CALIFORNIA
HEALTH BENEFITS REVIEW PROGRAM

EXECUTIVE SUMMARY
Analysis of Senate Bill 890: Basic Health Care Services

A Report to the 2009-2010 California Legislature
April 17, 2010

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EXECUTIVE SUMMARY

California Health Benefits Review Program Analysis of Senate Bill 890

The California Senate Committee on Health requested on February 22, 2010, that the California Health Benefits Review Program (CHBRP) conduct an evidence-based assessment of the medical, financial, and public health impacts of a proposed Senate Bill (SB) 890 that would require health policies regulated by the California Department of Insurance (CDI) to cover medically necessary "basic health care services." CHBRP undertook this analysis pursuant to the provisions of the program's authorizing statute. [1]

Provisions of SB 890

SB 890 would make the four following changes to the CDI-regulated health insurance market:

- Create a benefits floor or minimum benefits standard by requiring CDI-regulated health insurance policies to provide coverage for "basic health care services" (BHCS). The definition of BHCS would be the same as that used for plans regulated by the Department of Managed Health Care (DMHC) as specified in Sections 1345 Health & Safety Code and Section 1300.67 of Title 28 of the Code of California Regulations.

- Prohibit such policies from having an annual limit or lifetime limit on BHCS.

- Establish that BHCS must be covered per medical necessity, and thus create a medical necessity standard for these services for CDI-regulated health insurance policies.

- Provide the commissioner the authority to approve copayments, deductibles, or limitations (for example, benefit limitations such as visit limits or dollar limits).

SB 890 would affect 2,438,000 Californians enrolled in CDI-regulated health insurance policies.

SB 890 would *not* prohibit policies "from charging subscribers or insureds a copayment or a deductible for a basic health care service or from setting forth, by contract, limitations on maximum coverage of basic health care services, provided that the copayments, deductibles, or limitations are reported to, and held unobjectionable by, the commissioner and set forth to the subscriber or insured."

According to the bill author, this legislation would establish consistent benefit coverage requirements, irrespective of regulator. Current law permits CDI-licensed health insurers to have annual and lifetime limits in coverage, whereas DMHC-regulated HMOs do not. SB 890 would prohibit such annual and lifetime benefit limits. CDI-regulated policies have benefit mandates as

[1] On February 22, 2010 CHBRP was requested to analyze bill language that was intended to be included in a gutted/amended version of SB 890. That language may be found in Appendix A. SB 890 was subsequently amended on April 6, 2010 to include the provisions related to BHCS. On April 13, 2010, SB 890 was further amended to include a number of provisions related to health care coverage and individual market reform. CHBRP's analysis is limited to the provision that adds Section 10112.56 to the Insurance Code per the original request submitted on February 22, 2010.

do DMHC-regulated plans, but CDI-regulated policies have no minimum benefit floor, which DMHC-regulated plans have under "basic health care services." Thus SB 890 would require CDI-regulated policies to cover medically necessary basic health care services in the same manner as plans regulated by the DMHC. Establishing consistent benefit mandate laws and regulations would "level the playing field" across both DMHC- and CDI-regulated markets and would prevent plans and insurers from "regulator shopping," in which different requirements incentivize plans (and the market) to move towards CDI-regulated policies. CDI-regulated policies have statutory benefit standards that allow for less comprehensive health insurance products that have historically lower medical loss ratios (proportion of premium spent on medical care) and higher administrative costs than DMHC-regulated plans. The bill author seeks to reverse this trend out of concern over the growing proportion of CDI-regulated policies in the market, especially in the individual market.

Potential Effects of Health Care Reform

On March 23, 2010, the federal government enacted the federal Patient Protection and Affordable Care Act (P.L.111-148), which was amended by the Health Care and Education Reconciliation Act (H.R.4872) that the President signed into law on March 30, 2010. These laws (referred to as P.L. 111-148) came into effect after CHBRP received a request for analysis for SB 890. There are provisions in P.L.111-148 that go into effect by 2014 that would dramatically affect the California health insurance market and its regulatory environment. For example, the law would establish state-based health insurance exchanges, with minimum benefit standards, for the small-group and individual markets. How these provisions are implemented in California would largely depend on regulations to be promulgated by federal agencies, and statutory and regulatory actions to be undertaken by the California state government.

