



CALIFORNIA
HEALTH BENEFITS REVIEW PROGRAM

EXECUTIVE SUMMARY

Analysis of Assembly Bill 754: Durable Medical Equipment

A Report to the 2009-2010 California Legislature
June 24, 2010

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EXECUTIVE SUMMARY

California Health Benefits Review Program Analysis of Assembly Bill 754

The California Senate Committee on Health requested on April 23, 2010, that the California Health Benefits Review Program (CHBRP) conduct an evidence-based assessment of the medical, financial, and public health impacts of Assembly Bill (AB) 754, a bill that would impose a health benefit mandate on health insurance regulated by the California Department of Managed Care (DMHC)¹ or the California Department of Insurance (CDI). AB 754 would require DMHC-regulated health plans and CDI-regulated insurers² to provide coverage for durable medical equipment (DME) and provide it in parity with coverage for other health benefits.

Potential Effects of Health Care Reform

On March 23, 2010, the federal government enacted the Federal Patient Protection and Affordable Care Act (PPACA), which was amended by the Health Care and Education Reconciliation Act (H.R.4872) that President Obama signed into law on March 30, 2010. There are provisions in PPACA that go into effect by 2014 that would affect the California health insurance market and its regulatory environment. For example, the law would establish state-based health insurance exchanges, with minimum benefit standards, for the small-group and individual markets. How these provisions are implemented in California would largely depend on regulations to be promulgated by Federal agencies, and statutory and regulatory actions to be undertaken by the California State government.

There are also provisions in PPACA that go into effect within the short term (e.g., within 6 months of enactment), that would expand the number of Californians obtaining health insurance and potentially affect their sources of insurance. For example, one provision would allow children to enroll in their parent's health plan or policy until they turn 26 years of age (effective 6 months following enactment). This may decrease the number of uninsured and/or potentially shift those enrolled with individually purchased insurance to group-purchased insurance. Given the uncertainty surrounding implementation of these provisions and given that PPACA was only recently enacted, the potential effects of these short-term provisions are not taken into account in the baseline estimates presented in this report. CHBRP's analysis of specific mandate bills typically address the marginal effects of the mandate bill—specifically how the state mandate would affect coverage, utilization, costs, and the public health, holding all other factors constant. There are specific requirements under PPACA that would affect the marginal impacts of AB 754 as estimated in this report. PPACA would prohibit California plans and policies from imposing lifetime limits on coverage (effective 6 months following enactment.). Therefore, AB 754's provisions to prohibit lifetime limits would be superseded by the federal legislation and would

¹ The DMHC was established in 2000 to enforce the Knox-Keene Health Care Service Plan of 1975; see Health and Safety Code, Section 1340.

² The CDI licenses "disability insurers." Disability insurers may offer forms of insurance that are not health insurance. This report considers only the impact of the benefit mandate on health insurance policies, as defined in Insurance Code, Section 106(b) or subdivision (a) of Section 10198.6.

have no effect on cost. PPACA would prohibit California plans and policies from imposing restrictive annual limits on coverage (effective 6 months after enactment). The U.S. Secretary of the Department of Health and Human Services is to define what “restrictive” means before the effective date. Beginning in 2014, use of annual limits is prohibited for all plans. The potential effects of AB 754 as presented in this report, could be altered, depending on the level at which the Secretary determines annual limits to be “restrictive.”

Analysis of AB 754

Approximately 19.5 million Californians (51%) have health insurance that may be subject to a health benefit mandate law passed at the state level. Of the rest of the population, a portion is uninsured, and therefore not affected by health insurance benefit mandate laws. Others have health insurance not subject to health insurance benefit mandate laws. Uniquely, California has a bifurcated system of regulation for health insurance subject to state level benefit mandate law. DMHC regulates health care service plans that offer coverage for benefits to their enrollees through health care service plan contracts. CDI regulates health insurers that offer coverage for benefits to their enrollees through health insurance policies.

“DME” commonly references external, reusable items used in the treatment of a medical condition or injury or to preserve a patient’s function. Hundreds of items are commonly referred to as DME and covered through an enrollee’s health insurance, providing that the enrollee’s plan or policy includes a DME benefit.

