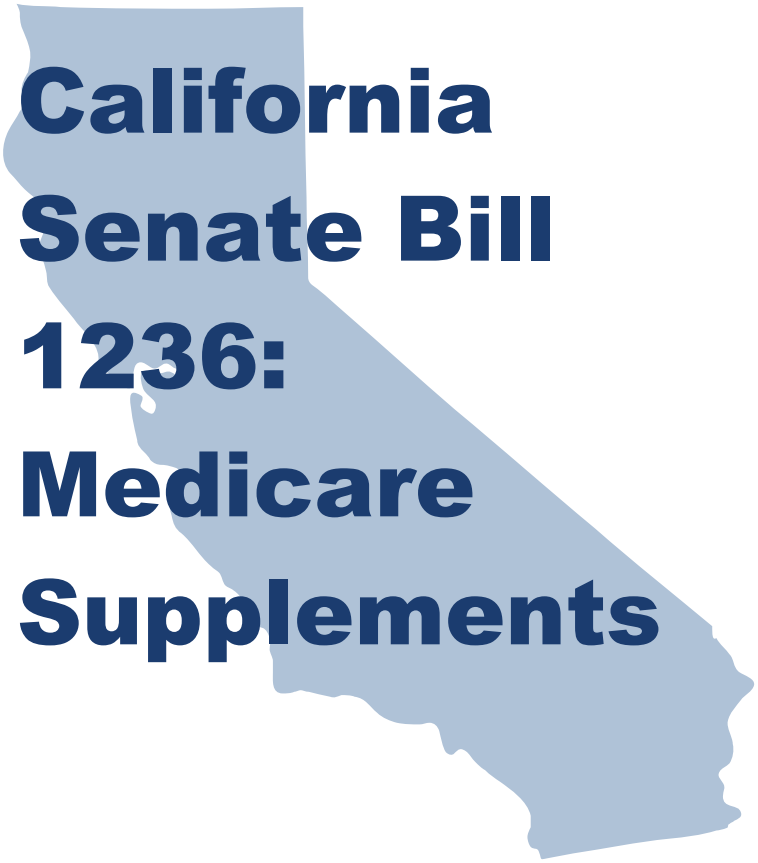
Abbreviated Analysis

California Senate Bill 1236: Medicare Supplements



Report to the 2023–2024
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CHBRP

California Health Benefits Review Program (CHBRP), Office of Research, University of California, Berkeley

www.chbrp.org

Revision History

Date	Description of Revisions
04/18/24	The national source (NAIC, 2021) initially used to estimate Californians enrolled in Medicare Supplement plans and policies did not take into account California's uniquely divided regulatory system for health insurance. It estimated only enrollment in Medicare Supplement policies regulated by the California Department of Insurance (CDI). This revision also uses information on Californians enrolled in Medicare Supplement plans regulated by the Department of Managed Health Care (DMHC), available through the DMHC "Enrollment Summary Report – 2023."[1]

[1] https://www.dmhc.ca.gov/DataResearch/FinancialSummaryData.aspx

Summary

The California Senate Committee on Health requested that the California Health Benefits Review Program (CHBRP).[2] conduct an abbreviated analysis of the financial impacts of California Senate Bill 1236, Medicare Supplements. SB 1236 would require two periods of open enrollment for Medicare Supplemental Insurance: (1) the 6-month period beginning with the first day of the month in which a beneficiary first enrolled for benefits under Medicare Part B; and (2) an annual 90-day period beginning each January 1. The second would be a new requirement. SB 1236 would also prohibit both pricing discrimination and denial/condition of issuance/effectiveness of the Medicare Supplement coverage contract based on applicant health status, claims experience, receipt of health care, medical condition, or age of applicant. The last would be a new prohibition.

The Medicare Program is a federal public health insurance program for persons 65 years of age and older and specified persons with disabilities who are under 65 years of age. Federal law provides for the issuance of Medicare supplement policies or certificates, also known as Medigap coverage, which are advertised, marketed, or designed primarily as a supplement to reimbursements under the Medicare Program, including coverage of applicable deductible, copayment, or coinsurance amounts. This analysis projects the potential impacts of SB 1236 on estimated baseline premiums and enrollment in Medicare Supplement policies and plans regulated by the California Department of Insurance (CDI) or the Department of Managed Health Care (DMHC). The predicted increases in Medicare Supplement premiums due to SB 1236 are driven by what is commonly known as adverse selection. Adverse selection occurs when lower cost or healthier patients forego buying insurance until they need it, while higher cost or sicker patients actively buy insurance to protect them from risk. This imbalance in enrollment results in fewer lower cost or healthier enrollees and a greater number of higher cost or sicker enrollees in insurance products. The higher use of services by higher cost or sicker patients causes premiums to increase.

Analytic Approach and Key Assumptions

For this analysis, CHBRP has assumed that postmandate, premiums for Medicare Supplement insurance will be community rated without regard for age of the applicant, which contrasts to typical Medicare Supplement premium prices in California at baseline, which are based on attained age.

The people most likely to take advantage of the new open enrollment period, guaranteed issue coverage, and community-rated premiums are new enrollees with higher health care costs and perceived needs due to chronic illness, cancer, or injuries requiring rehabilitative skilled nursing services. These enrollees may have been denied Medicare Supplement coverage before or faced waiting periods or specific exclusions based on their individual characteristics (e.g., pre-existing conditions, receipt of health care, health status, age). However, there is also a group of eligible people who would take advantage of the new, annual open enrollment opportunities by cancelling their current Medicare Supplement or deciding not to purchase a Medicare Supplement, and waiting until they need services to enroll. Healthier, lower cost Medicare beneficiaries could cancel their Medicare supplemental insurance for two reasons: 1) premiums will increase, and they will decide they don't want to pay the higher premiums; or 2) they can now purchase a guaranteed-issue policy during a future open enrollment period when they perceive a need for the additional coverage. These people would be eligible for coverage but would save money by not enrolling and not paying premiums in a Medicare Supplement, whereas those enrolled in the Medicare Supplement postmandate would be those most likely to use services and incur cost sharing that would be covered by the Medicare Supplement policy. The claims

[2] Refer to CHBRP's full report for full citations and references.

experience of enrollees in the Medicare Supplement would be higher than under current law, resulting in higher premiums for those enrolled in the Medicare Supplement. Those higher premiums would act as a further impediment to healthy, lower cost people enrolling in the policy, resulting in further adverse selection and premium increases.

