise covered drug when the refill is ordered for the purpose of placing drugs on the same refill schedule.

Provision 3 (prohibition): AB 2418 would prohibit plans and insurers that provide prescription drug benefits from denying coverage for the refill of covered prescription topical ophthalmic products after 70% of the predicted days of use.

CHBRP is aware of laws in other states that are similar (or relevant) to the requirements AB 2418 proposes.

- Laws prohibiting or restricting mandatory-mail-order requirements for outpatient prescription drug benefits are present in 37 other states.
- A law requiring coverage of refills for synchronization is present in one other state.
- Laws requiring coverage of early refills for topical ophthalmic products are present in four other states.

In addition, CHBRP is aware regulations and directives make similar provisions effective for Medicare beneficiaries.

Analytic Approach and Key Assumptions

The bill refers to placing “all of the enrollee’s medications on the same schedule for refill.” Because the length of intended use may vary by prescription, CHBRP has assumed that AB 2418 would affect the efforts of enrollees to synchronize scheduled refills for “some or all” drugs (not just efforts to synchronize “all”). The bill refers to “products at 70 percent of the predicted days of use.” Because refills might be requested “at and after” 70% of use, CHBRP has assumed that AB 2418 would affect the efforts of enrollees seeking refills at and after 70% of predicted use (not just “at” 70%).

CHBRP is aware that many factors may influence implementation and details of the terms of benefit coverage addressed by AB 2418. In this report, the *Medical Effectiveness* section focuses on medication adherence and the *Benefits Coverage, Utilization, and Cost Impacts* section focuses on cost.

Background on Disease or Condition

Prescription drugs are a part of standard treatment regimens for many diseases and conditions. In the analysis of the medical effectiveness related to the three provisions of AB 2418, CHBRP did not examine the effectiveness of prescription drugs in treating the many conditions for which they are prescribed. For the purposes of this review, therefore, CHBRP makes the assumption that FDA-approved drugs are effective for treatment of the conditions for which they have been approved when taken as prescribed.

Similarly, the report does not attempt to provide background information on all of the diseases or conditions that may be treated with prescription drugs. CHBRP would note, however, that topical ophthalmic products can be prescribed for a number of serious and prevalent conditions,

including glaucoma, uveitis, allergic conjunctivitis, and chronic dry eye disease. In the presence of such conditions, drugs, including topical ophthalmic products, are used to prevent vision loss (including blindness), as well as pain, inflammation, and other symptoms.

Medical Effectiveness

CHBRP evaluated the literature relevant to the particular terms and conditions of insurance and health plans that would be affected by this bill: establishing a process for enrollees to opt out of mandatory mail order, synchronizing prescription drugs to the same schedules, and refilling topical ophthalmic products at or after 70% days of expected use.

- For the mail order opt-out provision, CHBRP did not identify any studies comparing mandatory mail order with opt-out to mandatory mail order without opt-out. One study that examined the effects of mandatory mail order, in comparison to optional mail order, found that mandatory mail order was associated with lower medication adherence. Because of the limited number of studies on this topic, CHBRP assessed the quality of the evidence as *insufficient* to make a determination on effectiveness.
- For the refill synchronization provision, CHBRP identified two relevant studies, but only one provided evidence for or against refill synchronization specifically. That study found that medication adherence was improved for patients with all drug refills synchronized in comparison to patients with no refill synchronization. Again, because of the limited literature on this topic, CHBRP found the quality of the evidence to be *insufficient* to make a determination on effectiveness.
- For the topical ophthalmic products refill provision, CHBRP did not identify any studies or practice guidelines that examined either refill or brief lapses in treatment of these drugs. The lack of studies in this area again led to a determination of *insufficient* evidence.