There are also provisions in P.L.111-148 that go into effect within the short term (e.g., within 6 months of enactment), that would expand the number of Californians obtaining health insurance and potentially impact their sources of insurance. For example, one provision would allow children to enroll onto their parent's health plan or policy until they turn 26 years of age (effective 6 months following enactment). This may decrease the number of uninsured and/or potentially shift those enrolled with individually purchased insurance to group-purchased insurance. Given the uncertainty surrounding implementation of these provisions and given that P.L.111-148 was only recently enacted, the potential effects of these short-term provisions are not taken into account in the baseline estimates presented in this report. CHBRP's analysis of mandate bills typically address the marginal effects of the mandate bill—specifically how the state mandate would impact coverage, utilization, costs, and the public health, holding all other factors constant. P.L.111-148 would require plans and policies to cover certain preventive services at first dollar—with no copayments and with preventive services being exempt from deductibles (effective 6 months after enactment). Since these would be covered, the marginal cost impact and public health impacts projected in this analysis may be diminished due to the recently enacted federal health care reform.

Benefits to Be Newly Mandated Under SB 890

SB 890 refers to Sections 1345 Health & Safety Code and Section 1300.67 of Title 28 of the Code of California Regulations to define BHCS. Taking into account existing state and federal mandates already in place, SB 890 would newly mandate coverage for (1) preventive benefits for adults (physical exams, immunizations, health education, vision screenings, and hearing screenings), (2) preventive benefits for children (physical exams, immunizations, health education, well baby exams, vision screenings, and hearing screenings), (3) maternity coverage, (4) physical, occupational, and speech therapy, (5) home health care, and (6) hospice services.

Analytic Approach for SB 890

As discussed, SB 890 would make four changes to the CDI-regulated health insurance market. CHBRP's medical effectiveness, cost impact, and public health impact analyses will focus on the effects of the first two: setting BHCS as the minimum benefit floor, and prohibiting policies from setting annual or lifetime benefit limits. In the case of the benefit floor, since outpatient doctor's office visits, ambulatory services, diagnostic services, and inpatient hospitalizations are broad categories of coverage for which, by definition, health insurance policies provide reimbursement, CHBRP's analysis will focus on the following categories of benefits: (1) preventive benefits for adults (physical exams, immunizations, health education, vision screenings, and hearing screenings), (2) preventive benefits for children (physical exams, immunizations, health education, well baby exams, vision screenings, and hearing screenings), (3) maternity coverage, (4) physical, occupational, and speech therapy, (5) home health care, and (6) hospice services.

The third change—requiring that BHCS be covered per medical necessity criteria—would affect the way in which coverage determinations are made for BHCS for CDI-regulated policies. Because the adjudication of claims based on medical necessity by insurers cannot be predicted and because regulator behavior in dealing with those coverage determinations through the independent medical review (IMR) process also cannot be predicted, CHBRP is not able to assess the effects of this specific provision for this analysis. Instead, this report provides contextual information regarding the current regulatory framework for enforcing medical necessity determinations and how insurers use medical necessity criteria for coverage determinations.

The fourth change—providing the Insurance Commissioner authority to determine appropriate cost-sharing and benefit limitation levels—would affect the types of policies and products available in the market, depending on the regulations that may be promulgated and the way in which the Commission decides to enforce the provisions of SB 890. Because future regulator behavior cannot be predicted, the effects of this provision cannot be addressed for this analysis. Instead, the following provides contextual information regarding the comparative size and available products of CDI-regulated health insurance policies in California. In addition, historical information and background regarding the two agencies that oversee health insurance in California is provided.

Medical Effectiveness

SB 890 would require health insurers regulated by the California Department of Insurance (CDI) to provide coverage for a large number of health care services for which coverage is not required under current law. CDI-regulated insurers voluntarily cover some of these services. The medical effectiveness review focused on evidence of the effectiveness of services for which SB 890 would most likely affect coverage.