Enrollment and Premium Impacts

Postmandate, the number of enrollees in Medicare Supplement policies will decrease from 1,131,751 to 1,027,251, a 9% decrease. Overall, the average monthly premiums for Medicare Supplement will increase from $239.03 to $319.04 per member per month (PMPM), a 33% increase, because the average new enrollees in Medicare Supplements will use more services than the average enrollee at baseline. The new entrants to the Medicare Supplement market are likely to be higher cost enrollees, and they will displace lower cost enrollees who find it advantageous to disenroll from their Medicare Supplement rather than pay higher premiums to continue their coverage postmandate. The new entrants will include people who were denied Medicare Supplement coverage in the past, or faced waiting periods or specific exclusions, who will have a new opportunity to enroll when the new open enrollment opportunities are expanded by SB 1236. Some high-cost, high-need patients may be in Medicare Advantage plans currently but will move to traditional Medicare with a Medicare Supplement to improve their ability to seek out care from more providers that may not be in their current Medicare Advantage network.

Other Considerations

It is possible that SB 1236 will result in insurers leaving the Medicare Supplement market in California due to the expanded open enrollment period and community-rated premiums, resulting in fewer choices for Californians with traditional Medicare.

Policy Context

The Senate Committee on Health has requested that the California Health Benefits Review Program (CHBRP)[3] conduct an abbreviated analysis of the financial impacts of SB 1236, Medicare Supplements.

Beneficiaries of Medicare, a Federal health insurance program, can include persons 65 years of age and older and persons with disabilities under 65 years of age, as well as people with end-stage renal disease (permanent kidney failure, sometimes called ESRD, requiring dialysis or a transplant). Medicare includes several parts, including Parts A (Hospital Insurance), and Part B (Medical Services). Part A covers inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care. Part B covers outpatient care, some doctors' services, medical supplies, and preventive services. Medicare Part D (prescription drug coverage) helps cover the cost of prescription drugs (including many recommended shots or vaccines). Medicare's benefit design includes substantial cost-sharing requirements in the form of deductibles, copays, and coinsurance, with no limit on out-of-pocket spending in traditional Medicare (Parts A and B). To help with these expenses and to limit their exposure to catastrophic out-of-pocket costs for Medicare-covered services, beneficiaries in traditional Medicare may secure enrollment in a Medicare Supplement (also known as Medigap), a form of private health insurance. Medicare Supplement benefits were standardized through the Federal Omnibus Budget Reconciliation Act of 1990. By spreading enrollee costs over the course of the year (through monthly premium payments), Medicare Supplement can make health care costs more predictable.

Medicare Part C, also known as Medicare Advantage (MA), is also a form of private health insurance. It offers an alternative to traditional Medicare for health and drug coverage and includes all Part A (Hospital Insurance) and Part B (Medical Insurance) coverage. Medicare Part C may also offer additional coverage, such as: Vision, Hearing, Dental, Health and wellness programs, and Medicare prescription drug coverage (Part D). Medicare Advantage plans often have caps on out-of-pocket spending, which provide additional financial protection when compared to traditional Medicare. Medicare Advantage is very popular in California, with 55% of Medicare beneficiaries enrolled in a Medicare Advantage Plan (KFF, 2023).Medicare Advantage enrollees typically do not need a separate Medicare Supplement.

Existing California law[4] places requirements on Medicare Supplement plans and policies that are regulated by the California Department of Insurance (CDI) or the California Department of Health Care Services (DMHC). SB 1236 would also place requirements on these plans and policies. SB 1236 would require two periods of open enrollment for Medicare Supplemental Insurance: (1) the 6-month period beginning with the first day of the month in which a beneficiary first enrolled for benefits under Medicare Part B; and (2) an annual 90-day period beginning each January 1. The second would be a new requirement. SB 1236 would also prohibit both pricing discrimination and denial/condition of issuance/effectiveness of the Medicare Supplement coverage contract based on applicant health status, claims experience, receipt of health care, medical condition, or age of applicant. The last would be a new prohibition.

The full text of SB 1236 can be found in Appendix A.

[3] CHBRP's authorizing statute is available at www.chbrp.org/about/faqs.
[4] HSC 1358.11 and INS 10192.91.

Points of alignment and variation between the existing state law and SB 1236 are noted below, in Table 1.

Table 1. Alignment and Variation Between Existing State Law* and SB 1236

Issue	Existing State Law* Requires	SB 1236 Would Require
Open Enrollment – alignment	During the 6-month period beginning with the first day of the first month in which a person is both 65 years of age or older and is enrolled for benefits under Medicare Part B.	During the 6-month period beginning with the first day of the first month in which a person is both 65 years of age or older and is enrolled for benefits under Medicare Part B.
Open Enrollment – variation	Six months following any of the following: (1) termination of employer sponsored plan/policy or loss of eligibility due to divorce or death of spouse; (2) termination of health care services for a military retiree or eligible spouse/dependent as a result of military base closure or beneficiary relocation. Sixty days following: (1) beneficiary relocation to a location not served by the plan/policy; (2) issuer termination of the plan/policy; (3) beneficiary loss of Medi-Cal eligibility. Annual 60-day open enrollment period commencing with the beneficiary's birthday – for a plan/policy of equal or lesser value.	Annual 90-day open enrollment period beginning each January 1.
Prohibitions – alignment	Prohibits denial/condition of issuance/effectiveness based on applicant health status, claims experience, receipt of health care, or medical condition.	Prohibits denial/condition of issuance/effectiveness based on applicant health status, claims experience, receipt of health care, or medical condition.
Prohibitions – variation		Prohibits denial/condition of issuance/effectiveness based on applicant age.

Source: California Health Benefits Review Program, 2024.
Note: * HSC 1358.11 and INS 10192.91.

Requirements in Other States

Connecticut, Massachusetts, Maine, New York (Boccuti et al., 2018), Rhode Island (Rhode Island Office of the Health Insurance Commissioner, 2023), and Vermont (Ball, 2023) require either continuous or annual guaranteed issue protections for Medicare Supplement for all beneficiaries in traditional Medicare ages 65 years and older, regardless of medical history. Minnesota has passed a similar law that will be in effect in 2025 (Minesota Legislature, 2023). Guaranteed issue protections prohibit insurers from denying a Medicare Supplement to eligible applicants, including people with pre-existing conditions, such as diabetes and heart disease.

In the last session, Hawai‘i considered a similar bill that did not pass (Hawai‘i Legislature, 2023).

Impacts

As discussed in the *Policy Context* section, SB 1236 would require Medicare Supplement plans and policies regulated by the Department of Managed Health Care (DMHC) or the California Department of insurance (CDI) to offer two annual open enrollment periods for Medicare Supplement products, during which the insurance carriers would be prohibited from discriminating in the pricing of monthly premiums or denying applicants for pre-existing conditions due to age, applicant health status, claims experience, receipt of health care, or medical condition.

