



## ISSUE ANALYSIS

# Assembly Bill 2587: Benefit Mandates

The California Assembly Committee on Health requested the California Health Benefits Review Program (CHBRP) to conduct an evidence-based assessment of the medical, financial, and public health impacts of Assembly Bill (AB) 2587 (Berryhill). AB 2587 was sent to CHBRP on March 12, 2010, for analysis because it was determined to be a mandate repeal bill, and CHBRP undertook this analysis pursuant to the provisions of the program's authorizing statute.

### Provisions and Legislative Intent of AB 2587

The bill language, as introduced on February 19, 2010, and requested for analysis, is included in Appendix A of this Issue Analysis. AB 2587 would add section 1367.001 to the Health and Safety Code and Section 10112.55 to the Insurance Code. It would allow health plans and insurers to be *out of* compliance with current or future benefit mandates when the Labor Market Information Division of the Employment Development Department (EDD-LMI) declares that the unemployment rate has been greater than 5.5% for four consecutive quarters. The bill would go into effect on January 1, 2011.

AB 2587 defines “benefit mandates” as “a requirement to do any of the following:

- Permit a subscriber or enrollee to obtain health care treatment or services from a particular type of health care provider.
- Offer or provide coverage for the screening, diagnosis, or treatment of a particular disease or condition.
- 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.”

Health plans, regulated under the California Department of Managed Health Care (DMHC) would still be required to cover “basic health care services” as required under Section 1367 of the Health and Safety Code.

According to the bill author, although many Californians might be better able to afford, and better satisfied with, a lower-coverage health plan, they are currently forced to purchase higher-cost plans that incorporate state-mandated benefits. In addition, the recent recession and the corresponding job losses have caused many to lose their employer-based health insurance. This bill seeks to increase the availability of affordable health insurance plans and policies.

The author believes that allowing flexibility to exclude one or more of the state level–mandated benefits will make health insurance more affordable for Californians. In addition, current law establishes a minimum benefit floor (basic health care services) for DMHC-regulated plans. Beyond meeting these basic requirements, the author states, a DMHC-regulated plan should be able to provide to consumers a variety of choices and reduce the burden these mandates impose on the Californians who least can afford it: individual purchasers and those who work in small- and medium-sized businesses.<sup>1</sup>

Approximately 19.5 million Californians (51%) have health insurance that may be subject to state health benefit mandate laws (CHBRP, 2010). Of the remainder of the population, a portion is uninsured, and therefore not affected by health insurance benefit mandate laws. Others have health insurance not subject to state health insurance benefit mandate laws. California is unique in that it has a bifurcated system of regulation for health insurance subject to state law. The DMHC regulates health care service plans, which offer coverage for benefits to their enrollees through health plan contracts. The California Department of Insurance (CDI) regulates health insurers, which offer coverage for benefits to their enrollees through health insurance policies.

There is potential for all DMHC-regulated plans and CDI-regulated policies—through which 19.5 million Californians are currently insured—to be affected. However, the potential effects of AB 2587 would depend on whether (1) the unemployment rate remains above 5.5%, (2) health plans and insurers were to develop “limited-mandate” products for the group and individual markets in response to this bill, (3) group purchasers were to make those products available for their employees, and (4) people in the individual market would purchase them. In addition, health plans and insurers would need to consider whether they ought to develop limited-mandate plans in response to this bill, given that the new requirement of the federal law (Patient Protection and Affordable Care Act (P.L.111-148), as amended by the Health Care and Education Reconciliation Act (H.R.4872).

## Analytic Approach for AB 2587

CHBRP received this request for analysis on March 12, 2010, and in response, CHBRP is submitting this Issue Analysis for the Legislature’s consideration prior to the April, 2010, Assembly Health Committee hearings. This Issue Analysis is organized to provide the following information:

- Unemployment trends and the employment-based health insurance coverage trends.
- Cost of benefit mandates based on the literature and potential cost impacts of introducing limited-mandate plans into the market based on CHBRP analyses of other “repeal” bills.
- Medical effectiveness of benefit mandates that would potentially be affected by AB 2587
- Potential public health impacts of introducing limited-mandate plans into the market based on CHBRP analyses of other “repeal” bills.
- Other important policy considerations pertaining to AB 2587, including implementation considerations and interactions with the new federal Patient Protection and Affordable Care Act (P.L.111-148, signed on March 23, 2010), as amended by the Health Care and

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<sup>1</sup> Personal communication with Brent Finkel, Office of the Assembly Member Tom Berryhill, April 2, 2010.

Education Reconciliation Act (H.R.4872) that the President signed into law on March 30, 2010.

## Summary of Findings

CHBRP's Issue Analysis of AB 2587 presents the following:

- Over the last 20 years, the unemployment rates were usually above 5.5% but fell below 5.5% during two periods, 1999-2001 and 2005-2007.
- From 2001-2007, about 55%-57% of California adults under 65 had continuous health insurance coverage for the entire year provided through an employer. That share fell to an estimated 51.3% in 2009. During 2001-2007, about a quarter of California adults were uninsured all or part of the year and in 2009, that rate rose to almost 30%.
- AB 2587 would permit the health plans and insurers to potentially not comply with 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.
- 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.
- The amount and strength of the evidence regarding the medical effectiveness of the services for which coverage may be excluded under AB 2587 varies. The outcomes that are most important for assessing effectiveness also differ. Nevertheless, many of the mandates and mandated offerings require health insurance products to provide coverage for health care services for which there is strong evidence of effectiveness.
- CHBRP's analysis of AB 1904 (2010) which would allow out-of-state carriers to market health insurance products that are not subject to California benefit mandates ("limited-mandate plans"), was used as a point of reference for potential effects of AB 2587. 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.
  - CHBRP's analysis of AB 1904 estimated that allowing the sales of these limited-mandate plans in California could potentially reduce premiums by up to 5.0%.
  - As a result, CHBRP estimates that 12,000 to 28,000 persons could become newly insured. 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. The newly insured therefore could face beneficial health outcomes as they use effective health care services.
  - It is important to note that coverage under limited-mandate plans would likely attract low-risk enrollees rather than those uninsured with chronic or high-risk conditions.