Preventive Services for Adults

Physical exams

- Adults who receive periodic health evaluations (i.e., periodic physical exams) were more likely to receive three screening tests for which there is evidence of effectiveness: cholesterol screening, fecal occult blood testing for colorectal cancer, gynecological examinations/Pap tests for cervical cancer.

- Findings from studies of the effects of periodic health evaluations on adults' receipt of counseling regarding health behaviors, immunization, and mammography were inconsistent.

- Findings regarding the effects of periodic health evaluations on health outcomes for adults were inconsistent.

Immunizations

- The Centers for Disease Control and Prevention recommend the following immunizations for adults based on evidence from randomized controlled trials (RCTs) and nonrandomized studies.

    - Hepatitis A vaccine—adults at increased risk
    - Hepatitis B vaccine—adults at increased risk
    - Human papillomavirus vaccine—all females age 11 to 26 years
    - Influenza vaccine—annually for all adults age 50 or older and younger adults at increased risk
    - Measles-mumps-rubella vaccine—all adults aged 19 to 49 years plus older adults at increased risk
    - Meningococcal conjugant vaccine—adults at increased risk
    - Pneumococcal polysaccharide vaccine—all elderly adults, and non-elderly adults at increased risk
    - Tetanus and diphtheria toxoid and pertussis vaccine—booster every 10 years for all adults
    - Varicella (i.e., chicken pox) vaccine—adults who lack immunity
    - Zoster (i.e., shingles) vaccine—all adults age 60 years or older

Health education

- There is evidence that the following **health education services that can be delivered as part of routine office visits** improve adults' behaviors associated with prevention of illness or injury.
    - Brief, multisession counseling interventions regarding alcohol misuse
    - Brief advice regarding smoking cessation
- There is also evidence that the following types of intensive, multisession health education services that cannot be delivered as part of a routine office visit are effective.
    - Psychotherapy interventions for alcoholism
    - Smoking cessation counseling interventions
    - Counseling to prevent sexually transmitted infections among adults at increased risk
    - Weight loss counseling and behavioral interventions for obese adults
    - Counseling and behavioral interventions to promote a healthy diet among adults with hyperlipidemia and other risk factors for cardiovascular and other diet-related chronic diseases
    - Self-management education for persons with arthritis, asthma, diabetes, and other chronic conditions.

Vision screening

- No studies of the effectiveness of screening adults for refractive error (i.e., nearsightedness, farsightedness, and astigmatism) were identified.
- There is insufficient evidence to assess the effectiveness of screening adults for glaucoma. *The lack of evidence for the effectiveness of glaucoma screening is not evidence that screening provides no benefit.*

Hearing screening

- No studies comparing hearing outcomes in screened versus unscreened adults were identified.
- Findings from a single multicomponent study of adults aged 55 to 74 years suggest that
    - Questionnaires and pure tone audiometry are accurate screening tests for hearing loss
    - Use of hearing aids is associated with improvements in hearing and quality of life
    - Persons who begin using hearing aids at a younger age have better hearing and report that hearing loss is associated with fewer adverse effects than persons who begin using hearing aids at an older age.

Preventive Services for Children

Physical exams

- No studies of the effectiveness of periodic physical examinations for children were identified.

- A guideline issued by the American Academy of Pediatrics that is based on expert opinion recommends that all children and adolescents receive periodic physical examinations. Recommendations regarding the frequency and content of physical examinations vary depending on the child's age (e.g., recommends more frequent visits for infants and toddlers than for older children).

Immunizations

- The Centers for Disease Control and Prevention recommend the following immunizations for children based on evidence from RCTs and nonrandomized studies.
    - Haemophilus influenza type B conjugate vaccine—all children
    - Hepatitis A vaccine—all children
    - Hepatitis B vaccine—all children
    - Human papillomavirus vaccine—all females age 11 to 26 years
    - Influenza vaccine—annually for all children age 6 months to 18 years
    - Measles-mumps-rubella vaccine—all children
    - Meningococcal conjugant vaccine– all children age 11 to 12 years plus younger children at increased risk
    - Pneumococcal conjugant vaccine—all children
    - Pneumococcal polysaccharide vaccine—children at increased risk
    - Inactivated poliovirus vaccine—all children
    - Rotavirus vaccine—all children
    - Tetanus and diphtheria toxoid and pertussis vaccine—all children plus booster every 10 years for adolescents
    - Varicella (i.e., chicken pox) vaccine—all children

Health education

- There is evidence that brief advice and counseling prevents smoking among adolescents and increases the percentage of adolescent smokers who quit smoking.