SB 1236 is unlikely to impact Medi-Cal beneficiaries. Medicare enrollees who are also enrolled in Medi-Cal already get help with their out-of-pocket Medicare costs from Medi-Cal, where their Part B premiums and related cost sharing for Part B and the cost of benefits not covered by Medicare (e.g., vision, dental) are paid by Medi-Cal. Medicare enrollees who are dually enrolled in Medi-Cal are unlikely to purchase Medicare Supplement coverage because of this existing protection. There may be rare cases of dually eligible enrollees purchasing a separate Medicare Supplement, but it is cost-prohibitive for low-income Medi-Cal enrollees to purchase a Medicare Supplement on their own, given average premiums reach over $2,800 per year. Medicare beneficiaries who are also eligible for Medi-Cal can enroll in Medi-Call at any time and do not need to sign up during a specific open enrollment period.

This section explains the potential impacts of SB 1236 on estimated baseline premiums and enrollment in Medicare Supplement plans and policies. The predicted increases in Medicare Supplement premiums due to SB 1236 are driven by what is commonly known as adverse selection. Adverse selection occurs when lower cost or healthier patients forgo buying insurance until they need it, while higher cost or sicker patients actively buy insurance to protect them from risk. This imbalance in enrollment results in fewer lower cost or healthier enrollees and a greater number of higher cost or sicker enrollees in insurance products. The higher use of services by higher cost or sicker patients causes premiums to increase.

Analytic Approach and Key Assumptions

For the purposes of comparing the baseline Medicare Supplement market to the postmandate Medicare Supplement market, CHBRP has made the following analytic assumptions:

1) Premiums for Medicare Supplement insurance will be community rated rather than based on the applicant's age when the policy is originally issued or based on attained age.[5] Current law prohibits discrimination by health status, claims experience, receipt of health care, or medical condition if a Medicare beneficiary applies during their initial open enrollment period or due to a qualifying event (e.g., moving into a new market). SB 1236 would require the same premium pricing and denial prohibitions as in current law but expand their availability so that Medicare beneficiaries would have annual open enrollment opportunities. In addition, for new applicants during open enrollment, the premium offered to them by a Medicare Supplement insurer will not vary by age. At baseline, initial Medicare Supplement premiums are priced based on the age of the applicant. In subsequent years, the premium is based on the attained age of the enrollee and increases over time. Prohibiting age as a premium pricing factor will make the premium the same for anyone applying to a plan, regardless of age. This will increase the premiums paid by younger people (closer to 65) and decrease premiums paid by older enrollees.

2) The people most likely to enroll postmandate using the new open enrollment period, guaranteed issue coverage, and community-rated premiums are new enrollees with higher health care costs and perceived needs due to chronic illness, cancer, or injuries requiring rehabilitative skilled nursing services. These enrollees may have been denied Medicare Supplement coverage before or faced waiting periods or specific exclusions based on their

[5] Community rating without regard to attained age would further increase adverse selection, which would increase premiums more than the estimates provided in this report. If pure community rating were used, everyone would be charged the same premium regardless of age at issue or age at application.

individual characteristics (e.g., pre-existing conditions, receipt of health care, health status). However, there is also a group of eligible people who would take advantage of the new, annual open enrollment opportunities by cancelling their current Medicare Supplement or not signing up for a plan when they initially enroll in Medicare and waiting until they need services to enroll in a Medicare Supplement. Healthier, lower cost Medicare beneficiaries could cancel their Medicare supplemental insurance for two reasons: 1) their premiums will increase, and they will decide they don't want to pay the higher premiums; or 2) they can now purchase a guaranteed-issue policy during a future open enrollment period when they perceive a need for the additional coverage. CHBRP estimated that 14% of current Medicare supplemental insurance policyholders will leave the Medicare Supplemental market in 2025 (Ortner, 2022). Ortner (2022) analyzed the impact of community rating on the Medicare Supplement in Washington State and estimated that the 16% increase in premiums caused by the shift to community rating would result in the disenrollment of 7% of the current market. However, the report did not predict the impact of new, higher cost enrollees joining the community-rated market during the extended open enrollment period. CHBRP assumed that the disenrollment impact would be double (14%) of that predicted in Washington, given the likely larger increases in premiums due to lower cost people disenrolling and higher cost applicants securing community-rated coverage. The previous enrollees would save money by not paying premiums in a Medicare Supplement, whereas those enrolled in the Medicare Supplement would be those most likely to use services and incur cost sharing that would be covered by the Medicare Supplement policy. The claims experience of enrollees in the Medicare Supplement would be higher than under current law, resulting in higher premiums for those enrolled in the Medicare Supplement. Those higher premiums would act as a further impediment to healthy, lower cost people enrolling in the policy, resulting in further adverse selection and premium increases.

3) CHBRP assumed no additional utilization of services would occur due to new enrollment in Medicare Supplement insurance coverage. Given the Medicare Supplement applicants and enrollees already have existing Medicare coverage, CHBRP focused on the cost sharing that Medicare Supplements would pay for if a Medicare beneficiary obtained new supplemental coverage due to SB 1236. Conversely,

4) Of all Medicare enrollees without supplemental coverage (in both traditional Medicare Parts A/B or in Medicare Advantage), approximately 20% of the enrollees with high health care spending or high-need clinical conditions will opt into a Medicare Supplement during the next open enrollment period postmandate in 2025. A small portion of Medicare beneficiaries opt to change their Medicare Advantage (10%) or Part D Prescription Drug Plan (21%) each year, and CHBRP anticipates that most enrollees will maintain their baseline Medicare Supplement enrollment status, (Fuglesten Biniek et al., 2022). The enrollees likely to opt into or disenroll from a Medicare Supplement are more likely to be in individual market Medicare Supplement products, rather than group market products. The high-need clinical conditions are skilled nursing service use (2.2% of Medicare beneficiaries), lymphoma (1.7%), leukemia (0.3%), and lung cancer (1.3%). High health care spending was defined as spending more than $10,000 (1.1%) each year, after excluding the previously listed categories.[6]

5) CHBRP assumes that the current range of Medicare Supplement options offered by insurance carriers in California will continue to be available in 2025. CHBRP does not estimate the impact of insurance carrier exits from the Medicare Supplement market in 2025 due to SB 1236.

6) CHBRP assumes that the premiums for Medicare Supplements do not vary substantially between the individual and group market or based on the regulatory agency overseeing the insurance policy. CHBRP used premium data from the National Association of Insurance Commissioners (which contains information on monthly premiums in CDI-regulated Medicare Supplements only) to calculate baseline premiums in California for the combined individual and group market. Equivalent premium data was not available for the DMHC-regulated market.

[6] The prevalence of high-need clinical conditions and high health care spending was calculated based on the Medicare 5% National Sample file from the Centers for Medicare & Medicaid Services (CMS) Standard Analytical Files of Medicare Claims.