CHBRP estimated that approximately 266,000 to 298,000 persons could switch from plans and policies with mandated benefits to limited-mandate plans. For this population, out-of-pocket expenditures for benefits previously covered could potentially increase by an estimated \$19.4 million to \$20.1 million. In addition, these insured persons would have an increased risk of foregoing treatment for services no longer covered under limited-mandate plans. 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.<sup>2</sup>

- The provisions of AB 2587 and the current context in which it is being considered raises important policy considerations regarding implementation. For example, the recently enacted federal health care reform law (P.L. 111-148) would require coverage of “essential health benefits” by plans offered to the small group and individual markets via the state-based exchanges by 2014. It is unclear whether carriers would seek to develop limited-mandate plans in light of these and other new federal requirements.

## Unemployment and Employment-Based Insurance Trends

AB 2587 would allow health plans and insurers to forego compliance with current or future benefit mandates until the EDD-LMI declares that the unemployment rate has been no more than 5.5% for four consecutive quarters. Each month, the EDD-LMI releases revised (for 2 months prior) and preliminary (for prior month) labor force data. These data are based on a monthly survey of 5,500 California households as part of the Current Population Survey (CPS) conducted by the Bureau of the Census in cooperation with the federal Bureau of Labor Statistics (BLS).

The unemployment rate reported by the EDD-LMI is derived by dividing the number of unemployed by the civilian labor force (EDD-LMI, 2010). The “civilian labor force” is composed of individuals, aged 16 years and older, who are not members of the Armed Services, and are not in institutions such as prisons, mental hospitals, or nursing homes. The “unemployed” in this case are defined as individuals, aged 16 years or older, who are not working but are able to work, available for work, and seeking either full-time or part-time work. To be considered “seeking work,” an individual must have been engaged in at least one active job search activity (e.g., actively contacting an employment agency, sending out resumes) in the 4 weeks preceding the interview for the survey (BLS, 2010).<sup>3</sup>

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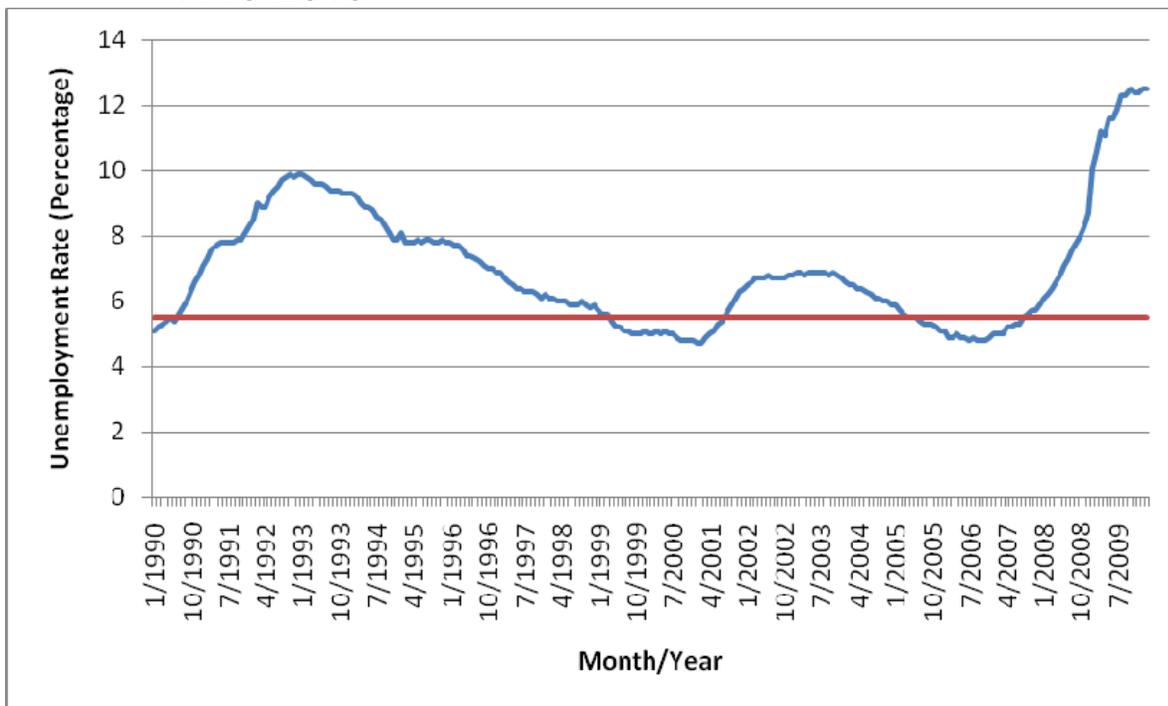
<sup>2</sup> These scenarios are highly dependent on whether and the extent to which health insurance carriers decide to offer limited-mandate plans in California in response to AB 2587. As discussed in the “Other Policy Considerations” section, there are a number of factors that would affect a carrier’s decision to do so.

<sup>3</sup> The EDD-LMI rate matches the standard definition of unemployment, using the same methodology as the BLS official rate called “U-3,” but does not capture all aspects of labor market conditions. The unemployment rate reported by EDD-LMI, for example, excludes from the workforce “marginally attached workers,” defined as those persons not in the labor force who want and are available for work, and who have looked for a job some time in the prior 12 months, but were not counted as unemployed because they had not searched for work in the 4 weeks preceding the survey.<sup>3</sup> These are often referred to as “discouraged workers.” Similarly, the rate reported by EDD-LMI considers as employed “involuntary part-time” workers, defined as persons who indicated that they would like to work full time but were working part time (1 to 34 hours) because of an economic reason, such as their hours were cut back or they were unable to find full-time jobs. Definitions for this and other classifications of the labor force used in conducting the Current Population Survey can be viewed on the BLS Web page, “Labor Force Statistics (CPS),” available at: [www.bls.gov/cps/lfcharacteristics.htm](http://www.bls.gov/cps/lfcharacteristics.htm). Accessed on March 30, 2010.