Benefit Coverage, Utilization, and Cost Impacts

Coverage impact

- Postmandate there would be no changes in benefit coverage. However, as noted in Table 1, there would be changes in the terms of benefit coverage for prescription drugs as follows:
 - 1.1 million enrollees who currently have mandatory-mail-order requirements for some prescription drugs (usually for maintenance drugs) would have an AB 2418–compliant opt-out process.
 - 10.28 million enrollees would have coverage for refills ordered for the purpose of placing drugs on a synchronized refill schedule.
 - 10.43 million enrollees would have coverage for topical ophthalmic product refills at or after 70% of the predicted days of use, which is earlier than the premandate average of at or after 75% to 85% of the predicted days of use.

Utilization impact

- Although utilization would not increase due to implementation of the AB 2418–compliant opt-out process, there would be some switches from existing mandatory-mail-order refills to retail pharmacy refills. CHBRP estimates the switch rates would be at 23.3% postmandate.
- CHBRP cannot estimate the impact on utilization due to synchronizing refills. However, CHBRP anticipates that there would be minimal impact.
- CHBRP estimates that in one year, 0.1 more prescriptions per 1,000 covered enrollees would be refilled for topical ophthalmic products.

Cost impact

- Total net expenditures are estimated to increase by \$3.3 million or 0.003% for the year following implementation of the mandate, mainly due to changes in the terms of benefit coverage and utilization for topical ophthalmic products, as well as the administrative costs associated with providing changed terms of benefit coverage for the some enrollees.
- The mandate is estimated to increase premiums by about \$1.35 million. The distribution of the impact on premiums is as follows:
 - Total premiums for private employers purchasing group health insurance are estimated to increase by \$845,000, or 0.0015%.
 - Total employer premium expenditures for CalPERS HMOs are estimated to increase by \$6,000, or 0.0001%.
 - Enrollee contributions toward premiums for group insurance are estimated to increase by \$332,000, or 0.001%.
 - Total premiums for purchasers of individual market health insurance are estimated to increase by \$165,000, or 0.001%.
 - State expenditures for Medi-Cal Managed Care Plans are estimated to increase by \$154,000, or 0.0009%.

Increases in per member per month premiums for the newly mandated terms of benefit coverage in all markets as a result of AB 2418 would be less than \$0.01 in DMHC-regulated plans and CDI-regulated policies subject to AB 2418.

Public Health Impacts

- CHBRP finds insufficient evidence to suggest that opt-outs from mandatory mail order, refill synchronization, or early refills for topical ophthalmic products would improve medication adherence. Although CHBRP estimates a very limited increase in filled prescriptions for topical ophthalmic medications due to the 70% refill provision, CHBRP estimates these enrollees could (on average) have filled their prescriptions at 75 to 80%; the extra time (generally a single day) of use is unlikely to have a measurable impact on adherence. Due to insufficient medical effectiveness evidence and unlikely impact on adherence despite very limited increases in filled prescriptions, the public health impact on health outcomes, gender or racial/ethnic disparities, and premature death in the first year postmandate is unknown. Please note that the absence of evidence is not evidence of

no effect. It is possible that an impact — positive or negative — could result, but current evidence is insufficient to inform an estimate.

- CHBRP estimates that AB 2418 would modify coverage and increase the financial burden for enrollees who would be using the mail order opt-out process by increasing out-of-pocket expenses by \$61.87 per enrollee among approximately 29,821 enrollees switching from mandatory-mail-order refills to retail pharmacy refills.

Long Term Impacts

- *Medical Effectiveness* found insufficient evidence to suggest that opt-outs from mandatory mail order, refill synchronization, or early refills for topical ophthalmic products would improve medication adherence; therefore, any potential long-term impacts of AB 2418 on public health are unknown.

Interaction With the Federal Affordable Care Act

Because AB 2418 specifies terms and conditions of existing benefit coverage, but does not require new benefit coverage, it would not directly interact with essential health benefits (EHBs) or the ACA's preventive services mandate.⁸

⁸ Resources on EHBs and other ACA impacts are available on the CHBRP website: www.chbrp.org/other_publications/index.php.

