CALIFORNIA
HEALTH BENEFITS REVIEW PROGRAM

Executive Summary
Analysis of Senate Bill 136: Tobacco Cessation

A Report to the 2011-2012 California Legislature
April 7, 2011

CHBRP 11-08

A Report to the 2011-2012 California State Legislature

Analysis of Senate Bill 136
Tobacco Cessation

April 7, 2011

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

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

Suggested Citation:

California Health Benefits Review Program (CHBRP). (2011). *Analysis of Senate Bill 136: Tobacco Cessation.* Report to California State Legislature. Oakland, CA: CHBRP. 11-08.

EXECUTIVE SUMMARY

California Health Benefits Review Program Analysis of Senate Bill 136

The California Senate Committee on Health requested on February 4, 2011, that the California Health Benefits Review Program (CHBRP) conduct an evidence-based assessment of the medical, financial, and public health impacts of Senate Bill (SB) 136, a bill that would require coverage of tobacco cessation benefits. In response to this request, CHBRP undertook this analysis pursuant to the provisions of the program's authorizing statute.[1]

Analysis of SB 136

Approximately 21.9 million Californians (59%) have health insurance that may be subject to a health benefit mandate law passed at the state level.[2] Of the rest of the state's population, a portion is uninsured (and so has no health insurance subject to any benefit mandate) and another portion has health insurance subject to other state law or only to federal laws.

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

DMHC-regulated plans and CDI-regulated policies would be subject to SB 136. Therefore, the mandate would affect the health insurance of approximately 21.9 Californians (59%).

SB 136 would require health care service plans and health insurance policies[5] to include coverage for smoking cessation services, to be selected by the enrollee and the provider. These services would include:

- Telephone, group, or individual counseling.
- All prescription and over-the-counter (OTC) medications approved by the Food and Drug Administration (FDA) to help smokers quit, including drugs for nicotine replacement

[1] CHBRP's authorizing statute is available at http://www.chbrp.org/documents/authorizing_statute.pdf.
[2] CHBRP's estimates are available at http://www.chbrp.org/other_publications/index.php.
[3] The DMHC was established in 2000 to enforce the Knox-Keene Health Care Service Plan Act of 1975; see Health and Safety Code, Section 1340.
[4] 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.
[5] SB 136 would amend Section 1367.27 of the *Health and Safety Code* and Section 10123.175 of the *Insurance Code*. Health care service plans, commonly referred to as health maintenance organizations, are regulated and licensed by the California Department of Managed Health Care (DMHC), as provided in the Knox-Keene Health Care Services Plan Act of 1975. The Knox-Keene Health Care Services Plan Act is codified in the *California Health and Safety Code*. Health insurance policies are regulated by the California Department of Insurance and are subject to the *California Insurance Code*.

therapy (NRT) and prescription drug therapies in, but not limited to, the form of gum, dermal patch, inhaler, nasal spray, and lozenge, varenicline, and bupropion SR[6] or similar drugs that counter the urge to smoke or the addictive qualities of nicotine.

Conditions placed on the benefit include:

- Counseling and medications may be limited to two courses of treatment per year.
- Step therapy[7] is prohibited for prescription drugs, and plans and insurers are prohibited from requiring counseling or the completion of a cessation program as part of the cessation benefit after the first treatment.
- At least four counseling sessions must be provided in each course of treatment, each session lasting at least 10 minutes.

SB 136 would become inoperative on the date that the state determines that, taking into account any state savings identified,[8] SB 136 would result in the state assuming additional costs pursuant to subparagraph (B) of paragraph (3) of subsection (d) of Section 1311 of the federal Patient Protection and Affordable Care Act (ACA). The ACA establishes that under health benefit Exchanges, qualified health plans are required to offer essential health benefits (to be established federally). This provision requires that states assume the costs of any additional benefits they require in addition to the essential health benefits specified under section 1302(b).