For further details on the underlying data sources and methods used in this analysis, please see Appendix B.

Baseline and Postmandate Enrollment and Premiums

Below, Table 1 provides estimates of how many Californians have health insurance that could be impacted by SB 1236.

Table 1. SB 1236 Impacts on Medicare Supplement Enrollment, Claim Costs, and Premiums, 2025.

	Baseline (2025)	Postmandate Year 1 (2025)	Increase/ Decrease	Percentage Change
Enrollment numbers[7]				
Medicare supplement	1,131,751	1,027,251	-104,500	-9%
Medicare Advantage, or traditional Medicare without Medicare Supplement	3,988,896	4,093,396	104,500	3%
Claims and premiums				
2025 average monthly claim costs Medicare Supplement market, PMPM	191.23	255.23	64.01	33%
2025 average monthly premiums Medicare Supplement market, PMPM[8]	239.03	319.04	80.01	33%

Source: California Health Benefits Review Program, 2024.
Key: PMPM = per member per month.

The number of enrollees in Medicare Supplement policies will decrease by 104,500 (-9%) postmandate (see Table 1). Overall, the average monthly premiums for Medicare Supplement policies will increase by $64.01 (33%) per member per month (PMPM) due to SB 1236, because new enrollees in Medicare Supplements will use more services than the average enrollee at baseline. The new entrants to the Medicare Supplement market are likely to be higher cost enrollees, and they will displace lower cost enrollees who find it advantageous to disenroll from their Medicare Supplement rather than pay higher premiums to continue their coverage. The new entrants will include people who were denied Medicare Supplement coverage in the past, or faced waiting periods or specific exclusions, who will have a new opportunity to enroll when the new open enrollment opportunities are expanded by SB 1236. Some high-cost, high-need patients may be in Medicare Advantage plans currently but will move to traditional Medicare with a Medicare Supplement to improve their ability to seek out care from more providers that may not be in their current Medicare Advantage network.

Baseline and Postmandate Expenditures

CHBRP provides several subgroup analyses here to illustrate the potential impact of SB 1236 on specific groups with chronic illness, skilled nursing needs, or high costs.

Subgroup Analyses

CHBRP specifically analyzed six subgroups likely to take advantage of the changes proposed by SB 1236. In some cases, the subgroup would be more likely to enroll in a new Medicare Supplement if able due to the relative costs they

[7] The National Association of Insurance Commissioners 2022 Medicare Supplement Loss Ratio Report provided key information on enrollment and premiums by state.
[8] Table 1 provides an estimate of premium pricing and increases due to SB 1236, which would require community rating in Medicare Supplements. Pure community rating would result in all enrollees in a Medicare Supplement paying the same premium, regardless of their actual age. Currently, most Medicare Supplements are priced based on attained age (i.e., the age someone is when the plan renews each year). If the state of California interpreted SB 1236 to allow age-based modified community rating, where an enrollee's premium would be community rated within categories of attained age, CHBRP estimates premiums would increase by 24% rather than the 33% increase estimated based on pure community rating.

pay out of pocket compared to the community rated within attained age categories they would be offered. In the case of lower cost, relatively healthy current enrollees in Medicare Supplements would disenroll from their plan until a future open enrollment period when their relative risk would exceed the premium offered to them. Table 2 provides estimates of the average Medicare Supplemental claim costs for each group and the number of enrollees expected to change their behavior due to SB 1236. The claim cost is the amount paid by an insurance company on behalf of the member. In the case of Medicare Supplements, the insurance company is paying some or most of the cost sharing on behalf of the member that a member would normally pay under traditional Medicare. In these analyses, the actual cost for a specific beneficiary does not change due to their use of services. However, what changes is the amount of money paid by the individual out-of-pocket (as someone who does not have a Medicare Supplement at baseline) or by the Medicare Supplement insurer once the individual opts into coverage due to SB 1236. Medicare Supplements pay for specific noncovered benefits and cost-sharing amounts as the secondary coverage source for people in traditional Medicare.

Table 2. Summary of Claim Costs and Enrollee Movement SB 1236 Postmandate, 2025

Cohorts	Enrollment	Avg. Medicare Supplemental Claim Costs, $
Medicare Supplement enrollees at baseline	1,131,751	191.23
Moving into Medicare Supplement – skilled nursing	17,900	830.85
Moving into Medicare Supplement – lymphoma	13,700	415.56
Moving into Medicare Supplement – leukemia	2,600	526.98
Moving into Medicare Supplement – lung cancer	10,700	770.08
Moving into Medicare Supplement – other high cost	9,000	1,823.52
Moving out of Medicare Supplement – due to premium increases	(158,400)	5.18
Medicare Supplement enrollees – postmandate	1,027,251	255.23

Source: California Health Benefits Review Program, 2024.

The overall number of enrollees in Medicare Supplements in California will decrease by 104,500 postmandate. 158,400 enrollees at baseline would disenroll from their coverage postmandate due to increases in premiums, while there are 53,900 new enrollees who will enroll in Medicare Supplements postmandate. The new enrollees will have higher needs and higher costs than their existing enrollees postmandate. Premandate, the average claim costs for Medicare Supplement enrollees were $191.23 per month. Postmandate, that number increases to $255.23 per month on average, driven by: 1) A relatively small group of enrollees (6.8%) into Medicare Supplement insurance coverage with higher claims (ranging from $415.56 per month in spending by lymphoma patients to $1,823.52 per month in spending from other high-cost patients); and 2) People who are likely to exit the Medicare Supplement market completely are lower cost enrollees, with $5.18 in average claims per month (Table 2).

The changes described above in Table 2 reflect the relative claims experience of many Medicare beneficiaries who first enroll in Medicare Supplement plans at age 65 years when they initially enroll in Medicare, in comparison to applicants who have been unable to access Medicare Supplement insurance coverage due to pre-existing conditions, or higher premiums based on health status, use of health care services, or age.

Individual Examples

Examples are provided below to illustrate how certain enrollees would experience the impacts of SB 1236 differently. All subgroup examples are based on a simplifying assumption that enrollees or applicant are in the individual Medicare Supplement market.

At baseline, people who newly qualify for Medicare use the open enrollment period to enroll in a Medicare Supplement at a lower-than-average monthly premium. These enrollees will typically stay in Medicare Supplement insurance policies in the long term, due to their perceived risk at enrollment or because the Medicare Supplement premium will offset their likely cost sharing each year. Postmandate, many of these enrollees with few high-cost needs will exit the market due to a 113% increase in premiums for their age and health status. Baseline, their premium would have been $150 per month based on their initial age at application of 67, and premiums based on attained age. However, the shift to community rating would mean that all applicants would be offered the same premium without regard to age, increasing the premium to $319. Due to their comparatively good health status, and the perception that they could come back to the market in the future through open enrollment without penalty will result in them disenrolling or turning down the Medicare Supplement due to cost.