- There is insufficient evidence to determine whether brief counseling interventions prevent or reduce alcohol use among adolescents. *The lack of evidence for the effectiveness of these health education services for adolescents is not evidence that such counseling is not beneficial*.

- There is evidence that the following types of intensive, multisession health education services that cannot be delivered as part of a routine office visit improve the health of children or adolescents.
    - Counseling to prevent sexually transmitted infections among sexually active adolescents
    - Weight loss counseling and behavioral interventions for obese children age 6 years or older
    - Asthma self-management education

Vision screening

- No studies were identified that compared prevalence of amblyopia (i.e., lazy eye) or refractive error (i.e., nearsightedness, farsightedness, and astigmatism) among screened and unscreened children were identified. *The lack of evidence for the effectiveness of screening for amblyopia and refractive error is not evidence that screening provides no benefit*.

- Evidence from a large, well-designed RCT suggests that children who are screened multiple times as infants or toddlers are less likely to have amblyopia (i.e., lazy eye) at age 7.5 years than children who are screened only once.

Hearing screening

- Evidence from nonrandomized studies with comparison groups suggest that participation in a universal newborn screening program increases the likelihood that a child with permanent congenital hearing loss will be diagnosed by age 9 months.

- Children with permanent congenital hearing loss diagnosed through universal screening programs have higher scores on tests of receptive and expressive language than children with permanent hearing loss who did not participate in a universal screening program.

<u>Physical, Occupational, and Speech Therapy</u>

- Physical, occupational, and speech therapy are used to help persons recover from many types of injuries or illnesses and to cope with multiple chronic conditions.

- Most studies of the effectiveness of physical, occupational, and speech therapy assess impact on persons with specific injuries, illnesses, and conditions. Findings from studies that enrolled persons with one condition may not generalize to persons with other conditions.

- There is evidence that some forms of physical, occupational, and speech therapy are effective for treatment of some injuries, illnesses, and conditions.

<u>Home Health Services</u>

- Most studies of home health services have evaluated the impact of these services on elderly persons, and many of them have been conducted outside the United States.

- There is *clear and convincing evidence* that home health services are associated with statistically significant *reductions* in days of hospitalization and nursing home use and with a nonsignificant decrease in mortality relative to usual care.

- There is *clear and convincing evidence* that home-based rehabilitation is associated with *fewer* days of hospitalization than inpatient rehabilitation.

- There is *insufficient evidence* to determine whether home care improves physical or mental health outcomes for children with very low birth weight, genetic disorders, or chronic conditions. *Insufficient evidence indicates a lack of evidence regarding the medical effectiveness of home health services for children. It is not the same as evidence of no effect.*

Hospice Care Services

- Most studies of hospice care that have strong research designs were published in the 1980s. Pain control medication and standards of care for pain control may have changed since these studies were conducted.

- Most studies have evaluated the impact of hospice care on persons with terminal cancers.

- The *preponderance of evidence* suggests that hospice care *reduces* some symptoms associated with terminal illness, such as anxiety, diarrhea, and nausea.

- The evidence of the effects of hospice care on pain and quality of life is *ambiguous*.