Table 1. AB 2418 Impacts on Benefit Coverage, Utilization, and Cost, 2015

	Premandate	Postmandate	Increase/ Decrease	Change Postmandate
Benefit coverage				
Total enrollees with health insurance subject to state-level benefit mandates (a)	23,389,000	23,389,000	0	0%
Total enrollees with health insurance subject to AB 2418	23,083,000	23,083,000	0	0%
Number of enrollees subject to mandatory-mail-order provision with:				
Noncompliant opt-out process	1,071,000	0	-1,071,000	-100%
No opt-out process	0	0	0	0%
Percentage of enrollees subject to mandatory-mail-order provision with:				
Noncompliant opt-out process	4.6%	0.0%	-4.6%	-100%
No opt-out process	0.0%	0.0%	0.0%	0%
Number of enrollees with possible refill denial when synchronizing refill schedule	10,283,000	-	-10,283,000	-100.000%
Percentage of enrollees with possible refill denial when synchronizing refill schedule	44.5%	0.0%	-44.5%	-100.000%
Number of enrollees with possible denial when refilling TOPs at or after 70%	10,428,000	-	-10,428,000	-100.000%
Percentage of enrollees with possible denial when refilling TOPs at or after 70%	45.2%	0.0%	-45.2%	-100.000%
Utilization and cost				
Outpatient prescription drug utilization (Filled prescriptions per 1,000 covered enrollees)				
Retail	5,373.0	5,387.1	14.0	0.261%
Mail order – Mandatory	22.0	16.9	-5.1	-23.200%
Mail order – Optional	813.0	813.0	0	0.000%
Total	6,208.1	6,217.0	9.0	0.143%
Outpatient prescription drug unit cost (Average cost per filled prescription)				
Retail for < 30-day supply	\$82.98	\$82.92	-\$0.05	-0.066%
Mail order – Mandatory for 60- to 90-day supply	\$143.92	\$143.92	\$0.00	0.000%

Table 1. AB 2418 Impacts on Benefit Coverage, Utilization, and Cost, 2015 (Cont'd)

	Premandate	Postmandate	Increase/ Decrease	Change Postmandate
Mail order – Optional for 60- to 90-day supply	\$224.91	\$224.91	\$0.00	0.000%
Total	\$101.78	\$101.66	-\$0.12-	-0.122%
Outpatient prescription drug cost sharing				
(Average enrollee cost sharing per filled prescription)				
Retail for < 30-day supply	\$13.99	\$13.99	\$0.00	0.017%
Mail order – Mandatory for 60- to 90-day supply	\$25.48	\$25.48	\$0.00	0.000%
Mail order – Optional for 60- to 90-day supply	\$25.73	\$25.73	\$0.00	0.000%
Total	\$15.57	\$15.56	-\$0.01-	-0.062%
TOPs utilization				
(Filled prescriptions per 1,000 covered enrollees)	91.6	91.7	0.1	0.123%
TOPs unit cost				
(Average cost per filled prescription)	\$91.20	\$91.21	\$0.01	0.011%
TOPs cost sharing				
(Average enrollee cost sharing per filled prescription)	\$20.43	\$20.42	-\$0.01	-0.060%
Expenditures				
Premium expenditures by payer				
Private employers for group insurance	\$54,590,722,000	\$54,591,567,000	\$845,000	0.002%
CalPERS HMO employer expenditures (c)	\$4,297,494,000	\$4,297,500,000	\$6,000	0.000%
Medi-Cal Managed Care Plan expenditures	\$17,504,711,000	\$17,504,865,000	\$154,000	0.001%
Enrollees for individually purchased insurance	\$16,930,080,000	\$16,930,245,000	\$165,000	0.001%
Enrollees with group insurance, CalPERS HMOs, Covered California, and Medi-Cal Managed Care (a) (b)	\$22,232,708,000	\$22,233,040,000	\$332,000	0.001%
Enrollee expenses				
Enrollee out-of-pocket expenses for covered benefits (deductibles, copayments, etc.)	\$12,867,143,000	\$12,868,988,000	\$1,845,000	0.014%
Enrollee expenses for noncovered benefits (d)	\$0	\$0	\$0	0.000%
Total expenditures	\$128,422,858,000	\$128,426,203,000	\$3,345,000	0.003%

Source: California Health Benefits Review Program, 2014

Notes:

(a) This population includes persons with privately funded and publicly funded (e.g., CalPERS HMOs, Medi-Cal Managed Care Plans, Healthy Families Program) health insurance products regulated 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 enrollees include employee contributions to employer-sponsored health insurance enrollee contributions for publicly purchased insurance.