By contrast, applicants with skilled nursing needs, cancer diagnoses, or other high-cost needs who face barriers to enrolling in the premandate Medicare Supplement insurance market due to the restricted open enrollment periods, pre-existing condition exclusions, waiting periods, and initial premiums will be allowed to enroll in Medicare Supplement insurance plans postmandate. The higher postmandate premiums ($319.04 on average per month) are lower than the expected out-of-pocket spending the enrollee would expect without Medicare Supplement insurance coverage.

In Example 1, CHBRP provides a scenario faced by a 67-year-old who had already enrolled in a Medicare Supplement insurance policy at open enrollment when they had turned 65 and enrolled in traditional Medicare. At baseline, the enrollee would pay $150 per month based on their attained age of 67 years for a total of $1,800 per year. Their actual cost sharing not covered by their Medicare Supplement is only $240 per year (this is the assumed Part B deductible, which cannot be covered by Medicare Supplement) (Medicare, 2024). Postmandate, because higher cost applicants would enroll in Medicare Supplement and premiums would be the same for everyone enrolled in the plan regardless of age, the premium paid by the 67-year-old enrolled at baseline would increase by $2,030 per year (113%).

Example 1. 67-Year-Old Enrolled in Medicare Supplement at Baseline

Category	Baseline	Postmandate Year 1 (2025)	Increase/ Decrease	Percentage Change
Annual premiums	$1,800	$3,830	$2,030	113%
Annual cost sharing	$240	$240	—	0%
Total patient costs	$2,040	$4,070	$2,030	100%

Table Notes: Assumes member is enrolled in Plan G postmandate, with baseline premiums of $150/month and an average postmandate premium of $319.

Example 2 provides a profile of an applicant who is enrolled in traditional Medicare with no supplemental coverage and is being treated for cancer. At baseline, they do not pay any premiums because they cannot find a Medicare Supplement that will accept them with their cancer diagnosis, resulting in $9,500 in out-of-pocket spending related to use of their traditional Medicare (Part A/B) benefits. In traditional Medicare, there is no out-of-pocket maximum, and in Part B, coinsurance is 20%. Postmandate, the ability to enter the Medicare Supplemental market and enroll in a plan would save the 67-year-old cancer patient $5,430 per year (57%) overall because their out-of-pocket spending related to cost sharing would decrease by $9,260 per year, and their premiums for a Medicare Supplement would be $3,830 per year. In this example, the limits of a Medicare Advantage plan's provider network may mean that a Medicare Supplement is a more attractive option for the enrollee.

Example 2. 67-Year-Old Cancer Patient Enrolled in Traditional Medicare

Category	Baseline	Postmandate Year 1 (2025)	Increase/ Decrease	Percentage Change
Annual premiums	—	$3,830	$3,830	N/A
Annual cost sharing	$9,500	$240	($9,260)	−97%
Total patient costs	$9,500	$4,070	($5,430)	−57%

Table Notes: Assumes member is enrolled in Plan G postmandate, with baseline premiums of $150/month and an average postmandate premium of $319.

In Example 3, CHBRP provides a scenario faced by a 75-year-old who had already enrolled in a Medicare Supplement insurance policy at open enrollment when they had turned 65 and enrolled in traditional Medicare. At baseline, the enrollee would pay $200 per month based on their attained age of 75 years for a total of $2,400 per year. Their actual cost sharing covered by their Medicare Supplement is only $240 per year (this is the assumed Part B deductible, which cannot be covered by the Medicare Supplement) (Medicare, 2024). Postmandate, because higher cost applicants would enroll in Medicare Supplement and premiums would be the same for everyone enrolled in the plan regardless of age, the premium paid by the 75-year-old enrolled at baseline would increase by $1,430 per year (60%).

Example 3. 75-Year-Old Enrolled in Medicare Supplement at Baseline

Category	Baseline	Postmandate Year 1 (2025)	Increase/ Decrease	Percentage Change
Annual premiums	$2,400	$3,830	$1,430	60%
Annual cost sharing	$240	$240	—	0%
Total patient costs	$2,640	$4,070	$1,430	54%

Table Notes: Assumes member is enrolled in Plan G postmandate, with baseline premiums of $200/month and an average postmandate premium of $319.

Example 4 provides a profile of a 75-year-old applicant who is enrolled in traditional Medicare with no supplemental coverage and is being treated for cancer. At baseline, they do not pay any premiums because they cannot find a Medicare Supplement that will accept them with their cancer diagnosis, resulting in $9,500 in out-of-pocket spending related to use of their traditional Medicare (Part A/B) benefits. In traditional Medicare, there is no out-of-pocket maximum, and in Part B, coinsurance is 20%. Postmandate, the ability to enter the Medicare Supplemental market and enroll in a plan would save the 75-year-old cancer patient $5,430 per year (57%) overall because their out-of-pocket spending related to cost sharing would decrease by $9,260 per year, and their premiums for a Medicare Supplement would be $3,830 per year. In this example, the limits of a Medicare Advantage plan's provider network may mean that a Medicare Supplement is a more attractive option for the enrollee. Example 4 looks identical to Example 2 because the age of applicant does not matter in a community-rated insurance market, so both beneficiaries save the same amount due to being denied from purchasing Medicare Supplement coverage at baseline.

Example 4. 75-Year-Old Cancer Patient Enrolled in Traditional Medicare

Category	Baseline	Postmandate Year 1 (2025)	Increase/ Decrease	Percentage Change
Annual premiums	—	$3,830	$3,830	N/A
Annual cost sharing	$9,500	$240	($9,260)	−97%
Total patient costs	$9,500	$4,070	($5,430)	−57%

Table Notes: Assumes member is enrolled in Plan G postmandate, with baseline premiums of $200/month and an average postmandate premium of $319.

In all four examples, baseline premiums in the Medicare Supplement insurance market are based on attained age of the applicant. Due to open enrollment, guaranteed issue, and community rating requirements the two healthier examples (Examples 1 and 3) will see their premiums increase substantially, while those who were kept out of the market before due to their cancer diagnoses will save money because the cost of their premiums under SB 1236 will be less than their out-of-pocket spending at baseline.

Postmandate Administrative Expenses and Other Expenses

CHBRP estimates that the increase in administrative costs of DMHC-regulated plans and/or CDI-regulated policies will remain proportional to the increase in premiums. CHBRP assumes that if health care costs increase because of increased utilization or changes in unit costs, there is a corresponding proportional increase in administrative costs. CHBRP assumes that the administrative cost portion of premiums is unchanged. All health plans and insurers include a component for administration and profit in their premiums. In the Medicare Supplement insurance market, the portion of the premium attributable to administrative costs, overhead, profit, and other nonmedical sources of spending is roughly 20%.