Economists do not define full employment (or the “natural employment rate”) as 100% because at any point in time, there will always be a percentage of the labor market that is willingly unemployed due to “frictional” unemployment, such as job changes or initial entry into the labor force. Moreover, the contemporary macroeconomics literature suggests that a tradeoff exists between unemployment and inflation, and that unemployment levels below a certain range are unsustainable, accelerating inflation in such a way that hampers economic growth (OECD, 2001).<sup>4</sup> Although there is no consensus on a specific figure, econometric estimates put this long-term rate of natural unemployment in the range of 5.2%-6.1% for the United States (OECD, 2001).

Figure 1 presents monthly data for the seasonally adjusted unemployment rate in California from January 1990 through January 2010. The vertical axis shows the unemployment rate as reported monthly by EDD-LMI, and the horizontal axis tracks the month and year for the data. As of February 2010, the unemployment rate in California is 12.5%. A horizontal bar shows the AB 2587 threshold of 5.5%. During this time, unemployment rates were usually above 5.5% but fell below 5.5% during two periods, 1999-2001 and 2005-2007.

**Figure 1. California Unemployment Rate (Seasonally Adjusted), 1990-2010**



Source: California Employment Development Department (EDD), Labor Market Information Division, 2010.

<sup>4</sup> This concept of the lowest sustainable level of unemployment is known as NAIRU: the nonaccelerating inflation rate of unemployment.

## Relationship Between Employment and Health Insurance

The portion of the population covered through employment-based insurance has been relatively stable over the past decade. However, with the recent recession, and corresponding job losses, the rates of those who have employer-based insurance have declined (see Table 1).

**Table 1. Health Insurance Coverage During the Previous 12 Months Among Adults, Age 19-64, California, 2001-2009**

	2001	2003	2005	2007	2009
Employment-based coverage all year	57.0%	55.1%	56.2%	57.3%	51.3%
Medi-Cal coverage all year	8.6%	9.0%	8.7%	8.5%	9.1%
Privately purchased coverage all year	5.7%	5.8%	5.9%	5.9%	5.6%
Uninsured all or part of the year	25.4%	25.7%	24.8%	23.9%	29.5%

*Source:* Lavarreda et al., 2010

*Note:* Numbers will not add up to 100% because this table does not show those with other publicly funded health insurance, other than Medi-Cal, as well as any combination of coverage types during the previous year that did not include a period of being uninsured.

From 2001-2007, about 55%-57% of California adults under 65 had continuous health insurance coverage for the entire year provided through an employer. That share fell to an estimated 51.3% in 2009 (Lavarreda et al, 2010). During that period, about a quarter of California adults were uninsured all or part of the year prior to being surveyed. In 2009, the latter percentage rose to almost 30%. Other sources of insurance include the state's Medi-Cal program and coverage purchased privately in the individual market.

The rates of employment and health insurance coverage are linked because the majority of the non-elderly adult population attains coverage through an employer. Holahan and Garrett estimate that a 1.0 percentage point increase in the national seasonally adjusted unemployment rate leads to a 0.59 percentage point increase in the percentage of non-elderly adults who are uninsured (Holohan and Garrett, 2009). Nationally, this means an increase in the unemployment rate of 1% causes 1.1 million more non-elderly adults to become uninsured. Such an increase in unemployment also causes an estimated 0.20 percentage point increase in the number of nonelderly adults receiving Medicaid coverage (Medi-Cal in California), and a 0.18 percentage point increase in non-group (purchased in the individual market) coverage. Rising unemployment may also impact the number of children without coverage, but these estimates suggest the effect is weak, as children usually become eligible for coverage through public programs, notably SCHIP (Healthy Families in California) and Medicaid (Medi-Cal).

Rising unemployment rates also exacerbate the underlying trend of health insurance cost growth outpacing personal income growth (Gilmer and Kronick, 2009). In addition to losing access to employer-sponsored coverage, the newly unemployed suffer an immediate loss of personal income, as well as potential long-term income setbacks attributable to gaps in employment, the increased costs of COBRA premiums in the immediate post-employment period or individual policies subsequently. Additionally, the rising out-of-pocket costs for health care (associated with increases in coinsurance and deductible levels) exacerbates income setbacks. The

unemployed in a recession are therefore disproportionately affected by the increasing costs of health care.

## Cost of Health Insurance Benefit Mandates

AB 2587 seeks to reduce the costs of health plans and policies in the market by allowing health plans and insurers in California to not comply with existing and future benefit mandates. (For the purposes of discussion, this Issue Analysis refers to these plans and policies as “limited-mandate plans.”) Given the time constraints, CHBRP did not model the cost impacts of AB 2587; however, CHBRP’s prior analyses and research may help inform policymakers on the potential impacts of AB 2587.

### **Market Share, Offer Rates, Scope of Benefits Offered, and Take-Up Rates**

The ultimate cost impact of AB 2587 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 2587 could 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 2587 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 2587 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, 99.5% 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 (77.7%) of employees have comprehensive benefit packages; although in the CDI-regulated small-group market, about 60% of employees have high-deductible health plans (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 45.0% of enrollees in the DMHC-regulated individual market and about 64.2% 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.

## Cost of Mandates: Summary of the Literature

The financial cost of mandated health insurance benefits are sometimes defined as either the *full* cost or as the *marginal* cost of the mandate. The full cost of the mandate is really the total cost of the benefit. The marginal cost equals the full cost of the benefit minus the cost associated with the benefit that would be covered by the market place in the absence of the legal requirement imposed by the mandate. For example, outpatient prescription drugs are not currently required to be covered under current California benefit mandates; however, over 95% of the privately insured market has coverage for outpatient prescription drugs. Therefore, to measure the cost of any potential mandate to cover outpatient prescription drugs, it is appropriate to measure the *marginal* cost of expanding coverage to the portion of the market that does not currently have coverage. The *cumulative* cost of mandated benefits would be dependent upon the number of mandated benefits and the nature of the mandates (e.g., which markets are affected, whether the mandates require that carriers to provide coverage or simply offer coverage for a benefit, etc.). This section summarizes literature that speaks to the cumulative costs of mandates, including the available literature and experience of limited-mandate plans in California and other states.