Currently, six states (Colorado, Maryland, New Jersey, New Mexico, Oregon, and Rhode Island) mandate coverage for smoking cessation treatment (ALA, 2009). North Dakota provides a $150 lifetime smoking cessation benefit for specific group plans.

Medical Effectiveness

Efficacy of Smoking Cessation Treatments

The literature on the efficacy of behavioral interventions (e.g., counseling, brief advice) and pharmaceuticals for smoking cessation is large and includes numerous meta-analyses of randomized controlled trials (RCTs), the strongest form of evidence for CHBRP analyses. These meta-analyses provide clear and convincing evidence that behavioral and pharmacological treatments and combinations of the two improve quit rates and increase the likelihood of sustained abstinence from smoking. These conclusions about the efficacy of smoking cessation interventions are not likely to be diminished or altered with the publication of new studies, because of the large quantity of literature summarized in the meta-analyses.

[6] Bupropion SR at strengths of 100 or 150 milligrams is the only formulation of bupropion approved by the FDA for smoking cessation. It was originally approved for sale under the brand name Zyban. Other formulations and strengths of bupropion are marketed in the United States but are not approved for smoking cessation.
[7] *Step therapy* requires an enrollee to try a first-line medication (often a generic alternative) prior to receiving coverage for a second-line medication (often a brand-name medication).
[8] Section C of SB 136 would request that CHBRP prepare a report by December 31, 2014, evaluating the requirements of this section and determining any state savings as a result of those requirements.

Behavioral interventions

- There is clear and convincing evidence that use of multiple types of counseling increases smoking cessation.

- Individual, group, and telephone counseling by physicians and other health professionals increases smoking cessation.

- Brief counseling interventions (as little as a few minutes) are effective, and the preponderance of evidence suggests that more intensive counseling is associated with larger effects.

- Psychologists, physicians, pharmacists, and nurses are all effective in providing smoking cessation counseling.

- RCTs that enrolled smokers at high risk for adverse health outcomes (e.g., persons with coronary heart disease, pregnant women) report similar findings to RCTs that enrolled smokers who were not at increased risk relative to other smokers.

Pharmacotherapy

- Pharmacological agents for smoking cessation are commonly divided into those used in initial attempts to quit smoking ("first-line agents"), followed by those used when initial attempts to quit have not been successful ("second-line agents"). First-line agents for smoking cessation include the following: NRT administered by gum, patch, lozenge, nasal spray, and inhaler; varenicline, a nicotine receptor partial agonist[9]; and the non-nicotine agent bupropion SR, an antidepressant useful in treating certain addiction syndromes. Second-line agents include clonidine and nortriptyline.

- Among first-line agents:

    - There is clear and convincing evidence that NRT administered by gum, lozenge, patch, nasal spray, and inhaler increases smoking cessation.
    - There is also clear and convincing evidence that varenicline and bupropion[10] increase smoking cessation.
    - There is a preponderance of evidence that varenicline is more effective than bupropion.
    - There is a preponderance of evidence that smokers who receive a combination of pharmacological agents are more likely to abstain from smoking than persons who receive a single pharmacological agent.

[9] The nicotine receptor partial agonist simulates the effects of nicotine to reduce cravings and the pleasurable effect of smoking cigarettes.

[10] Although bupropion SR at strengths of 100 or 150 milligrams is the only formulation of bupropion approved by the FDA for smoking cessation, meta-analyses regarding the efficacy of bupropion for smoking cessation do not indicate whether all of the RCTs they included in their analyses assessed bupropion SR. Some of the RCTs included may have evaluated other formulations of bupropion or other strengths of the medication.

- Among second-line agents:
    - There is clear and convincing evidence that clonidine and nortriptyline also increase smoking cessation relative to placebo.
    - There is a preponderance of evidence that smokers who receive both counseling and pharmacological agents are more likely to abstain from smoking than smokers who only receive counseling.