Maternity Services

- CHBRP has completed three reports on the effectiveness of prenatal care services. These reports have concluded that many prenatal care services reduce the likelihood of poor birth outcomes for mothers and newborns. These services include

    - Counseling regarding behavioral risk factors (e.g., smoking, alcohol use)
    - Screening for fetal abnormalities (e.g., Down syndrome)
    - Screening and treatment for infectious disease (e.g., human immunodeficiency virus)
    - Screening and treatment for metabolic, nutritional, and endocrine disorders (e.g., gestational diabetes)
    - Screening for hypertensive disorders and treatment to prevent preeclampsia and eclamptic seizures
    - Screening for placenta previa
    - Use of progestational agents to prevent preterm delivery
    - Medications to prevent neurological and respiratory impairment in fetuses at risk for preterm delivery

Utilization, Cost, and Coverage Impacts

SB 890 would affect 2,438,000 people enrolled in CDI-regulated policies. SB 890 does not directly affect privately purchased plans regulated by DMHC nor would it directly affect publicly purchased DMHC-regulated plans, California Public Employees' Retirement System Health Maintenance Organizations (CalPERS HMOs), Medi-Cal Managed Care, or Healthy Families.

The bill could affect utilization and cost in two ways: (1) by requiring CDI-regulated policies to cover medically necessary BHCS and (2) by prohibiting those policies from using an annual or lifetime benefit limits for BHCS.

The main cost effect of SB 890 is driven by additional coverage for maternity services within the CDI-regulated individual market. Currently, 216,000 individuals are covered for maternity care in this market, and the mandate would extend this coverage to 963,000 individuals without maternity services coverage. This represents a 446% increase.

Coverage

- Currently, 97% of enrollees in the group market and 88% in the individual market have coverage for **adult preventive services.**

- Current coverage for **preventive services for children** is estimated to be approximately 100% in the group market and 88% in the individual market.

- Coverage for **physical, occupation, and speech therapy** are estimated to be approximately 100% in the group market and 85% in the individual market.

- Coverage for **home health services** is estimated to be approximately 100% in the group markets and 88% in the individual market.

- Coverage for **hospice services** is estimated to be approximately 100% in the group market and 88% in the individual market.

- Coverage for **maternity services** is estimated to be 100% in the group market (due to existing federal requirements) and 18% in the individual market.

For those with current gaps in coverage, SB 890 would extend coverage to 100%. Table 1 shows the number of persons in group (large and small) and the individual market who would be gaining coverage. Again, the effect of SB 890 would be most pronounced in the individual market for maternity services where coverage would be added for 963,000 individuals in the CDI-regulated individual market, or 82% of that market.

Utilization

- For enrollees without coverage for specific BHCS services (except maternity services), CHBRP relied on the RAND Health Insurance Experiment (HIE). For enrollees with

coverage for specific services, CHBRP relied on data reflected in the Milliman Health Cost Guidelines (HCGs) to model the effects of cost sharing on health care utilization. As summarized in Table 1, utilization for specific BHCS is estimated to increase by a range: approximately 1.8% (for home health visits) to 2.4% (for adult physical exams) over premandate levels. There are two exceptions where CHBRP assumed no increase in utilization as a result of the mandate

- Childhood immunizations: CHBRP estimates no increase in utilization of these services since children are generally required to have immunizations before enrolling in schools, and enrollees without coverage can obtain immunizations through the Vaccine for Children program.
- Vision exams: Although many enrollees in the CDI-regulated market currently do not have coverage for routine vision exams under their health insurance policy, many employers offer separate vision plans to cover these services. CHBRP assumed that all group enrollees without vision exam coverage through their CDI-regulated policy would have access to either discounted or partially covered vision exams through other sources. Thus, CHBRP assumed no increase in utilization for enrollees in the small- and large-group markets newly covered for vision exams under the mandate. In the individual market, CHBRP assumed an increase in utilization for vision exams for adults but not for children since responses to an estimated 100% of children in the individual market currently have coverage for this service.

- To estimate the impact on utilization of SB 890 on maternity services, CHBRP relied on our *Analysis of AB 1825: Maternity Services*. CHBRP estimates no increase in utilization for maternity services as result of coverage since (1) most women deliver in a hospital, so utilization for maternity-related hospitalization is not estimated to change, and (2) most women are likely to continue to face large out-of-pocket expenditures for maternity services (including prenatal care), regardless of whether or not their insurance policy includes maternity benefits. This is because about 70% of the women in CDI-regulated individual policies are currently in high-deductible health plans (HDHPs).