The impact of allowing health plans and insurers to offer limited-mandate insurance products in California could result in lower premiums for Californians in all segments of the insurance market. In analyzing a related piece of legislation (AB 1214), CHBRP estimated that waiving all 44 of California's mandates, while maintaining the basic health care services as required by the Knox-Keene Act for DMHC-regulated health plans, would reduce premiums by about 4.8% (CHBRP, 2007). In CHBRP's analysis of AB 1904 (2010), CHBRP estimated that allowing the sales of limited benefit plans in California (by out-of-state carriers) could potentially reduce premiums by about 4.8%-5.0% (CHBRP, 2010).

The potential for premium savings due to the availability of limited benefit plans in other states varies. When CHBRP's scope was initially expanded to evaluate repeal bills, that is, elimination of one or more mandated benefits, CHBRP, to obtain information on the market response, identified states that have passed legislation allowing the development of limited-mandate plans (e.g., Arizona, Arkansas, Colorado, Florida, Georgia, Kansas, Kentucky, Louisiana, Maryland, Minnesota, Montana, New Jersey, North Carolina, North Dakota, Tennessee, Texas, Utah, Washington, and West Virginia). Interviews with carriers, state representatives, insurance brokers, and a review of the literature indicated that neither insurers nor employers have widely embraced limited-mandate plans (CHBRP, 2009). In Texas, for example, since September 2003, carriers have been allowed to offer Consumer Choice Health Benefit Plans that do not include all the required mandates.<sup>5</sup> Carriers are required to file with the Texas Department of Insurance the premium reductions associated with the mandated benefits that are *not* covered under the specific Consumer Choice Health Benefit Plan. Based on a review of these filings, premium savings range from 0% to 20%, although most average from about 3%-7% and are thus consistent with CHBRP's findings discussed above.<sup>6</sup> In addition, the take-up rate of these Consumer Choice Health Benefit Plan were low during the initial year but then picked up within three years after

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<sup>5</sup> Art. 3.80 Insurance Code, Texas Consumer Choice of Benefits Health Insurance Plan Act

<sup>6</sup> Larger reported savings (on the order of 20%-40%) for CCHBPs are attributed to cost-sharing rather than waiver of benefit mandates. SB 541 Consumer Choice Plans as of September 15, 2009. [www.tdi.state.tx.us/health/documents/lhccplst\\_73004.pdf](http://www.tdi.state.tx.us/health/documents/lhccplst_73004.pdf)

implementation. The take up was from those who were previously insured rather than those that were previously uninsured (TDI, 2008).

In another study, the Texas Department of Insurance has been collecting mandated benefit cost and experience data from their largest carriers for the privately insured market since 1992. For the most recent study period—October 2004 to September 2005—they estimate that mandated benefits cost 3.10% of total premiums for individual (non-group) benefit plans 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 that individually are rare, and telemedicine services; both benefits had claims totaling less than 0.01% of total claims (TDI, 2005).

Estimates for the *cumulative* cost of the mandated benefits vary. Recent studies estimate the cumulative cost ranges from 5% to 19% of premiums. 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).

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

A Massachusetts study estimated *total* costs associated with the state's 26 mandated benefit 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. However, this same 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 premiums (Bachman et al., 2008).

LaPierre et al. (2009) used Community Tracking Survey data from 1997-2003 to examine the impact of mandates on premiums for indemnity and health maintenance organization (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 service (or benefit) mandates and provider mandates tended to reduce HMO family premiums, whereas coverage mandates (e.g. mandates requiring coverage of dependants) had the opposite effect.

In summary, 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.

## Medical Effectiveness of Existing Mandated Benefits

AB 2587 would permit the health plans and insurers to potentially not comply with 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 (2007), Senate Bill (SB) 92 (2009), and this year's report on AB 1904 (2010). 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 present summary is drawn from CHBRP's report on AB 1904, which provides the most up-to-date assessment of the medical effectiveness of the preventive, diagnostic, and treatment services for which coverage is mandated. This summary presents evidence contained in the previous reports along with evidence regarding the effectiveness of services to which a new mandate enacted in 2009 applies.<sup>7,8</sup> 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).

The amount and strength of the evidence regarding the medical effectiveness of the services for which coverage may be excluded under AB 2587 varies. The outcomes that are most important for assessing effectiveness also differ. Nevertheless, many of the mandates and mandated offerings addressed by AB 2587 require health insurance products to provide coverage for health care services for which there is strong evidence of effectiveness.

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<sup>7</sup> Since this Issue Analysis presents a summary of the *Medical Effectiveness* section presented in the *Analysis of AB 1904: Out-of-State Carriers*, refer to that analysis for further information on supporting literature, literature review methods, and a detailed discussion of findings.

<sup>8</sup> 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.

Findings regarding the medical effectiveness of specific health care services addressed by the mandates and mandated offerings that could be excluded under AB 2587 are described below. The mandates are grouped by major categories of diseases, conditions, populations, and types of services. The findings are summarized in Appendix B.

- 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*.

## The Potential Public Health Impacts of Allowing Limited-Mandate Plans to Compete in the California Market

Given time constraints, CHBRP was not able to model the public health impacts of AB 2587 *per se*. However, CHBRP has completed several recent analyses that can inform AB 2587. In CHBRP's analyses of AB 1214 (2007), SB 92 (2009), and this year's report on AB 1904 (2010), CHBRP estimates the potential number of previously uninsured persons who would take up the newly available limited-mandate plan and the number of persons who would move from a plan or policy with mandated benefits to these new limited-mandate plans.

As discussed earlier, evidence suggests that nearly 30% of Californians under the age of 65 are currently uninsured. 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). 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). In CHBRP's report, *Analysis of AB 1904: Out-of-State Carriers*, CHBRP presents hypothetical scenarios and a corresponding range of individuals who could be newly covered because they take up limited-mandate plans: an estimated 12,000 to 28,000 persons.<sup>9</sup> Although CHBRP did not conduct a similar scenario analysis for AB 2587, it is likely that there would be a similar take-up of limited-mandate plans due to reduction in premiums and these newly insured individuals would likely realize improved health outcomes and reduced financial burden for medical expenses.

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<sup>9</sup> These scenarios are highly dependent on whether and the extent to which health insurance carriers decide to offer limited-mandate plans in California in response to AB 2587. As discussed in the "Other Policy Considerations" section, there are a number of factors that would affect a carrier's decision to do so. For further discussion on how these scenarios were constructed, please see CHBRP's *Analysis of AB 1904: Out-of-State Carriers*.