A definition of DME in California statute or regulation does not explicitly exist.^{3, 4} AB 754 would define DME as “equipment that is used for the treatment of a medical condition or injury or to preserve the patient’s functioning and that is designed for repeated use and includes, but is not limited to, manual and motorized wheelchairs, scooters, oxygen equipment, crutches, walkers, electric beds, shower and bath seats, and mechanical patient lifts.” Broadly interpreted, this definition could include, beyond the listed nine items, many items traditionally excluded from DME benefit coverage, such as external prostheses and orthotics (such as shoe inserts), hearing aids, or eye glasses. On the other hand, a narrow interpretation could exclude items frequently covered through a DME benefit but that do not precisely fit the definition provided in AB 754, such as liquid or gaseous oxygen, enteral or parenteral formulae, or any of a host of miscellaneous supplies, such as sterile syringes or lubricants for ostomy equipment.

For this analysis, CHBRP has defined DME as the more than 1,000 codes in the Healthcare Common Procedure Coding System (HCPCS) categorized as DME. However, it should be noted alternate interpretations of the mandate language could expand or contract what is considered “DME.”

AB 754 would require that enrollees with health insurance regulated by the DMHC or CDI have DME coverage and have coverage at the same level or “at parity” with other health care benefits. DMHC-regulated health plans would be required to ensure that “the amount of the benefit for

³ Personal communication with S. Lowenstien, DMHC, June 2010.

⁴ Personal communication with B. Hinze, CDI, June 2010.

DME and services shall be no less than the annual and lifetime benefit maximums applicable to the basic health care services.”⁵ If the plan has no annual or lifetime maximum benefit limits for basic health care services, it would not be allowed to apply such limits to the DME benefit. DMHC-regulated plans would also be required to ensure that cost sharing (copayments, coinsurance, deductibles, and maximum out-of-pocket amounts) be no more than the most common amounts applied by the plan for basic health care services. CDI-regulated policies would be required to ensure that benefit limits are no less than the “annual and lifetime benefit maximums applicable to all benefits in the policy.” In addition, these policies would be required to provide DME with cost-sharing levels on par with those applied to the “most common amounts contained in the policy.”

AB 754 would not alter health plans’ and insurers’ ability to “conduct a utilization review to determine medical necessity prior to authorizing these services.” Medically necessary DME is usually considered to be equipment that treats an injury or preserves functioning. For example, equipment that would be solely used for the patient’s comfort or convenience (such as air conditioners) would not generally be considered medically necessary, but specialized wheelchair cushions to prevent pressure ulcers would be considered necessary.

Medical Effectiveness

- There are two major groups of persons who use DME:
 - Persons who use DME temporarily while being treated for an injury or illness or recovering from surgery
 - Persons who use DME on a long-term basis due to a physical disability or chronic illness
- For persons in either group, use of DME can improve health, functioning, and quality of life.
- CHBRP’s analysis of DME utilization among persons with privately funded health insurance in 2008 concluded that persons with the following diseases and conditions have the highest out-of-pocket costs for DME. Most persons with these diagnoses use DME on a long-term basis.
 - Persons with diagnoses related to physical disabilities
 - Persons with sequelae from traumatic injuries such as spinal cord injuries and head trauma

⁵ Pursuant to Section 1368.2 of the Health & Safety Code and Section 1300.67 of the California Code of Regulations, DMHC-regulated Plans are required to cover medically necessary “basic health care services,” including: (1) Physician services; (2) Hospital inpatient services and ambulatory care services; (3) Diagnostic laboratory and diagnostic and therapeutic radiologic services; (4) Home health services; (5) Preventive health services; (6) Emergency health care services, including ambulance and ambulance transport services, out-of-area coverage and ambulance transport services provided through the “911” emergency response system; (7) Hospice care.