Premiums and Expenditures

As summarized in Table 1, the total net annual expenditures for all plans and policies are estimated to increase by $49,075,000 or 0.06% for the year following implementation of the mandate. Approximately 82% of the expenditure increase is attributable to maternity services, and the other 18% is associated with other BHCS.

- CalPERS HMO, MediCal Managed Care, and Healthy Families are not directly affected by the mandate.

- The increase in out-of-pocket expenditures for benefits that would be newly covered (e.g., copayments and deductibles) are estimated to increase by $32,342,000 or 0.54%.

- Total premiums expenditures for private employers purchasing group insurance are estimated to increase by $4,380,000 or 0.01%.

- Total premiums expenditures for enrollees in the group market are estimated to increase by $1,355,000 or 0.01%.

- Total premium expenditures for individuals purchasing individual insurance are estimated to increase by $127,949,000 or 2.14%.

- Out-of-pocket expenditures for noncovered benefits for enrollees in policies subject to SB 890 will be reduced by $116,951,000, or 100%.

Other Cost Impacts

- SB 890 would prohibit lifetime and annual dollar limits on BHCS. Responses to CHBRP's SB 890 Coverage Survey suggest that few policies currently have significant annual or lifetime limits.

    - In terms of annual benefit limits, about 0.6% of the group market and 0.1% of the individual market are estimated to have annual benefit limits. The annual average dollar limits for this proportion of policies with limits are $70,000 for group policies and $100,000 for individual policies.
    - In terms of lifetime benefit limits, responses to CHBRP's SB 890 Coverage Survey indicated that all policies had lifetime benefit limits that were close to $5 million (group policies have an average lifetime dollar limit of approximately $4.900 million, and individual policies have an average lifetime dollar limit of approximately $5.200 million).
    - It is possible that carriers with a smaller proportion of market share that are not captured by CHBRP's survey have more stringent annual or lifetime limits, however these survey responses capture 79% of the CDI-regulated market.
    - Eliminating annual and lifetime benefit limits has the following effect: removing annual dollar limits would increase per member per month (PMPM) covered claim costs by about $0.63-$0.68 in the large-group plans, $0.05-$0.06 in the small-group plans, and $0.00-$0.02 in the individual plans.

- CHBRP estimates the impact on the number of insured when the premium increase (or decrease) faced by any segment of the population is at least a 1% increase. Using CHBRP's standard methodology, premium changes associated with SB 890 are projected to lead to a net *increase* of uninsured of approximately 9,629, of which 9,335 are due to the addition of maternity coverage, and 294 are due to other BHCS. Since the premium increases for large group and small group were less than 1%, CHBRP does not estimate an increase in the number of uninsured persons in these markets.

Public Health Impacts

- Comprehensive preventive care is associated with preventing a myriad of conditions that can lead to premature death. Immunizations protect against infectious diseases that can result in death, and health education counseling can lead to a reduction in risky behaviors that can

affect mortality rates. It is estimated that as a result of SB 890, there will be an increase in adult preventive services in 10,763 more physical examinations, 12,380 immunizations, 4,427 vision exams, and 2,615 hearing/speech exams. Although CHBRP is unable to estimate precisely the impact these services will have on public health, some improvement in public health would be expected.

- It is estimated that as a result of SB 890, there will be an increase in pediatric preventive services in 3,058 more physical examinations, 4,440 well baby exams, and 1,618 hearing screening exams. Although CHBRP is unable to estimate precisely the impact these services will have on public health, some improvement in public health would be expected.

- CHBRP estimates that as a result of SB 890, utilization of physical, occupational, and speech therapy will increase by 4,489 visits. Some public health benefit would be expected from this increased utilization.

- CHBRP estimates that 8,300 pregnancies would be newly covered as a result of SB 890. CHBRP is not able to predict exactly what the impact of SB 890 would be on the utilization of effective prenatal services would be, but it stands to reason that some reduction in pregnant women smoking, low–birth weight births, hepatitis B transmissions, HIV transmissions, cases of preeclampsia, and cases of respiratory distress syndrome would be expected.