In California, racial and ethnic minorities are more likely to be low income and more likely to be uninsured compared to white non-Hispanics. Among the newly insured, a larger proportion of minorities compared to white non-Hispanics could change from being uninsured to insured under AB 2587. It is important to note, however, that coverage under limited-mandate plans would likely attract low-risk enrollees rather than those uninsured with chronic or high-risk conditions.

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. 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 non-elderly 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).

In CHBRP's analysis of AB 1904, we present scenarios with estimates of the number of persons who could move from a plan or policy with mandated benefits to these new limited-mandate plans. Approximately 266,000 to 298,000 persons could switch to limited-mandate plans under two reasonable scenarios. Although CHBRP did not conduct a similar scenario analysis for AB 2587, it is likely that there would be a similar switching from plans or policies with mandated benefits to limited-mandate plans due to reduction in premiums. Out-of-pocket expenditures for benefits previously covered could potentially increase for this population by an estimated \$19.4 million to \$20.1 million. In addition, these insured persons would 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 or policy with full coverage for these health problems, at least until federal requirements go into effect.

A number of mandates are associated with health benefits primarily for females (e.g., breast/cervical cancer, maternity care-related mandates, and prescription contraceptives). Insured females who opt to move from a plan or policy with mandated benefits to a limited-mandate plan would be at greater risk for underinsurance and reduced access to these services compared to males.

To assess the public health impact if coverage for a particular benefit is excluded from a limited-mandate 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)	<p><u>Mandates with potential mortality impact</u></p> <ul style="list-style-type: none"> <li>• Cancer screening tests for breast, cervical, and colorectal cancers</li> <li>• Diagnostic tests and treatments for breast cancer</li> <li>• Diabetes management medications, services, and supplies</li> <li>• Medication and psychosocial treatments for severe mental illness and alcoholism</li> <li>• Preventive services for children and adolescents</li> <li>• Pediatric asthma management</li> </ul> <p><u>Mandates with potential morbidity impact</u></p> <ul style="list-style-type: none"> <li>• Prescription contraceptive devices (morbidity related to problems occurring from unplanned pregnancy)</li> </ul>
Moderate (fewer than 1 in 20 persons to 1 in 2,000 persons)	<p><u>Mandates with potential mortality impact</u></p> <ul style="list-style-type: none"> <li>• HIV testing</li> <li>• Services for the diagnosis and treatment of osteoporosis</li> <li>• Prenatal diagnosis of genetic disorders</li> </ul> <p><u>Mandates with potential morbidity impact</u></p> <ul style="list-style-type: none"> <li>• Prosthetic devices</li> <li>• Orthotic devices for some conditions</li> <li>• Special footwear for persons with rheumatoid arthritis</li> <li>• Pain management medication for persons with terminal illnesses</li> <li>• Acupuncture</li> <li>• Diagnosis and treatment of infertility</li> <li>• Surgery for the jawbone and associated bone joints</li> </ul>
Limited (1 in 2,000 persons or fewer)	<p><u>Mandates with potential mortality impact</u></p> <ul style="list-style-type: none"> <li>• Medical formulas and foods for persons with phenylketonuria</li> <li>• Expanded alpha-fetoprotein screening</li> </ul> <p><u>Mandates with potential morbidity impact</u></p> <ul style="list-style-type: none"> <li>• Home care services for elderly and disabled adults</li> <li>• Hospice care</li> </ul>

Source: California Health Benefits Review Program, 2010.

In addition to the benefit mandates listed in Table 2, there are a number of other benefit mandates on the books. Their potential impacts on public health, if they were dropped, are either limited or unknown: 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 were dropped, including tests for screening and diagnosis of prostate cancer, transplantation services for persons with HIV, intoxication exclusion<sup>10</sup>, 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 a review of “summary of benefits” documents or disclosure forms for carriers that offered limited-mandate or limited-mandate plans in other states that have laws permitting the development of these plans<sup>11</sup>, CHBRP determined which mandated benefits are most likely to be dropped once limited-mandate plans are permitted. The medically effective mandated benefits that are most likely to be dropped 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.

## Other Policy Considerations Pertaining to AB 2587

AB 2587 would allow health plans and insurers to be out of compliance with current or future benefit mandates when the Labor Market Information Division of the Employment Development Department declares that the unemployment rate has been greater than 5.5% for four consecutive quarters. This language, as well as the current context of this bill, raises a number of questions regarding potential implementation and compliance.

### **Administrative and Regulatory Factors**

There is the question as to whether health plans and insurers would choose to develop limited-mandate products for the group and individual markets in response to unemployment rates and the potential administrative and regulatory “hassle factor” that they would need to overcome to market such limited-mandated plans.

To determine whether it is worthwhile to develop such limited-mandate plans, carriers would first need to determine whether the potential decreases in premiums associated with the limited benefit plan would be sufficient to attract low-cost enrollees. Competitor and market analysis would also need to be conducted. In addition, other practical matters related to marketing, enrolling, and administering a range of options for individual and group purchasers would need to be settled: for example, how many additional limited-mandate plan options or variants would

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<sup>10</sup> The intoxication exclusion mandate prohibits insurance companies from excluding coverage for injuries resulting from or related to intoxication.

<sup>11</sup> 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.

the carrier be willing to develop and market? How can marketing be done in a way to ensure the purchasers are aware that these plans or policies do not contain certain mandated benefits (and what legal ramifications would they face if such disclosures are not made?) Another issue would be what carriers may have to do if the unemployment rate falls below 5.5% for a quarter then begins a four-quarter period of being higher than 5.5%? How often would they market the limited-mandate plans and then halt their sales and over what period?