(c) Of the increase in CalPERS employer expenditures, about 57% or \$3,000 would be state expenditures for CalPERS members who are state employees or their dependents.

(d) 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.

Key: CalPERS HMOs=California Public Employees' Retirement System Health Maintenance Organizations; CDI=California Department of Insurance; DMHC=Department of Managed Health Care; TOPs= topical ophthalmic products

ACKNOWLEDGMENTS

This report provides an analysis of the medical, financial, and public health impacts of Assembly Bill 2418. In response to a request from the California Assembly Committee on Health on February 25, 2014, the California Health Benefits Review Program (CHBRP) undertook this analysis pursuant to the program's authorizing statute, which established CHBRP to provide independent and impartial analysis of proposed health insurance benefit mandates and repeals.

Laura Trupin, MPH, and Margaret Fix, MPH, both 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. Stephen McCurdy, MD, MPH, and Meghan Soulsby, MPH, both of the University of California, Davis, prepared the public health impact analysis. Ying-Ying Meng, PhD, and AJ Scheitler, MEd, both of the University of California, Los Angeles, prepared the cost impact analysis. Susan Pantely, FSA, MAAA, of Milliman, provided actuarial analysis. Debbie Stern, RPh, of Rxperts, Inc., and Jacque L. Duncan, MD, of the University of California, San Francisco, provided technical assistance with the literature review and expert input on the analytic approach. John Lewis, MPA, 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) and a member of the CHBRP Faculty Task Force, Brent Fulton, PhD, of the University of California, Berkeley, reviewed the analysis for its accuracy, completeness, clarity, and responsiveness to the Legislature's request.

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

California Health Benefits Review Program
1111 Franklin Street, 11th Floor
Oakland, CA 94607
Tel: 510-287-3876
[Email: chbrpinfo@chbrp.org](mailto:chbrpinfo@chbrp.org)
www.chbrp.org

All CHBRP bill analyses and other publications and resources are available on the CHBRP website, www.chbrp.org.

Garen Corbett, MS
Director

California Health Benefits Review Program Committees and Staff

A group of faculty, researchers, and staff complete the analysis that informs California Health Benefits Review Program (CHBRP) reports. The CHBRP **Faculty Task Force** comprises rotating senior faculty from University of California (UC) campuses. In addition to these representatives, there are other ongoing contributors to CHBRP from UC that conduct 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 manages all external communications, including those with the California Legislature. 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.

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 of its National Advisory Council. CHBRP assumes full responsibility for the report and the accuracy of its contents.

Faculty Task Force

Joy Melnikow, MD, MPH, *Vice Chair for Public Health*, University of California, Davis
Ninez Ponce, PhD, *Vice Chair for Cost*, University of California, Los Angeles
Ed Yelin, PhD, *Vice Chair for Medical Effectiveness*, University of California, San Francisco
Susan L. Ettner, PhD, University of California, Los Angeles
Theodore Ganiats, MD, University of California, San Diego
Sheldon Greenfield, MD, University of California, Irvine
Sylvia Guendelman, PhD, LCSW, University of California, Berkeley