- Persons with respiratory diseases and related conditions
- Persons with diagnoses related to the digestive system
- DME encompasses such a wide range of devices and products that a systematic review of the literature on the effectiveness of all of these devices and products was not feasible.
- The medical effectiveness portion of this analysis addresses the following question: “Does health insurance coverage for DME affect use of DME or health outcomes for persons with conditions for which DME is commonly used?”
- There is insufficient evidence to assess the impact of health insurance coverage for DME on use of DME and health outcomes for persons who use DME.
 - The few studies that have been conducted suggest that need is the primary factor associated with use of DME.
 - No studies were found that specifically address the effects of increasing annual or lifetime limits for DME coverage on DME usage or the impact of reducing deductibles, coinsurance, or copayments for DME on such usage.
 - No studies were found that address the impact of coverage for DME on health outcomes.

Utilization, Cost, and Coverage Impacts

In order to define DME for this analysis, CHBRP reviewed codes from the HCPCS categorized as DME and removed codes related to items of DME for which benefit coverage is already mandated.

Table 1 summarizes the estimated benefit coverage, utilization, and cost impacts of AB 754.

Coverage Impacts

- Total net annual expenditures are estimated to increase by \$135,933,000 annually, or 0.18%.
- *Coverage for DME:* Prior to the mandate, approximately 93.32% of enrollees with health insurance subject to the mandate have at least some coverage for DME.
 - *Coverage with annual limits:* Approximately 33.16% of enrollees who have some coverage for DME are subject to an annual benefit limit. When present, average annual benefit limits range from \$1,960 to \$3,088 among CDI-regulated policies (large group, small group, and individual markets) and from \$2,418 to \$2,751 among DMHC-regulated plans (large group, small group, and individual markets).
 - For health benefits other than DME, annual limits are uncommon and are much less restrictive when present. CHBRP estimates that 0.6% of enrollees in the group market and 0.1% of enrollees in the individual market have health insurance with annual

limits for health benefits other than DME. When applicable, annual limits that enrollees may face for other health care benefits average \$70,000 for group policies and \$100,000 for individually purchased policies.

- *Coverage with lifetime limits:* CHBRP estimates that no plans or policies currently have a lifetime maximum specific to DME. AB 754 would prohibit any plans/or policies from introducing such limits in the future.
 - Post-mandate, all of these enrollees would have DME benefits compliant with AB 754, which would frequently mean lower cost sharing levels and fewer (or much higher) annual benefit limits for DME.
- Post-mandate, the 1,301,462 (6.68%) of enrollees previously without DME coverage would gain DME benefits compliant with AB 754.

Utilization Impacts

- Post-mandate, CHBRP estimates that there would be a \$52.01 (6.99%) per DME user per year increase in DME utilization and related expenses.
 - An increase in DME utilization and related expenses is anticipated for two reasons: (1) about 1,301,462 enrollees (6.68% of current enrollees) will have new benefit coverage and so could access more DME and/or more expensive DME post-mandate; and (2) similarly, enrollees who had coverage subject to annual limits may access more DME or more expensive DME when these limits are increased or removed.
 - Such a limited increase in DME utilization and related expenses is expected for four reasons: (1) prior to the mandate, most enrollees (93.32%) have some coverage for DME; (2) content experts indicate that people in need of DME access it regardless of benefit coverage—this suggests that AB 754 would be more likely to produce cost shifts from users to plans and insurers, rather than changes in DME utilization; (3) AB 754 would not affect plans' and insurers' ability to use medical necessity criteria in making coverage determinations for DME; and (4) AB 754 would not prevent plans and insurers from altering benefit structures to make DME more frequently subject to coinsurance.

Cost Impacts

- *Premiums:* The mandate is estimated to increase premiums by \$276,306,000. The distribution of the impact on premiums is as follows:
 - Total premiums for private employers are estimated to increase by \$161,681,000, or 0.37%.
 - Enrollee contributions toward premiums for group insurance are estimated to increase by \$50,314,000, or 0.39%.
 - Total premiums for those with individually purchased insurance are estimated to increase by \$64,311,000, or 1.07%.
 - Total premium expenditures for CalPERS HMOs would not increase because the DME coverage is already compliant with the mandate.