AB 2587 also raises implementation questions regarding the unemployment data “trigger” embodied in the bill. First, the EDD-LMI official unemployment estimates are released monthly rather than quarterly.<sup>12</sup> It is unclear, for example, whether data for one month were to show a rise of unemployment to a level above 5.5%, but the quarterly average for that period remained below 5.5%, whether the Department would issue a declaration announcing unemployment had been below the threshold for that quarter. The issuance of a declaration under the provisions of AB 2587 would also likely be a separate process from its monthly data releases. Second, in its monthly data releases, EDD-LMI presents both seasonally adjusted and non-seasonally adjusted unemployment rates. The rate cited in the report headline is the seasonally adjusted rate, but the specific rate to be used is not specified by bill language.<sup>13</sup> Non-seasonally adjusted data show more variation throughout a given four-quarter period, and therefore may impact the determination of the quarterly rates. Third, EDD-LMI revises its unemployment data on an annual basis. This revision, also called a “benchmark,” reflects updates to the datasets used to generate the monthly estimates and is released in stages early each calendar year, occurring in March for 2010 (EDD-LMI, 2008). As noted previously, the EDD-LMI monthly releases also provide preliminary unemployment estimates for the month prior, but only provide revised estimates for a given month in the report issued 2 months subsequent. These revision processes may impact both the timing and content of the “trigger” declaration of the Department specified in bill language.

In terms of regulatory oversight, according to the CDI, insurers would have to submit two policy forms for each policy: one that complies with benefit mandates and one (if they wish) that does not. Each policy form would be subject to review. According to the DMHC, health plans would need to file for approval for the marketing of any new plans or if there are changes to existing plans. Each filing is subject to review and approval and plans may not market those plans until they have been approved.

Once health plans and insurers have begun to market such limited-mandate plans, they would need to monitor the unemployment rates on a quarterly basis to ensure they maintain compliance with state law. AB 2587 does not specify how quickly a plan or insurer must comply with mandated benefits in the case that unemployment rates were to drop below 5.5% for four consecutive quarters. Given the ambiguity in language, per CDI, health insurers would need to reach compliance in short order and immediately switch out their limited-mandated policies with those policies with benefit mandates. In addition, CDI would also have to change their monitoring practice to ensure ongoing compliance. Since CDI only monitors policy forms that

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<sup>12</sup> EDD-LMI does release the Quarterly Census of Employment and Wages (QCEW) but notes on its Web site that “[t]hese data, based on the NAICS classification, provide the count of employment and wages for workers covered by unemployment insurance programs in the time period indicated. Note: These data are NOT the official, monthly estimates from the Employment Development Department.” For more information, see: [www.labormarketinfo.edd.ca.gov/qcew/cew-select.asp](http://www.labormarketinfo.edd.ca.gov/qcew/cew-select.asp).

<sup>13</sup> For an example of these monthly releases, see: [www.edd.ca.gov/About\\_EDD/pdf/urate201003a.pdf](http://www.edd.ca.gov/About_EDD/pdf/urate201003a.pdf)

are currently sold through periodic market conduct examinations, those examinations may not be frequent enough to provide adequate monitoring. According to CDI, they would most likely have to promulgate new regulations that would require insurers to annually report the extent to which they are marketing limited-mandate plans.<sup>14</sup> DMHC also would need to promulgate regulations—both to make clear by when plans must be in compliance if the unemployment rate dropped below 5.5% and to make clear how plans must demonstrate compliance.<sup>15</sup>

## **Consumer Disclosures**

Since AB 2587 would allow the development of limited-mandate plans, the potential options available in the California market could increase. Therefore, the information that ought to be provided to the consumer at the point of purchase and after enrollment, especially disclosures regarding which mandated benefits are included in the policy or plan, is an important factor for consideration.

The numerous health insurance options in California make choosing a health plan/policy a highly complex task. Making an informed choice would include an understanding of provider networks, covered benefits, coinsurance rates, deductibles, formulary structure, and many other important health plan/policy features. Research has found that many individuals in the United States have a limited understanding of health insurance products and thus struggle with selecting a health plan/policy (Garnick et al., 1993; Henrickson et al., 2006; Lubalin and Harris-Kojetin, 1999; Wroblewski, 2007).

Many individuals do not become familiar with the specific attributes of their health insurance plan/policy until they need to use health care services. A 2006 survey of Californian adults enrolled in HMOs (CHI, 2006) found that more than 40% of HMO consumers—most of whom were covered by employer-based plans, Medi-Cal Managed Care, or Medicare Advantage—reported a problem with their HMO in the last year, with 12% of adults enrolled in HMOs discovering that important benefits they needed were not covered, and 10% reporting they had misunderstood their coverage or benefits.

Health plans/insurers and employers often provide detailed health plan/policy information in order to increase consumers' understanding of health insurance. The provision of information on its own, however, is not sufficient in clarifying confusion around decisions since individuals can only process a limited number of factors when making a decision (Hibbard and Peters, 2003; Shaller, 2005). As such, many interventions to improve consumer knowledge have focused on simplified, standardized health insurance information to better facilitate comparison shopping among health insurance products, minimize unexpected outcomes, and improve consumer satisfaction (Kirsch, 2002).

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<sup>14</sup> Personal communication with Josephine Figueroa, CDI, March 26, 2010.

<sup>15</sup> Personal communication with Sherrie Lowenstein, DMHC, March 30, 2010

## **Risk Segmentation**

Since AB 2587 would allow the development of limited-mandate plans, there would be potential for greater risk segmentation in the market—especially within the small-group and individual markets in the near term. Risk segmentation can occur when consumers are offered a choice of products that vary in their scope of benefits. Healthier consumers tend to select the least extensive (and least expensive) product, and those anticipating the need for more health care services tend to select more extensive (and more expensive) products. In other words, benefit package design is an effective tool for segmenting insurance pools by health care risk. Health insurance products offering less than comprehensive insurance, at lower prices, will tend to attract healthier enrollees. CHBRP’s recent analysis of maternity benefits in the individual market provides evidence of risk segmentation (CHBRP, 2010).

The impact of greater market segmentation is highly controversial. Advocates for greater segmentation argue that the current health insurance market generally provides an insufficient number of product choices with basic benefits, effectively forcing individuals to purchase more generous benefits than they prefer or can necessarily afford. Advocates also argue that pricing products to reflect expected use of services (i.e., differentially underwriting) is a more equitable way of allocating insurance costs. For example, why should a nonsmoker subsidize a smoker’s health care costs (PRI, 2009)? Opponents argue that greater segmentation without adequate mechanisms to risk-adjust premiums encourages favorable selection of lower-risk individuals into lower-cost products. This risk segmentation can result in a “death spiral” for health plans/policies with extensive coverage, because over time, they attract a progressively sicker mix of enrollees and become more and more expensive (Families USA, 2006).