Generalizability of findings

The rates of abstinence from smoking found in the RCTs summarized above may be greater than those that would be achieved if SB 136 were enacted. Most of these RCTs used strict inclusion/exclusion criteria to maximize their ability to determine whether counseling or pharmacotherapy increases smoking cessation. These studies may have excluded some smokers who would have coverage for these treatments under SB 136. In addition, smokers who take the initiative to enroll in RCTs are probably more highly motivated to quit than the average smoker. Greater motivation may lead to higher rates of abstinence from smoking among persons enrolled in both the intervention and control groups of RCTs than would occur in the "real world." Clinician researchers may also work harder than other clinicians to ensure that smokers use recommended amounts of counseling and/or pharmacotherapy.

Effects of Coverage for Smoking Cessation Treatments

The evidence base from which conclusions can be drawn about the effects of coverage on utilization of smoking cessation treatments and abstinence from smoking is much less robust than the evidence base regarding the efficacy of these treatments.

Use of smoking cessation treatments

- The preponderance of evidence suggests that persons who have full coverage[11] for NRT and/or bupropion are more likely to use these smoking cessation medications than are persons who do not have coverage for them.

- The evidence of the effect of full coverage for smoking cessation counseling relative to no coverage is ambiguous.

- Findings from studies suggest that persons who have more generous coverage for NRT and/or counseling are more likely to use these smoking cessation treatments than are persons who have less generous coverage for them.

Abstinence from smoking

- The preponderance of evidence suggests that full coverage for smoking cessation counseling and pharmacotherapy is associated with improved abstinence from smoking relative to no coverage for smoking cessation treatments.

[11] For purposes of this report, full coverage for smoking cessation treatments is defined as coverage of all three modalities of smoking cessation.

- The evidence of the effect of more generous coverage for smoking cessation counseling and pharmacotherapy relative to less generous coverage on abstinence from smoking is ambiguous.

Benefit Coverage, Utilization, and Cost Impacts

In this section, CHBRP presents the cost impact of SB 136 on all plans or policies subject to mandate, which includes enrollment of 21.9 million Californians. The estimated increase of utilization of smoking cessation treatment is among the 1.93 million (estimated) adult smokers with DMHC- or CDI-regulated plans or policies, since they will be the population who might attempt to quit using services covered by this newly mandated benefit coverage. Unlike previous versions of smoking cessation treatment benefit mandates (see CHBRP report on SB 220 from 2010); SB 136 does not require that cost sharing be eliminated in order for coverage to be mandate compliant. CHBRP assumes that if SB 136 was enacted, all DMHC-regulated plans and CDI-regulated policies would then include mandate-compliant coverage for smoking cessation treatments that includes enrollee cost sharing.

Table 1 summarizes the expected benefit coverage, cost, and utilization impacts for SB 136.

Benefit Coverage Impacts

- Of the population subject to the mandate, 82.5% of enrollees have mandate-compliant coverage for smoking cessation-related counseling and 98.8% have mandate-compliant coverage for prescription smoking cessation treatment, but a lower percentage (62.0%) have mandate-compliant coverage for over-the-counter (OTC) smoking cessation treatment (Table 1). If SB 136 were enacted, 100% of this population would have mandate-compliant coverage for smoking cessation treatments.

- Medi-Cal Managed Care Plans (MMCPs), which cover 1.68 million adults subject to the mandate (11.7%), generally already provides mandate-compliant smoking cessation treatment benefits. If SB 136 were enacted, the mandate would eliminate the prior authorization requirements that currently exist in some MMCPs. Some individual Medi-Cal Managed Care Plans may need to be amended to comply with specific provisions of the bill, such as prior authorization restrictions beyond the first treatment. CHBRP did not have sufficient evidence to estimate the impact of any needed administrative changes on the utilization of smoking cessation services.

- CHBRP estimates no measurable impact of the mandate on the number of uninsured due to premium increases.