- CHBRP estimates that as a result of SB 890, utilization will increase by 2,772 home health visits, and a corresponding decrease in the number of hospitalizations would be expected. No increase in utilization of hospice care is expected as a result of SB 890.

- Although females use basic health care services at higher rates compared to males, the literature on the impact of coverage of basic health care services on utilization by gender is ambiguous. Therefore, the impact of SB 890 by gender is unknown.

- Research suggests that there could be a differential impact of coverage for basic health care services on utilization by race/ethnicity. These findings suggest that SB 890 could have a differential effect on utilization of basic health care services by racial and ethnic group, although the exact impact is unknown.

- Comprehensive preventive care is associated with preventing a myriad of conditions that can lead to premature death. Immunizations protect against infectious diseases that can result in death; health education counseling can lead to a reduction in risky behaviors that can affect mortality rates; and routine health care check-ups are important to improve screening rates for cancers which can be effectively treated if caught in the early stages. CHBRP estimates that utilization of specific BHCS will increase by 1.8%-2.5%. Although CHBRP is unable to determine precisely the impact of SB 980 on premature death, over time, SB 890 could potentially contribute to the reduction in premature death in California.

Table 1. SB 890 Impacts on Benefit Coverage, Utilization, and Cost, 2010

	Before Mandate	After Mandate	Increase/ Decrease	Change After Mandate
Coverage				
Total enrollees with health insurance subject to state regulation (a)	19,487,000	19,487,000	0	0.00%
Total enrollees with health insurance subject to SB 890				
In large- and small-group policies	1,259,000	1,259,000	0	0.00%
In individual policies	1,179,000	1,179,000	0	0.00%
Total	2,438,000	2,438,000	0	0.00%
Coverage of BHCS (Except Maternity)				
Number of individuals with adult preventative coverage				
In large- and small-group policies	1,227,000	1,259,000	32,000	2.61%
In individual policies	1,037,000	1,179,000	142,000	13.69%
Total	2,264,000	2,438,000	174,000	7.69%
Percentage of individuals with adult preventative coverage				
In large- and small-group policies	97.5%	100.0%	2.5%	2.61%
In individual policies	88.0%	100.0%	12.0%	13.69%
Total	92.9%	100.0%	7.1%	7.69%
Number of individuals with child immunology coverage				
In large- and small-group policies	1,259,000	1,259,000	0	0.00%
In individual policies	1,038,000	1,179,000	141,000	13.58%
Total	2,297,000	2,438,000	141,000	6.14%
Percentage of individuals with child immunology coverage				
In large- and small-group policies	100.0%	100.0%	0.0%	0.00%
In individual policies	88.0%	100.0%	12.0%	13.58%
Total	94.2%	100.0%	5.8%	6.14%
Number of individuals with child preventative coverage				
In large and small-group policies	1,259,000	1,259,000	0	0.00%
In individual policies	1,038,000	1,179,000	141,000	13.58%
Total	2,297,000	2,438,000	141,000	6.14%
Percentage of individuals with child preventative coverage				
In large- and small-group policies	100.0%	100.0%	0.0%	0.00%
In individual policies	88.0%	100.0%	12.0%	13.58%
Total	94.2%	100.0%	5.8%	6.14%

Table 1. SB 890 Impacts on Benefit Coverage, Utilization, and Cost, 2010 (cont'd)