As discussed in the *Public Health Impacts* section, another concern with greater risk segmentation in the individual market is that it leads to those individuals with greatest health care needs bearing a greater share of financial risk for their use of health care services. This could potentially increase the number of underinsured individuals with private insurance, i.e., individuals who have insurance that is inadequate in some manner (Blewett et al., 2006). Underinsurance, usually defined in terms of the proportion of household income spent on health care, is difficult to measure, because it involves both *increases* in cost sharing for covered benefits as well as *decreases* in the scope of covered benefits. The former is often included in health surveys, whereas detailed information about the latter is often lacking, particularly in the individual market. Increased cost sharing and decreased scope of coverage are likely to place individuals and families purchasing health care in the individual market at greater financial risk, and thus to result in a higher proportion of household income being spent on health care.

## **Federal Requirements under Health Care Reform**

A complicating factor is the passage of the new federal health care reform law. 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. 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 provisions of P.L.111-148 will 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. It will establish state-based health insurance exchanges, with minimum benefit standards, for the small-group and individual markets. Subsidies for low-income individuals will 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.

P.L. 111-148 will require “essential health benefits” to be covered by qualified health plans that provide health insurance in the small-group and individual markets through the state-based insurance exchanges, effective 2014. Section 1302 defines essential health benefits as emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, preventive and wellness services and chronic disease management, and pediatric services, including oral and vision care. It will also require that the scope of the essential health benefits be equal to the scope of benefits provided under a typical employer plan.

In addition, there are short-term provisions in P.L.111-148 that go into effect within 6 months or less of enactment that will affect the development, offer and take up of limited-mandate plans in response to AB 2587. For example:

- Children and young adults up to age 26 years of age will be allowed to enroll onto their parent’s health plan or policy (effective 6 months following enactment). This provision could shift some who are currently uninsured or enrolled in individually purchased insurance to group purchased insurance.
- A temporary high-risk pool for those with pre-existing conditions will be established (effective 90 days following enactment). How California chooses to implement this provision will have implications for health insurance coverage for those high-risk individuals who are currently without health insurance and/or are in California’s Major Risk Medical Insurance Program (MRMIP).
- For tax years 2010-2013, small groups (having 25 or fewer employees) will be eligible for a tax credit of up to 35% of the employer’s contribution toward the employee’s health insurance premium depending on how much the employer initially contributes. This tax credit may provide incentive to purchase plans or policies with more comprehensive benefit coverage rather than limited-mandate plans.
- Plans and policies will be required to cover preventive services with no copayment or deductibles. Required preventive services will include those rated A or B by the U.S. Preventive Services Task Force, recommended immunizations, preventive care for infants, children, and adolescents, and additional preventive care and screenings for women (effective 6 months after enactment).

The impact of AB 2587 would ultimately depend on whether carriers will develop limited-mandate plans, whether purchasers offer them and whether individuals take them up. In addition, the impacts 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.

# Appendices

## **Appendix A: Bill Language of AB 2587**

BILL NUMBER: AB 2587 INTRODUCED  
BILL TEXT

INTRODUCED BY Assembly Member Tom Berryhill

FEBRUARY 19, 2010

An act to add Section 1367.001 to the Health and Safety Code, and to add Section 10112.55 to the Insurance Code, relating to health care coverage.

### LEGISLATIVE COUNSEL'S DIGEST

AB 2587, as introduced, Tom Berryhill. Health care coverage: benefit mandates.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Existing law also provides for regulation of health insurers by the Department of Insurance. Existing law imposes certain benefit mandates on health care service plan contracts and health insurance policies.

This bill would exempt a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2011, from complying with those benefit mandates, as specified, until the Department of Managed Health Care or the Department of Insurance, as applicable, issues a declaration finding that the state unemployment rate has been no more than 5.5% for 4 consecutive quarters.

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 1367.001 is added to the Health and Safety Code, to read:

1367.001. (a) Notwithstanding any other provision of this chapter, until the department issues a declaration finding that the

state unemployment rate, as determined by the official statistics of the Labor Market Information Division of the Employment Development Department, has been no more than 5.5 percent for four consecutive quarters, a health care service plan contract issued, amended, or renewed on or after January 1, 2011, shall not be required to comply with the benefit mandates imposed by this chapter, including any benefit mandates that become operative on or after January 1, 2011.

(b) (1) For purposes of this section, "benefit mandate" means a requirement to do any of the following:

(A) Permit a subscriber or enrollee to obtain health care treatment or services from a particular type of health care provider.

(B) Offer or provide coverage for the screening, diagnosis, or treatment of a particular disease or condition.

(C) 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.

(2) Notwithstanding paragraph (1), "benefit mandate" does not include the requirement to provide basic health care services imposed under subdivision (i) of Section 1367.

SEC. 2. Section 10112.55 is added to the Insurance Code, to read:

10112.55. (a) Notwithstanding Section 10112.5 or any other provision of this part, until the department issues a declaration finding that the state unemployment rate, as determined by the official statistics of the Labor Market Information Division of the Employment Development Department, has been no more than 5.5 percent for four consecutive quarters, a health insurance policy issued, amended, or renewed on or after January 1, 2011, shall not be required to comply with the benefit mandates imposed by this part, including any benefit mandates that become operative on or after January 1, 2011.

(b) For purposes of this section, "benefit mandate" means a requirement to do any of the following:

(1) Permit a policyholder or insured 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.

(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.