Other Considerations for Policymakers

In addition to the impacts a bill may have on benefit coverage, utilization, and cost, related considerations for policymakers are discussed below.

Changes in Public Program Enrollment

CHBRP estimates that the mandate would produce no measurable impact on enrollment in publicly funded insurance programs due to the enactment of SB 1236. The number of enrollees in Medicare overall would not change due to SB

1236. However, there will be a reduction in the number of enrollees who have traditional Medicare with supplemental coverage due to the change to open enrollment processes and premium pricing practices.

Availability of Medicare Supplement Policies

It is possible that SB 1236 will result in insurers closing enrollment in the Medicare Supplement market in California due to the expanded open enrollment period and community-rated premiums, resulting in less competition and potentially higher premiums for Californians with traditional Medicare. California requires the renewal of existing insurance policies. Therefore, closing enrollment does not mean that existing enrollees would lose their coverage immediately, just that there could be no new entrants. However, the renewed policy would need to comply with the new community rating rules for pricing premiums.

Long-Term Impacts

In this section, CHBRP estimates the long-term impact of SB 1236, which CHBRP defines as impacts occurring beyond the first 12 months after implementation. These estimates are qualitative and based on the existing evidence available in the literature. CHBRP does not provide quantitative estimates of long-term impacts because of unknown improvements in clinical care, changes in prices, implementation of other complementary or conflicting policies, and other unexpected factors.

Premiums are likely to increase significantly in the Medicare Supplement insurance coverage market postmandate. The change in premium rating rules and open enrollment processes will allow Medicare beneficiaries with high expected cost sharing to join a Medicare Supplement when their perceived risk is highest and allows healthier people who are not yet using lots of Medicare services to wait until their perceived risk is highest before entering the market. Therefore, the 33% premium increase estimated in Table 1 could be an underestimate over time given the assumption that only 20% of enrollees with skilled nursing needs, cancer diagnosis, or more than $10,000 in claims would enroll in a Medicare Supplement in 2025. If all potential “high-risk” applicants decided to enroll in a Medicare supplement to address their perceived cost-sharing risk each year, premiums would more than double as lower cost people exit the market and higher cost enrollees enter. However, based on current market conditions and the assumption that 20% of higher cost or higher need applicants would enroll in a plan, it is likely that an equilibrium will be established in the Medicare Supplement around the estimated premium increase of 33% stated in this report.

The strong presence of integrated Medicare Advantage health maintenance organizations (HMOs) with organized provider networks may blunt the long-term impacts such that not all eligible applicants would take advantage of an open enrollment period to obtain a Medicare Supplement insurance policy over time. Medicare Advantage plans offer out-of-pocket maximums, limits on cost sharing, and other benefits that are attractive to their enrollees when paired with an adequate network of providers. A majority (55%) of California’s Medicare Beneficiaries are enrolled in Medicare Advantage plans (KFF, 2023). This makes them an attractive option for those who do not wish to sign up for a Medicare Supplement upon initial Medicare enrollment, as they provide robust benefits, out-of-pocket spending protection, and comprehensive provider networks.

As mentioned above, in the long term, SB 1236 could result in fewer insurance carriers willing to participate in the Medicare Supplement market in California. This could result in fewer options for Medicare beneficiaries in California, though the insurers that continue to participate may be able to develop a stable enrollment base spread among a smaller number of carriers, despite the large impacts predicted in the first year prior to establishing market equilibrium.

Appendix A. Text of Bill Analyzed

On February 21, 2024, the California Senate Committee on Health requested that CHBRP analyze SB 1236 as introduced on February 15, 2024.

SENATE BILL **NO. 1236**

Introduced by Senator Blakespear
(Coauthor: Assembly Member Schiavo)

February 15, 2024

An act to add Section 1358.25 to the Health and Safety Code, and to add Section 10192.25 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 1236, as introduced, Blakespear. Medicare supplement coverage: open enrollment periods.

Existing federal law provides for the Medicare Program, which is a public health insurance program for persons 65 years of age and older and specified persons with disabilities who are under 65 years of age. Existing federal law specifies different parts of Medicare that cover specific services, such as Medicare Part B, which generally covers medically necessary services and supplies and preventive services. 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, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance.

Existing federal law additionally provides for the issuance of Medicare supplement policies or certificates, also known as Medigap coverage, which are advertised, marketed, or designed primarily as a supplement to reimbursements under the Medicare Program for the hospital, medical, or surgical expenses of persons eligible for the Medicare Program, including coverage of Medicare deductible, copayment, or coinsurance amounts, as specified. Existing law, among other provisions, requires supplement benefit plans to be uniform in structure, language, designation, and format with the standard benefit plans, as prescribed. Existing law prohibits an issuer from denying or conditioning the offering or effectiveness of any Medicare supplement contract, policy, or certificate available for sale in this state, or discriminating in the pricing of a contract, policy, or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application that is submitted prior to or during the 6-month period beginning with the first day of the first month in which an individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B.

This bill, on and after January 1, 2025, would prohibit an issuer of Medicare supplement coverage in this state from denying or conditioning the issuance or effectiveness of any Medicare supplement coverage available for sale in the state, or discriminate in the pricing of that coverage because of the health status, claims experience, receipt of health care, medical condition, or age of an applicant, if an application for coverage is submitted during an open enrollment period, as specified in the bill. The bill would entitle an individual enrolled in Medicare Part B to a 90-day annual open enrollment period beginning

on January 1 of each year, as specified, during which period the bill would require applications to be accepted for any Medicare supplement coverage available from an issuer, as specified. The bill would require the open enrollment period to be a guaranteed issue period.

Because a violation of the bill's requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority Appropriation: no Fiscal Committee: yes Local Program: yes

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

SECTION 1. The Legislature finds and declares as follows:

(a) Existing state law requires insurance companies that sell Medicare supplement coverage, also known as Medigap coverage, to issue that insurance on a guaranteed-issue basis to eligible individuals without adjusting premiums based on medical underwriting, as long as their applications are submitted within a one-time open enrollment period.

(b) The open enrollment period in the state is during the six-month window beginning when the individual is enrolled for benefits under Medicare Part B. After this open enrollment period, there is no guarantee that Medigap coverage will be issued to individuals with preexisting medical conditions unless the individual satisfies certain conditions, and even if the coverage is issued, the premium may be significantly higher.