- *Expenditures:* State expenditures for Medi-Cal HMOs and the Healthy Families program would not increase because the DME coverage is already compliant with AB 754.
- In terms of per member per month (PMPM) costs, total premiums are expected to increase by \$0.50 and \$1.01 (large groups), \$0.96 and \$2.94 (small groups), and \$1.13 and \$5.13 (individually purchased insurance) for CDI-regulated policies and DMHC-regulated plans, respectively.
 - Post-mandate, many enrollees using DME would see a decrease in expenses.
 - Enrollees with DME coverage that became compliant with AB 754 would see a decrease in out-of-pocket expenses for covered benefits of \$113,769,000 due to required reductions in cost sharing and removal of annual DME benefit limits.
 - Enrollees who gained DME coverage would see a decrease in expenses of \$26,604,000.

Indirect Impacts

- *Shift of costs resulting from a lack of coverage:* enrollees in DMHC-regulated plans and CDI-regulated policies may have alternate sources for items of DME or additional sources of coverage for DME.
 - Some enrollees may be provided some items of DME by private or public programs, such as a charitable foundation or the California Department of Rehabilitation (CDOR). CHBRP is unable to estimate the extent to which distribution of DME items to enrollees may occur and so is unable to estimate the scope of cost reduction that could be expected. However, should AB 754 require an expansion of DME coverage, some cost reduction would be expected for programs providing items of DME.
 - Some enrollees may have DME coverage from a “secondary payer” for expenses related to medically necessary DME items and services. For example, a Department of Health Care Services (DHCS) summary received by CHBRP indicated that \$5,929,485.12 in DME-related expenses were paid in 2008 for Medi-Cal Fee for Service (FFS) beneficiaries who also had privately funded health insurance. DHCS was unable to identify what portion of the privately funded health insurance was regulated by the DMHC or CDI (as opposed to health insurance subject only to federal regulation), Therefore, CHBRP is unable to estimate the scope of cost reduction that could be expected for DHCS. However, some reduction would be expected for DHCS and other programs acting as “secondary” payers, should AB 754 require an expansion of DME coverage.
- *Impact on the uninsured:* The 1.41% premium increases among DMHC-regulated individual market plans estimated as a result of AB 754 may result in approximately 1,214 newly uninsured persons.

Public Health Impacts

- The health outcomes associated with the use of DME vary according to the type of DME that is being used. Some health outcomes include increased independence, mobility, functionality, survival, and decreased morbidity.
- AB 754 is not expected to affect the number of DME users, but is expected to increase the amount of DME used by each current DME user. The impact on health outcomes of this increase is unknown. There will be a reduction in administrative and financial burden for 72,000 newly covered DME users as well as for the 556,000 DME users with an increase in their scope of DME coverage.
- Existing data on utilization of DME and DME-related expenses indicate that there are no significant differences by gender or race/ethnicity. Therefore, AB 754 is not expected to have an impact on gender or racial disparities in health status.
- Although some types of DME, such as home oxygen equipment and parenteral nutrition (IV nutrition), are necessary for survival, AB 754 is not expected to affect the utilization of these types of DME. Therefore, AB 754 is not expected to lead to a reduction in premature death.
- Researchers have estimated that many of the health conditions associated with DME utilization have substantial societal costs. The impact of AB 754 on the economic loss associated with all DME-related diseases and conditions is unknown.