Utilization Impacts

- CHBRP used the 2008 and 2005 California Tobacco Survey data and the RAND Health Insurance Experiment's (HIE) estimated impact of cost sharing for "well care" to estimate premandate and postmandate utilization. Premandate, of the 1.93 million adult smokers

enrolled in DMHC- or CDI-regulated plans or policies, 308,604 used one or more smoking cessation treatments, with 252,226 using treatments covered through their existing insurance and 56,378 enrollees using treatments for which they were not covered.

- Postmandate, of the 1.93 million insured adult smokers, CHBRP estimates that the utilization of counseling services would increase by 9.2%, OTC treatments by 19.8%, and prescription treatments by 0.6% (Table 1).

- In total, the utilization of one or more smoking cessation treatments would increase by 11.2%, representing an additional 34,660 insured adult smokers receiving treatment postmandate.

Cost Impacts

- Increases in per member per month (PMPM) premiums for the newly mandated benefit coverage vary by market segment. Increases as measured by percentage changes in PMPM premiums are estimated to range from an average increase of 0.00% (for DMHC-regulated MMCPs) to an average increase of 0.17% (for CDI-regulated individual policies) in the affected market segments. Increases as measured by PMPM premiums are estimated to range from $0.00 to $0.33.

- In the privately funded large-group market, the increase in premiums is estimated to range from an average increase of $0.06 PMPM among DMHC-regulated plan contracts to an average increase of $0.23 PMPM among CDI-regulated policies.

- For enrollees in privately funded small-group insurance policies, health insurance premiums are estimated to increase by an average increase of $0.11 PMPM for DMHC contracts to an average increase of $0.28 PMPM for CDI policies.

- In the privately funded individual market, the health insurance premiums are estimated to range by an average increase of $0.08 PMPM to an average increase of $0.33 PMPM in the DMHC- and CDI-regulated markets, respectively.

- Among publicly funded DMHC-regulated health plans, CHBRP estimates that premium increases for Medi-Cal Managed Care Plans, MRMIB plans, and CalPERS HMOs would range from averages of 0.00% to 0.05% ($0.00 to $0.20).

- Total net health expenditures are projected to increase by $16.4 million (0.017%) (Table 1). This is due to a $32.9 million increase in health insurance premiums and enrollee expenses for newly covered benefits, partially offset by a reduction in enrollee out-of-pocket expenditures for previously noncovered benefits ($16.5 million).

Public Health Impacts

- CHBRP estimates that due to clear and convincing evidence of effectiveness of smoking cessation treatments and increased enrollee coverage, SB 136 would produce a positive public health impact by increasing the number of successful quitters by 2,364 enrollees annually. This would translate into real, improved health outcomes for these new quitters in the long term. Furthermore, literature indicates that the additional quitters enabled by SB 136 would reduce harms from secondhand smoke postmandate.

- CHRBP estimates that, for the overall population, any cost increase or physical harms from rare serious adverse events from pharmacotherapy would be outweighed by the benefits of smoking cessation.

- Due to lack of data, CHBRP cannot quantify the impact of SB 136 on reducing existing gender disparities in smoking prevalence nor on the relevant health outcomes in the insured population. Therefore, the impact of SB 136 on reducing gender disparities is unknown.

- Due to lack of data, CHBRP cannot quantify the impact of SB 136 on reducing racial/ethnic disparities in smoking prevalence nor on the relevant health outcomes in the insured population. Therefore, the impact of SB 136 on reducing racial/ethnic disparities is unknown.

- There is clear and convincing evidence that SB 136 would contribute to the reduction in premature death from smoking-related conditions such as cancer, low birth weight infants, and cardiovascular and respiratory diseases. However, CHBRP cannot estimate the precise magnitude.

- CHBRP estimates that SB 136 would increase utilization of smoking cessation treatments and increase quit rates postmandate. This increase would contribute to a reduction in economic loss due to reductions in lost productivity from smoking-related illness and premature death, but the magnitude cannot be estimated.