(c) As a result, it is extremely difficult for individuals whose health conditions or financial situations may have changed after their open enrollment period to switch to another Medicare supplement coverage plan that is more suitable.

(d) It is, therefore, the intent of the Legislature in enacting this act to do both of the following:

(1) Establish an annual open enrollment for applicants, and require Medigap coverage issuers in California to accept an individual's application for coverage or an application to switch to another eligible plan during that period.

(2) Prohibit issuers from denying the applicant Medigap coverage or making any premium rate distinctions due to any of the following:

(A) Health status.

(B) Claims experience.

(C) Medical condition.

(D) Whether the applicant is receiving health care services.

SEC. 2. Section 1358.25 is added to the Health and Safety Code, to read:

1358.25. (a) On and after January 1, 2025, an issuer of Medicare supplement coverage in this state shall not deny or condition the issuance or effectiveness of any Medicare supplement coverage contract available for sale in the state, or discriminate in the pricing of the contract because of the health status, claims experience, receipt of health care, medical condition, or age of an applicant, if an application for that coverage is submitted at either of the following times:

(1) Before or during the six-month period beginning with the first day of the month in which an individual first enrolled for benefits under Medicare Part B, as described in subdivision (a) of Section 1358.11.

(2) During an annual open enrollment period, including, but not limited to, the open enrollment period established in subdivision (b) of this section.

(b) An individual enrolled in Medicare Part B is entitled to a 90-day annual open enrollment period beginning on January 1 of each year, as described in this section.

(1) During the open enrollment period established pursuant to this subdivision, applications shall be accepted for any Medicare supplement coverage available from an issuer.

(2) The open enrollment period established pursuant to this section is a guaranteed issue period.

SEC. 3. Section 10192.25 is added to the Insurance Code, to read:

10192.25. (a) On and after January 1, 2025, an issuer of Medicare supplement coverage in this state shall not deny or condition the issuance or effectiveness of any Medicare supplement coverage policy or certificate available for sale in the state, or discriminate in the pricing of the policy or certificate because of the health status, claims experience, receipt of health care, medical condition, or age of an applicant, if an application for that coverage is submitted at either of the following times:

(1) Before or during the six-month period beginning with the first day of the month in which an individual first enrolled for benefits under Medicare Part B, as described in subdivision (a) of Section 10192.11.

(2) During an annual open enrollment period, including, but not limited to, the open enrollment period established in subdivision (b) of this section.

(b) An individual enrolled in Medicare Part B is entitled to a 90-day annual open enrollment period beginning on January 1 of each year, as described in this section.

(1) During the open enrollment period established pursuant to this subdivision, applications shall be accepted for any Medicare supplement coverage available from an issuer.

(2) The open enrollment period is a guaranteed issue period.

SEC. 4. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

Appendix B. Data Sources, Caveats, and Assumptions

Analysis-Specific Data Sources

For this analysis, CHBRP relied on CPT codes to identify services related to SB 1236. CPT copyright 2024 American Medical Association. All rights reserved. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein. CPT is a registered trademark of the American Medical Association.

Five Percent Sample Data

CHBRP estimated costs and membership information for enrollees in the California Medicare population using the 2021 Medicare 5% Standard Analytic Files (SAF). These files contain membership and cost information for a sample of enrollees in the Original Medicare population.

Analysis-Specific Caveats and Assumptions

The analytic approach and key assumptions are determined by the subject matter and language of the bill being analyzed by CHBRP. As a result, analytic approaches may differ between topically similar analyses, and therefore the approach and findings may not be directly comparable.

The analysis of SB 1236 was developed using assumptions around the cost of Medicare supplement premiums and claims cost in California and cost and membership information for cohorts that may enroll in or leave Medicare Supplement due to this proposed legislation.

Methodology and Assumptions for Baseline Population

- The population subject to the mandated offering includes individuals eligible for Medicare Supplement in California. CHBRP made the following assumptions about the population that SB 1236 could impact:
    - **Medicare Supplement enrollees** – CHBRP estimated the number of enrollees currently in Medicare Supplements using the number of covered lives from the "2022 Medicare Supplement Loss Ratios[9]" report by the National Association of Insurance Commissioners (NAIC) and the "Enrollment Summary Report – 2023" from the Department of Managed Healthcare (DMHC).[10] CHBRP assumed no enrollment trend between 2022 and 2025 for the NAIC enrollment and no enrollment trend between 2023 and 2025 for the DMHC data.
    - **Medicare eligibles not enrolled in Medicare Supplement** – CHBRP estimated the population not enrolled in Medicare Supplement using 2021 non-dual eligible enrollment from the California Department of Health Care Services (DHCS)'s report "Profile of the California Medicare Population: February 2022[11]". CHBRP assumed an annual growth in enrollment of 1.2% between 2021 and 2025, which was informed

[9] https://content.naic.org/sites/default/files/publication-med-bb-medicare-loss-report.pdf
[10] https://www.dmhc.ca.gov/DataResearch/FinancialSummaryData.aspx
[11] https://www.dhcs.ca.gov/services/Documents/OMII-Medicare-Databook-February-18-2022.pdf

by observed trend seen in the Medicare Monthly Enrollment[12] files from the Centers for Medicare and Medicaid Services (CMS).

- CHBRP estimated average Medicare Supplement premiums using California specific premium rates from the NAIC "2022 Medicare Supplement Loss Ratio" report. CHBRP trended 2022 premiums to 2025 using an annual trend rate of 3.0%.

- CHBRP assumed baseline claims costs were 80% of baseline premium costs. These were based on a nationwide loss ratio of 80% reported in the NAIC report.

Methodology and Assumptions for Interested Population Cohorts

- CHBRP assumed that the people most likely to take advantage of the new open enrollment period, guaranteed issue coverage, and attained age-based premium rating were those with higher health care costs and perceived needs due to chronic illness, cancer, or injuries requiring rehabilitative skilled nursing services. CHBRP used the 2021 Medicare 5% SAF to identify the prevalence and average patient cost sharing for members covered in the Medicare fee-for-service population for medical services only.

    - **Lymphoma** – Non-dual eligible enrollees with at least one diagnosis code starting with "C81 – C85" during 2021 or who were assigned HCC (Hierarchal Cost Condition) 10 under the CMS HCC 20 risk score model. CHBRP estimated the prevalence to be 1.7%.

    - **Leukemia** – Non-dual eligible enrollees with at least one diagnosis code starting with "C91 – C95" during 2021. CHBRP estimated the prevalence to be 0.3%.

    - **Lung Cancer** – Non-dual eligible enrollees with at least one diagnosis code starting with "C34" during 2021 or who are assigned HCC 9 under the CMS HCC 20 risk score model. CHBRP estimated the prevalence to be 1.3%.