Table 1. AB 754 Impacts on Benefit Coverage, Utilization, and Cost, 2010

	Before Mandate	After Mandate	Increase/ Decrease	Change After Mandate
Benefit Coverage				
Total enrollees with health insurance subject to state-level benefit mandates (a)	19,487,000	19,487,000	0	0.00%
Total enrollees with health insurance subject to AB 754	19,487,000	19,487,000	0	0.00%
Percentage of enrollees in plans/policies with coverage for DME				
AB 754-compliant (b)	40.50%	100.00%	59.50%	146.94%
Non-AB 754-compliant (c)	52.83%	0.00%	-52.83%	-100.00%
Total with DME coverage	93.32%	100.00%	6.68%	7.16%
Percentage of enrollees in plans/policies with no coverage for DME				
Total without DME coverage	6.68%	0.00%	-6.68%	-100.00%
Total	100.00%	100.00%	0.00%	0.00%
Number of enrollees in plans/policies with coverage for DME				
AB 754-compliant	7,891,401	19,487,000	11,595,599	146.94%
Non-AB 754-compliant	10,294,137	0	-10,294,137	-100.00%
Total with DME coverage	18,185,538	19,487,000	1,301,462	7.16%
Number of enrollees in plans/policies with no coverage for DME				
Total without DME coverage	1,301,462	0	-1,301,462	-100.00%
Total	19,487,000	19,487,000	0	0.00%
Utilization and Cost				
Estimated DME users per 1,000 enrollees per year	55	55	0	0.00%
Estimated average cost per DME user per year	\$743.56	\$795.57	\$52.01	6.99%
DME Benefit Provisions				
Average DME coinsurance rate	13.61%	3.24%	-10.37%	-76.18%
% of enrollees with DME coverage subject to annual benefit limit	33.16%	0.00%	-33.16%	-100.00%
Average annual benefit limit in non-AB 754-compliant plans/policies	\$3,187	N/A		
% of enrollees in non-AB 754-compliant plans/policies with enrollee expenses in excess of DME annual benefit limit	0.15%	0.00%	-0.15%	-100.00%
% of DME users in non-AB 754-compliant plans/policies with enrollee expenses in excess of DME annual benefit limit	2.73%	0.00%	-2.73%	-100.00%
Number of DME users in non-AB 754-compliant plans/policies with enrollee expenses in excess of DME annual benefit limit	15,453	0	-15,453	-100.00%

Table 1. AB 754 Impacts on Benefit Coverage, Utilization, and Cost, 2010 (Cont'd)

	Before Mandate	After Mandate	Increase/ Decrease	Change After Mandate
Expenditures				
Premium expenditures by private employers for group insurance	\$43,519,324,000	\$43,681,005,000	\$161,681,000	0.37%
Premium expenditures for individually purchased insurance	\$5,992,795,000	\$6,057,106,000	\$64,311,000	1.07%
Premium expenditures by persons with group insurance, CalPERS, Healthy Families, AIM or MRMIP (d)	\$12,820,614,000	\$12,870,928,000	\$50,314,000	0.39%
CalPERS HMO employer expenditures (e)	\$3,267,842,000	\$3,267,842,000	\$0	0.00%
Medi-Cal HMOs state expenditures	\$4,015,596,000	\$4,015,596,000	\$0	0.00%
Healthy Families Program state expenditures (f)	\$910,306,000	\$910,306,000	\$0	0.00%
Enrollees' out-of-pocket expenses for covered benefits (deductibles, copayments, etc.)	\$5,961,186,000	\$5,847,417,000	-\$113,769,000	-1.91%
Enrollees expenses for noncovered benefits (g)	\$26,604,000	\$0	-\$26,604,000	-100.00%
Total annual expenditures	\$76,514,267,000	\$76,650,200,000	\$135,933,000	0.18%

Source: California Health Benefits Review Program, 2010.

Notes: Small discrepancies in numbers among Tables 1, 5, and 6 are due to rounding.

(a) This population includes privately insured (group and individual) and publicly insured (e.g., CalPERS HMOs, Medi-Cal HMOs, Healthy Families Program, AIM, MRMIP) enrolled in health insurance products regulated by the DMHC or CDI. Population includes enrollees aged 0-64 years and enrollees 65 years or older covered by employment-sponsored insurance.

(b) AB 754-compliant plans have *no* annual benefit limits and *no* different cost sharing for DME benefits than for other health care benefits.

(c) Non-AB 754-compliant plans/policies do have differential benefit limits and/or do have different cost sharing for DME benefits than for other health care benefits.

(d) Premium expenditures by individuals include employee contributions to employer-sponsored health insurance and member contributions to public insurance.