- CHBRP finds clear and convincing evidence that smoking cessation is a cost-effective preventive treatment that results in improvements in long-term in multiple health outcomes and reduces both direct medical costs and indirect costs associated with smoking. CHBRP estimates between 16,548 to 29,314 life years would be gained annually under the new mandate. The expected reduction in smoking prevalence and mortality attributable to SB 136 would bring California closer to achieving *Healthy People 2020* goals.

Potential Effects of the Federal Affordable Care Act

The federal "Patient Protection and Affordable Care Act" (P.L.111-148) and the "Health Care and Education Reconciliation Act" (H.R.4872) were enacted in March 2010. These laws (together referred to as the "Affordable Care Act [ACA]") are expected to dramatically affect the California health insurance market and its regulatory environment, with most changes becoming

effective in 2014. How these provisions are implemented in California will largely depend on pending legal actions, funding decisions, regulations to be promulgated by federal agencies, and statutory and regulatory actions to be taken by California state government.

Essential health benefits offered by qualified health plans in the Exchange and potential interactions with SB 136

The ACA requires beginning 2014 that states "make payments…to defray the cost of any additional benefits" required of qualified health plans (QHPs) sold in the Exchange.[12] SB 136 would make the requirements of the bill inoperative if the state determines that the requirements would "result in the state assuming additional costs pursuant to subparagraph (B) of paragraph (3) of subsection (d) of Section 1311 of the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by subsection (e) of Section 10104 of Title X of that act." Therefore, the marginal impact as presented in this report would no longer apply after 2014 if the requirements of SB 136 were deemed to add fiscal costs for qualified health plans to be offered in the Exchange.

When promulgating regulations on essential health benefits (EHBs), the U.S. Department of Health and Human Services is to ensure that the EHB floor "is equal to the scope of benefits provided under a typical employer plan." CHBRP found some variation in coverage based on carrier surveys (such as the types of counseling services provided, and inclusion of OTC smoking cessation items). Assuming this is true nationally, there is likely variation in employer coverage for services mandated under SB 136. Therefore, it is uncertain whether federal regulations and guidance would deem all the services mandated under SB 136 as being included under EHBs. In order for the state to determine whether any additional fiscal liability for the state would be incurred under SB 136, the following factors would need to be examined:

- Differences in the scope of benefits in the final EHB package and the scope of mandated benefits in SB 136;
- The number of enrollees in QHPs; and,
- The methods used to define and calculate the cost of additional benefits.

All of these factors are unknown at this time, and are dependent upon the details of pending federal regulations, state legislative and regulatory actions, and enrollment into QHPs after the Exchange is implemented.

Preventive benefits as required under the ACA and SB 136

"New plans" (i.e., those not covered under the ACA's "grandfather" provisions) were required to cover certain preventive services at zero cost sharing beginning September 23, 2010. Tobacco use counseling and interventions are preventive services (US Preventive Services Task Force, 2010) that fall under USPSTF "A and B" benefits and thus under the ACA's requirement to cover those benefits at zero cost sharing. These services include:

[12] Affordable Care Act, 1311(d)(3)(B).

- Tobacco use counseling for pregnant women: The USPSTF recommends that clinicians ask all pregnant women about tobacco use and provide augmented, pregnancy-tailored counseling to those who smoke. Grade A, April 2009.[13]
- Tobacco use counseling and interventions for nonpregnant adults. The USPSTF recommends that clinicians ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products. Grade A, April 2009.[14]

[13] *USPSTF A and B Recommendations*. August 2010. U.S. Preventive Services Task Force. http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm
[14] *USPSTF A and B Recommendations*. August 2010. U.S. Preventive Services Task Force. http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm

Table 1. SB 136 Impacts on Benefit Coverage, Utilization, and Cost, 2011

	Before Mandate	After Mandate	Increase/ Decrease	Change After Mandate
Benefit Coverage				
Total enrollees with health insurance subject to state-level benefit mandates (a)	21,902,000	21,902,000	0	0%
Total enrollees with health insurance subject to SB 136	21,902,000	21,902,000	0	0%
Number of enrollees with coverage for counseling				
No coverage	3,843,297	0	-3,843,297	-100%
Mandate-compliant coverage with cost sharing	12,514,703	16,358,000	3,843,297	30.7%
Mandate-compliant coverage, no cost sharing	5,544,000	5,544,000	0	0.0%
Percentage of enrollees with coverage for counseling				
No coverage	17.5%	0.0%	-17.5%	-100%
Mandate-compliant coverage with cost sharing	57.1%	74.7%	17.5%	30.7%
Mandate-compliant coverage, no cost sharing	25.3%	25.3%	0.0%	0.0%
Number of enrollees with coverage for over-the-counter (OTC) treatments				
No coverage	8,329,710	0	-8,329,710	-100%
Mandate-compliant coverage with cost sharing	9,748,290	18,078,000	8,329,710	85.4%
Mandate-compliant coverage, no cost sharing	3,824,000	3,824,000	0	0.0
Percentage of enrollees with coverage for OTC treatments				
No coverage	38.0%	0.0%	-38.0%	-100%
Mandate-compliant coverage with cost sharing	44.5%	82.5%	38.0%	85%
Mandate-compliant coverage	17.5%	17.5%	0.0%	0%
Number of enrollees with coverage for prescription smoking cessation treatments				
No Coverage	279,441	0	-279,441	100.0%
Mandate-compliant coverage with cost sharing	17,798,559	18,078,000	279,441	1.6%
Mandate-compliant coverage, no cost sharing	3,824,000	3,824,000	0	0.0%
Percentage of enrollees with coverage for prescription smoking cessation treatments				
No coverage	1.3%	0.0%	-1.3%	-100%
Mandate-compliant coverage with cost sharing	81.3%	82.5%	1.3%	1.6%
Mandate-compliant coverage, no cost sharing	17.5%	17.5%	0.0%	0.0%

Table 1. SB 136 Impacts on Benefit Coverage, Utilization, and Cost, 2011 (Cont'd)

	Before Mandate	After Mandate	Increase/ Decrease	Change After Mandate
Utilization and Cost				
Number of enrollees who smoke and use:				
Counseling	139,510	152,341	12,831	9.2%
OTC treatments	218,566	261,739	43,173	19.8%
Prescription smoking cessation	72,080	72,540	459	0.6%
Total (at least one or more services)	308,604	343,265	34,660	11.2%
Average cost per course of treatment:				
Counseling	$200	$200	$0	0%
OTC treatments	$236	$236	$0	0%
Prescription smoking cessation	$240	$240	$0	0%
Expenditures				
Premium expenditures by private employers for group insurance	$52,713, 266,000	$52,725,172,000	$11,906,000	0.0226%
Premium expenditures for individually purchased insurance	$6,724,851,000	$6,730,843,000	$5,992,000	0.0891%
Premium expenditures by persons with group insurance, CalPERS HMOs, Healthy Families Program, AIM or MRMIP (b)	$15,173,472,000	$15,177,073,000	$3,601,000	0.0237%
CalPERS HMO employer expenditures (c)	$3,465,785,000	$3,467,377,000	$1,592,000	0.0459%
Medi-Cal Managed Care Plan expenditures	$8,657,688,000	$8,657,688,000	$0	0.000%
MRMIB Plan expenditures (d)	$1,050,631,000	$1,050,784,000	$153,000	0.0146%
Enrollee out-of-pocket expenses for covered benefits (deductibles, copayments, etc.)	$7,548,415,000	$7,558,116,000	$9,701,000	0.1285%
Enrollee expenses for noncovered benefits (e)	$16,548,000	$0	-$16,548,000	-100%
Total Expenditures	$95,350,656,000	$95,367,053,000	$16,397,000	0.0172%

Source: California Health Benefits Review Program, 2011.