    - **Nursing Home Patients** – Non-dual eligible enrollees who had at least one professional CPT code beginning with "993" during 2021. CHBRP estimated the prevalence to be 2.2%

    - **Other High-Cost Patients** – Other non-dual eligible enrollees with greater than $10,000 in cost sharing during 2021, with an adjustment intended to exclude the other patient types above. Since SB 1236 considers Medicare Supplement plans, we did not consider cost sharing for prescription drugs (e.g. Medicare Part D) claims in determining which enrollees exceeded this threshold. CHBRP estimated the prevalence to be 1.1%.

- CHBRP assumed the prevalence of these members in the general 2025 Medicare population matched the 2021 Medicare 5% sample. The average patient pay for each of these member cohorts was trended to 2025 using an annual trend of 5%.

Methodology and Assumptions for Population Shifts

- CHBRP assumed that 20% of each of the enrollee cohorts described in the "Methodology and Assumptions for Interested Population Cohorts" would enroll in Medicare supplement because of SB 1236.

- CHBRP assumed that some enrollees may cancel their Medicare Supplemental because of SB 1236 either because 1) premiums will increase and they will decide they don't want to pay the higher premiums or 2) they can disenroll now and later purchase a guaranteed-issue policy during a future enrollment period when they perceive a need for the additional coverage. CHBRP made the following assumptions about these members:

[12] https://data.cms.gov/summary-statistics-on-beneficiary-enrollment/medicare-and-medicaid-reports/medicare-monthly-enrollment/data

- **Prevalence:** CHBRP assumed that this cohort of enrollees represents 14% of the current Medicare Supplemental population informed by the "Washington State Medicare Supplemental Insurance Study[13]" from 2022. We are using a higher percentage than that report because SB 1236 will also change the rating to community rated (Washington State is already community rated), which will increase the premiums for younger people.
- **Patient Cost Sharing:** CHBRP estimated the patient cost sharing for this population as the 25th percentile of non-dual eligible enrollee cost sharing seen in the 2021 Medicare 5% SAF. This was trended from 2021 to 2025 using an annual trend rate of 5%.

Methodology and Assumptions for Premium Impact

- All members moving into Medicare Supplement from other coverages were assumed to enroll into Plan G, which is the richest Medicare Supplement plan covering all cost sharing except for the Part B deductible. Therefore, the Medicare Supplemental claim costs for these members were assumed to be their trended patient cost sharing for medical services less the Part B deductible. CHBRP assumed the 2025 Part B deductible to be $240.
  - Similarly, any member leaving the Medicare supplemental market was assumed to disenroll from Plan G.
- After using the assumptions above to estimate the claim cost impact in the Medicare Supplemental market, CHBRP assumed an 80% loss ratio to estimate the premium impact.
- The estimated premium impact represents a statewide average. Medicare Supplement premiums vary by area. Furthermore, the premium impacts will be higher in some areas than in others. For example, an area that has very little MA presence will not see as much shifting of members out of MA.

Variability of Results

Differences between our estimates and actual amounts depend on the extent to which future experience conforms to the assumptions made in this model. It is almost certain that actual experience will not conform exactly to the assumptions used in this model. Actual amounts will differ from projected amounts to the extent that actual experience is better or worse than expected.

Notably, there is significant uncertainty in how enrollees will react to changes in the Medicare supplemental product offering. Therefore, the actual impact of SB 1236 could vary significantly from the projections made in this model.

Model and Data Reliance

Milliman has developed certain models to estimate the values included in this report. The intent of the models was to estimate the impact on enrollment and premiums in the Medicare supplement market due to proposed bill SB 1236. We have reviewed this model, including its inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP).

The models rely on data and information as input to the models. We have relied upon certain data and information for this purpose and accepted it without audit. To the extent that the data and information provided is not accurate, or is not complete, the values provided in this report may likewise be inaccurate or incomplete.

Milliman's data and information reliance includes:

- Data publicly available from the California Department of Managed Health Care (DMHC), National Association of Insurance Commissioners, and the Center for Medicare and Medicaid Services (CMS) and
- All sources mentioned above in the Analysis-Specific Caveats and Assumptions section.

The models, including all input, calculations, and output may not be appropriate for any other purpose.

[13] https://www.insurance.wa.gov/sites/default/files/documents/wa_oic_medicare_supplemental_insurance_legislative_study_11-14-22_0.pdf

We have performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our investigation.

Qualifications to Perform Analysis

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The developer of this model and author of this paper is a member of the American Academy of Actuaries and meets the qualification standards for performing the analyses supported by this model.

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About CHBRP

The California Health Benefits Review Program (CHBRP) was established in 2002. As per its authorizing statute, CHBRP provides the California Legislature with independent analysis of the medical, financial, and public health impacts of proposed health insurance benefit-related legislation. The state funds CHBRP through an annual assessment on health plans and insurers in California.

A group of faculty, researchers, and staff complete the analysis that informs California Health Benefits Review Program (CHBRP) reports. The CHBRP **Faculty Task Force** comprises rotating senior faculty from University of California (UC) campuses. In addition to these representatives, there are other ongoing researchers and analysts who are **Task Force Contributors** to CHBRP from UC that conduct much of the analysis. The **CHBRP staff** works with Task Force members in preparing parts of the analysis, and manages external communications, including those with the California Legislature. As required by CHBRP's authorizing legislation, UC contracts with a certified actuary, **Milliman**, to assist in assessing the financial impact of each legislative proposal mandating or repealing a health insurance benefit. The **National Advisory Council** provides expert reviews of draft analyses and offers general guidance on the program to CHBRP staff and the Faculty Task Force. Information on CHBRP's analysis methodology, authorizing statute, as well as all CHBRP reports and other publications, are available at www.chbrp.org.

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Dylan Roby, PhD, of the University of California, Irvine, prepared the cost impact analysis. Matt Schoonmaker, FSA, MAAA, of Milliman, provided actuarial analysis. Content expert of MNM Benefits Solutions, Dawn McFarland, provided technical assistance with the literature search and expert input on the analytic approach. John Lewis, MPA, of CHBRP staff, prepared the Policy Context and synthesized the individual sections into a single report. A subcommittee of CHBRP's National Advisory Council (see previous page of this report) and a member of the CHBRP Faculty Task Force, Jack Needleman, PhD, of the University of California, Los Angeles, reviewed the analysis for its accuracy, completeness, clarity, and responsiveness to the Legislature's request.

CHBRP assumes full responsibility for the report and the accuracy of its contents. All CHBRP bill analyses and other publications are available at www.chbrp.org.

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Please direct any questions concerning this document to: California Health Benefits Review Program; MC 3116; Berkeley, CA 94720-3116, info@chbrp.org, or www.chbrp.org.

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