Task Force Contributors

Wade Aubry, MD, University of California, San Francisco
Janet Coffman, MA, MPP, PhD, University of California, San Francisco
Gina Evans-Young, University of California, San Francisco
Margaret Fix, MPH, University of California, San Francisco
Ronald Fong, MD, MPH, University of California, Davis
Brent Fulton, PhD, University of California, Berkeley
Erik Groessl, PhD, University of California, San Diego
Shana Lavarreda, PhD, MPP, University of California, Los Angeles
Stephen McCurdy, MD, MPH, University of California, Davis
Sara McMenamin, PhD, University of California, San Diego
Ying-Ying Meng, PhD, University of California, Los Angeles
Jack Needleman, PhD, University of California, Los Angeles
Nadereh Pourat, PhD, University of California, Los Angeles
Dominique Ritley, MPH, University of California, Davis
Dylan Roby, PhD, University of California, Los Angeles
AJ Scheitler, MEd, University of California, Los Angeles
Riti Shimkhada, PhD, University of California, Los Angeles
Meghan Soulsby, MPH, University of California, Davis
Steven Tally, PhD, University of California, San Diego
Chris Tonner, MPH, University of California, San Francisco
Laura Trupin, MPH, University of California, San Francisco
Byung-Kwang (BK) Yoo, MD, MS, PhD, University of California, Davis
Patricia Zrelak, PhD, RN, CNRN, NEA-BC, University of California, Davis

National Advisory Council

Lauren LeRoy, PhD, Fmr. President and CEO, Grantmakers In Health, Washington, DC, *Chair*

Stuart H. Altman, PhD, Professor of National Health Policy, Brandeis University, Waltham, MA
Deborah Chollet, PhD, Senior Fellow, Mathematica Policy Research, Washington, DC
Joseph P. Ditré Esq, Executive Director, Consumers for Affordable Health Care, Augusta, ME
Allen D. Feezor, Fmr. Deputy Secretary for Health Services, North Carolina Department of Health and Human Services, Raleigh, NC
Charles “Chip” Kahn, MPH, President and CEO, Federation of American Hospitals, Washington, DC
Jeffrey Lerner, PhD, President and CEO, ECRI Institute Headquarters, Plymouth Meeting, PA
Trudy Lieberman, Director, Health and Medicine Reporting Program, Graduate School of Journalism, City University of New York, New York City, NY
Donald E. Metz, Executive Editor, Health Affairs, Bethesda, Maryland
Marilyn Moon, PhD, Vice President and Director, Health Program, American Institutes for Research, Silver Spring, MD
Carolyn Pare, CEO, Buyers Health Care Action Group, Bloomington, MN
Michael Pollard, JD, MPH, Senior Fellow, Institute for Health Policy Solutions, Washington, DC
Christopher Queram, President and CEO, Wisconsin Collaborative for Healthcare Quality, Madison, WI
Richard Roberts, MD, JD, Professor of Family Medicine, University of Wisconsin-Madison, Madison, WI
Frank Samuel, LLB, Former Science and Technology Advisor, Governor’s Office, State of Ohio, Columbus, OH
Patricia Smith, President and CEO, Alliance of Community Health Plans, Washington, DC
Prentiss Taylor, MD, Corporate Medical Director, Advocate At Work, Advocate Health Care, Chicago, IL
J. Russell Teagarden, Vice President, Clinical Practices and Therapeutics, Medco Health Solutions, Inc, Brookfield, CT
Alan Weil, JD, MPP, Executive Director, National Academy for State Health Policy, Washington, DC

CHBRP Staff

Garen Corbett, MS, Director
John Lewis, MPA, Associate Director
Laura Grossmann, MPH, Principal Policy Analyst
Hanh Kim Quach, MBA, Principal Policy Analyst
Nimit Ruparel, MPP Policy Analyst
Karla Wood, Program Specialist

California Health Benefits Review Program
University of California
Office of the President
1111 Franklin Street, 11th Floor
Oakland, CA 94607
Tel: 510-287-3876 Fax: 510-763-4253
chbrpinfo@chbrp.org
www.chbrp.org

The California Health Benefits Review Program is administered by the Division of Health Sciences and Services at the University of California, Office of the President. The Division is led by John D. Stobo, MD, Senior Vice President.