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

(b) Premium expenditures by enrollees include employee contributions to employer-sponsored health insurance and enrollee contributions for publicly purchased insurance.

(c) Of the increase in CalPERS employer expenditures, about 58% or $923,000 would be state expenditures for CalPERS members who are state employees or their dependents.

(d) MRMIB Plan expenditures include expenditures for 874,000 enrollees of the Healthy Families Program, 8,000 enrollees of MRMIP, and 7,000 enrollees of the AIM program.

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

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

ACKNOWLEDGMENTS

This report provides an analysis of the medical, financial, and public health impacts of Senate Bill 136. In response to a request from the California Senate Committee on Health on February 4, 2011, the California Health Benefits Review Program (CHBRP) undertook this analysis pursuant to the program's authorizing statute.

Edward Yelin, PhD, and Chris Tonner, MPH, of the University of California, San Francisco, prepared the medical effectiveness analysis. Bruce Abbott, MLS, of the University of California, Davis, conducted the literature search. Diana Cassady, ScD, Dominique Ritley, MPH, and Meghan Soulsby, MPH, of the University of California, Davis, and Matthew Ingram, of the University of California, Berkeley, prepared the public health impact analysis. Shana Lavarreda, PhD, MPP, of the University of California, Los Angeles, prepared the cost impact analysis. Robert Cosway, FSA, MAAA, of Milliman, provided actuarial analysis. Garen Corbett, MS, of CHBRP staff prepared the introduction and synthesized the individual sections into a single report. A subcommittee of CHBRP's National Advisory Council (see final pages of this report) reviewed the analysis for its accuracy, completeness, clarity, and responsiveness to the Legislature's request.

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

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

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

Susan Philip, MPP
Director

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.

Faculty Task Force

Todd Gilmer, PhD, *Vice Chair for Cost*, University of California, San Diego
Joy Melnikow, MD, MPH, *Vice Chair for Public Health*, University of California, Davis
Ed Yelin, PhD, *Vice Chair for Medical Effectiveness*, University of California, San Francisco
Wayne S. Dysinger, MD, MPH, Loma Linda University Medical Center
Susan L. Ettner, PhD, University of California, Los Angeles
Theodore Ganiats, MD, University of California, San Diego
Sheldon Greenfield, MD, University of California, Irvine
Sylvia Guendelman, PhD, LCSW, University of California, Berkeley
Kathleen Johnson, PharmD, MPH, PhD, University of Southern California
Thomas MaCurdy, PhD, Stanford University

Task Force Contributors

Wade Aubry, MD, University of California, San Francisco
Diana Cassady, PhD, University of California, Davis
Janet Coffman, MPP, PhD, University of California, San Francisco
Eric Groessl, PhD, University of California, San Diego
Heather J. Hether, PhD, University of California, Davis
Mi-Kyung Hong, MPH, University of California, San Francisco
Matt hew Ingram, MPH, MPP, University of California, Berkeley
Shana Lavarreda, PhD, MPP, University of California, Los Angeles
Jennifer Lewsey, MS, University of California, San Diego
Stephen McCurdy, MD, MPH, University of California, Davis
Sara McMenamin, PhD, University of California, San Diego
Ying-Ying Meng, DrPH, University of California, Los Angeles
Ninez Ponce, PhD, University of California, Los Angeles
Dominique Ritley, MPH, University of California, Davis
Meghan Soulsby, MPH, University of California, Davis
Chris Tonner, MPH, University of California, San Francisco
Arturo Vargas Bustamante, PhD, MA, MPP, University of California, Los Angeles

National Advisory Council

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

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

CHBRP Staff

Susan Philip, MPP, Director
Garen Corbett, MS, Principal Policy Analyst
David Guarino, Policy Analyst
John Lewis, MPA, Principal Policy Analyst
Karla Wood, Program Specialist

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

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