(e) Of the CalPERS HMO employer expenditures, about 59% would be state expenditures for CalPERS members who are state employees, however CHBRP estimates no impact because CalPERS HMO is already compliant with the mandate.

(f) Healthy Families Program state expenditures include expenditures for 7,000 covered by the MRMIP and 7,000 covered by the AIM program.

(g) Some portion of these expenses may have been covered, prior to the mandate, by a state or federal program. For example, some enrollees in DMHC-regulated plans and CDI-regulated policies may also be beneficiaries of Medi-Cal, which could be a secondary payer for DME and related health services. Although CHBRP is unable to estimate a dollar figure, AB 754's expansion of DME coverage could result in a shift of some costs from such programs to plans and insurers.

Key: AIM=Access for Infants and Mothers; CalPERS HMOs=California Public Employees' Retirement System Health Maintenance Organizations; MRMIP=Major Risk Medical Insurance Program; CDI=California Department of Insurance; DMHC=Department of Managed Health Care.

Acknowledgements

This report provides an analysis of the medical, financial, and public health impacts of Assembly Bill 754, a bill to mandate the coverage of durable medical equipment at parity with other benefit coverage. In response to a request from the California Senate Committee on Health on April 23, 2010, the California Health Benefits Review Program (CHBRP) undertook this analysis pursuant to the program's authorizing statute.

Edward Yelin, PhD, Janet Coffman, MPP, PhD, and Mi-Kyung (Miki) Hong, MPH, all of the University of California, San Francisco, prepared the medical effectiveness analysis. Stephen L. Clancy, MLS, AHIP, of the University of California, Irvine, conducted the literature search. Helen Halpin, ScM, PhD, Sara McMenamain, PhD, and Nicole Bellows, PhD, all of the University of California, Berkeley, prepared the public health impact analysis. Robert Kaplan, PhD, and Dasha Cherepanov, PhD, both of the University of California, Los Angeles, prepared the cost impact analysis. Robert Cosway, FSA, MAAA, of Milliman, provided actuarial analysis. Joan Waranoff, MS, MBA, formerly of Blue Shield of California (retired) and Patricia L. Sinnott, PT, PhD, MPH, of the VA, Palo Alto Health Care System provided technical assistance with the literature review and expert input on the analytic approach. John Lewis, MPA, Susan Philip, MPP, and David Guarino, all of CHBRP staff prepared the background section and synthesized the individual sections into a single report. Sarah Ordódy provided editing services. A subcommittee of CHBRP's National Advisory Council (see final pages of this report) and a member of the CHBRP Faculty Task Force, Wayne Dysinger, MD, MPH, of Loma Linda University, reviewed the analysis for its accuracy, completeness, clarity, and responsiveness to the Legislature's request.

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

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California Health Benefits Review Program Committees and Staff

A group of faculty and staff undertakes most of the analysis that informs reports by the California Health Benefits Review Program (CHBRP). The CHBRP **Faculty Task Force** comprises rotating representatives from six University of California (UC) campuses and three private universities in California. In addition to these representatives, there are other ongoing contributors to CHBRP from UC. This larger group provides advice to the CHBRP staff on the overall administration of the program and conducts much of the analysis. The **CHBRP staff** coordinates the efforts of the Faculty Task Force, works with Task Force members in preparing parts of the analysis, and coordinates all external communications, including those with the California Legislature. The level of involvement of members of the CHBRP Faculty Task Force and staff varies on each report, with individual participants more closely involved in the preparation of some reports and less involved in others. As required by CHBRP's authorizing legislation, UC contracts with a certified actuary, Milliman Inc., to assist in assessing the financial impact of each legislative proposal mandating or repealing a health insurance benefit. Milliman also helped with the initial development of CHBRP methods for assessing that impact.

The **National Advisory Council** provides expert reviews of draft analyses and offers general guidance on the program to CHBRP staff and the Faculty Task Force. CHBRP is grateful for the valuable assistance and thoughtful critiques provided by the members of the National Advisory Council. However, the Council does not necessarily approve or disapprove of or endorse this report. CHBRP assumes full responsibility for the report and the accuracy of its contents.

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