**Appendix B:**

**Table B-1. Mandates Addressed in AB 2587, by Strength of Evidence**

<b>Description</b>	<b>Clear and Convincing Evidence that Test(s) and/or Treatment(s) Are Effective</b>	<b>Preponderance of Evidence that Test(s) and/or Treatment(s) Are Effective</b>	<b>Evidence of the Effectiveness of Test(s) and/or Treatment(s) Is Ambiguous</b>	<b>Insufficient Evidence to Determine whether Test(s) and/or Treatment(s) Are Effective</b>	<b>Preponderance of Evidence That Test(s) and/or Treatment(s) Are Not Effective</b>
<b>Cancer Screening and Treatment</b>					
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	
<b>Chronic Conditions</b>					
Diabetes management	X, except for special footwear				
Osteoporosis diagnosis, treatment, and management	X				
Human immunodeficiency virus screening	X				

**Table B-1. Mandates Addressed in AB 2587, by Strength of Evidence (Cont'd)**

<b>Description</b>	<b>Clear and Convincing Evidence That Test(s) and/or Treatment(s) Are Effective</b>	<b>Preponderance of Evidence that Test(s) and/or Treatment(s) Are Effective</b>	<b>Evidence of the Effectiveness of Test(s) and/or Treatment(s) Is Ambiguous</b>	<b>Insufficient Evidence to Determine Whether Test(s) and/or Treatment(s) Are Effective</b>	<b>Preponderance of Evidence That Test(s) and/or Treatment(s) Are Not Effective</b>
<b>Chronic Conditions (Cont'd)</b>					
Transplantation services for persons with HIV		X <sup>16</sup>			
Phenylketonuria, medical formulas and medical foods		X			
<b>Mental Illness and Substance Use Disorders</b>					
Parity in coverage for severe mental illness	X <sup>17</sup>				
Coverage for mental and nervous disorders	X				
Alcoholism	X				

<sup>16</sup> 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.

<sup>17</sup> The review of evidence regarding treatments for mental illness was limited to three severe mental illnesses: bipolar disorder, major depressive disorder, and schizophrenia.

**Table B-1. Mandates Addressed in AB 2587, by Strength of Evidence (Cont'd)**

<b>Description</b>	<b>Clear and Convincing Evidence That Test(s) and/or Treatment(s) Are Effective</b>	<b>Preponderance of Evidence That Test(s) and/or Treatment(s) Are Effective</b>	<b>Evidence of the Effectiveness of Test(s) and/or Treatment(s) Is Ambiguous</b>	<b>Insufficient Evidence to Determine Whether Test(s) and/or Treatment(s) Are Effective</b>	<b>Preponderance of Evidence That Test(s) and/or Treatment(s) Are Not Effective</b>
<b>Mental Illness and Substance Use Disorders (cont'd.)</b>					
Prohibition on exclusion of coverage for illnesses or injuries associated with intoxication or consumption of controlled substances not prescribed by a physician				X	
<b>Orthodontic Services</b>					
Orthodontic services for persons with oral clefts				X	
<b>Prostheses, Orthoses, and Footwear</b>					
Orthotic and prosthetic devices		X, prostheses and some orthoses <sup>18</sup>		X, some orthoses <sup>19</sup>	X, foot orthoses for deviated big toe
Prosthetic devices for laryngectomy			X <sup>20</sup>		

18 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.

19 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.

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

**Table B-1. Mandates Addressed in AB 2587, by Strength of Evidence (Cont'd)**

<b>Description</b>	<b>Clear and Convincing Evidence That Test(s) and/or Treatment(s) Are Effective</b>	<b>Preponderance of Evidence That Test(s) and/or Treatment(s) Are Effective</b>	<b>Evidence of the Effectiveness of Test(s) and/or Treatment(s) Is Ambiguous</b>	<b>Insufficient Evidence to Determine Whether Test(s) and/or Treatment(s) Are Effective</b>	<b>Preponderance of Evidence That Test(s) and/or Treatment(s) Are Not Effective</b>
<b>Prostheses, Orthoses, and Footwear (cont'd.)</b>					
Special footwear for persons with foot disfigurement		X, rheumatoid arthritis <sup>21</sup>	X, diabetes		
<b>Pain Management</b>					
Acupuncture		X <sup>22</sup>			
Pain management medication for persons with terminal illnesses		X, cancer <sup>23</sup>			
General anesthesia for dental procedures performed in hospitals				X <sup>24</sup>	

21 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.

22 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.

23 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.

24 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 B-1. Mandates Addressed in AB 2587, by Strength of Evidence (Cont'd)**

<b>Description</b>	<b>Clear and Convincing Evidence That Test(s) and/or Treatment(s) Are Effective</b>	<b>Preponderance of Evidence That Test(s) and/or Treatment(s) Are Effective</b>	<b>Evidence of the Effectiveness of Test(s) and/or Treatment(s) Is Ambiguous</b>	<b>Insufficient Evidence to Determine Whether Test(s) and/or Treatment(s) Are Effective</b>	<b>Preponderance of Evidence That Test(s) and/or Treatment(s) Are Not Effective</b>
<b>Pediatric Health</b>					
Comprehensive preventive services for children aged 16 years or younger		X, some recommended services <sup>25</sup>		X, some recommended services <sup>26,27</sup>	
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		

25 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.

26 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.

27 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 years 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 B-1. Mandates Addressed in AB 2587, by Strength of Evidence (Cont'd)**

<b>Description</b>	<b>Clear and Convincing Evidence That Test(s) and/or Treatment(s) Are Effective</b>	<b>Preponderance of Evidence That Test(s) and/or Treatment(s) Are Effective</b>	<b>Evidence of the Effectiveness of Test(s) and/or Treatment(s) Is Ambiguous</b>	<b>Insufficient Evidence to Determine Whether Test(s) and/or Treatment(s) Are Effective</b>	<b>Preponderance of Evidence That Test(s) and/or Treatment(s) Are Not Effective</b>
<b>Pediatric Health (cont'd)</b>					
Screening children for blood lead levels				X, children at increased risk	X, children at average risk
<b>Reproductive Health</b>					
Contraceptive devices requiring a prescription	X				
Infertility: diagnosis and treatment	X				
Prenatal diagnosis of genetic disorders		X			
Expanded alpha-fetoprotein screening		X			
<b>Surgical Procedures</b>					
Jawbone and associated bone joints		X <sup>28</sup>			
Reconstructive surgery			X, mastectomy with breast reconstruction <sup>29</sup>	X, clubfoot and craniofacial abnormalities	

28 Temporomandibular joint (TMJ) disorders were the only indication for jaw surgery for which evidence of effectiveness could be located.

29 Evidence was located for only three indications for reconstructive surgery: breast reconstructive following mastectomy, clubfoot, and craniofacial abnormalities.

**Table B-1. Mandates Addressed in AB 2587, by Strength of Evidence (Cont'd)**

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

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