	Before Mandate	After Mandate	Increase/ Decrease	Change After Mandate
Coverage of BHCS (Except Maternity) (con't.)				
Number of individuals with PT/OT/ST coverage				
In large- and small-group policies	1,256,000	1,259,000	3,000	0.24%
In Individual policies	1,006,000	1,179,000	173,000	17.20%
Total	2,262,000	2,438,000	176,000	7.78%
Percentage of individuals with PT/OT/ST coverage				
In large- and small-group policies	99.8%	100.0%	0.2%	0.24%
In individual policies	85.3%	100.0%	14.7%	17.20%
Total	92.8%	100.0%	7.2%	7.78%
Number of individuals with Hospice coverage				
In large- and small-group policies	1,258,000	1,259,000	1,000	0.08%
In Individual policies	1,039,000	1,179,000	140,000	13.47%
Total	2,297,000	2,438,000	141,000	6.14%
Percentage of individuals with Hospice coverage				
In large- and small-group policies	99.9%	100.0%	0.1%	0.08%
In Individual policies	88.1%	100.0%	11.9%	13.47%
Total	94.2%	100.0%	5.8%	6.14%
Number of individuals with home health coverage				
In large- and small-group policies	1,259,000	1,259,000	0	0.00%
In individual policies	1,040,000	1,179,000	139,000	13.37%
Total	2,299,000	2,438,000	139,000	6.05%
Percentage of individuals with home health coverage				
In large- and small-group policies	100.0%	100.0%	0.0%	0.00%
In individual policies	88.2%	100.0%	11.8%	13.37%
Total	94.3%	100.0%	5.7%	6.05%
Coverage of Maternity Services				
Number of individuals with maternity coverage				
In large- and small-group policies	1,259,000	1,259,000	0	0.00%
In individual policies	216,000	1,179,000	963,000	445.83%
Total	1,475,000	2,438,000	963,000	65.29%
Percentage of individuals with maternity coverage				
In large- and small-group policies	100.0%	100.0%	0.0%	0.00%
In individual policies	18.3%	100.0%	81.7%	445.83%
Total	60.5%	100.0%	39.5%	65.29%

Table 1. SB 890 Impacts on Benefit Coverage, Utilization, and Cost, 2010 (cont'd)

	Before Mandate	After Mandate	Increase/ Decrease	Change After Mandate
Coverage in Terms of Annual/Lifetime Dollar Benefit Limits				
Number of individuals in policies with lifetime dollar benefit limits				
In large- and small-group policies	1,256,000	—	−1,256,000	−100.0%
In individual policies	1,179,000	—	−1,179,000	−100.0%
Total	2,435,000	—	−2,435,000	−100.0%
Percentage of individuals in policies with lifetime dollar benefit limits				
In large- and small-group policies	99.8%	0.0%	−99.8%	−100.0%
In individual policies	100.0%	0.0%	−100.0%	−100.0%
Total	99.9%	0.0%	−99.9%	−100.0%
Average lifetime dollar benefit limit for individuals with a limit				
In large- and small-group policies	$4,900,000	N/A		
In individual policies	$5,200,000	N/A		
Total	$5,000,000	N/A		
Number of individuals in policies with annual dollar benefit limits				
In large- and small-group policies	8,000	0	−8,000	−100%
In individual policies	1,000	0	−1,000	−100%
Total	9,000	0	−9,000	−100%
Percentage of individuals in policies with annual dollar benefit limits				
In large- and small-group policies	0.6%	0.0%	−0.6%	−100.0%
In individual policies	0.1%	0.0%	−0.1%	−100.0%
Total	0.4%	0.0%	−0.4%	−100.0%
Average annual dollar benefit limit for individuals with a limit				
In large- and small-group policies	$70,000	N/A		
In individual policies	$100,000	N/A		
Total	$73,000	N/A		
Utilization and Cost				
Number of adult physical exams	450,779	461,542	10,763	2.39%
Number of child physical exams	361,425	368,923	7,498	2.07%
Number of PT/OT/ST visits	192,495	196,984	4,489	2.33%
Number of home health visits	151,681	154,453	2,772	1.83%
Number of child immunology procedures	1,491,173	1,491,173	0	0.00%
Number of members with uncomplicated pregnancies				
Covered by insurance	19,041	27,339	8,298	43.58%
Covered by AIM or Medi-Cal	3,483	3,483	0	0.00%
Not covered by insurance	8,298	0	−8,298	−100.00%
Total	30,822	30,822	0	0.00%
Average cost per uncomplicated delivery	$12,959	$12,959	$0	0.00%

Table 1. SB 890 Impacts on Benefit Coverage, Utilization, and Cost, 2010 (cont'd)

	Before Mandate	After Mandate	Increase/ Decrease	Change After Mandate
Expenditures				
Premium expenditures by private employers for group insurance	$43,519,324,000	$43,523,704,000	$4,380,000	0.01%
Premium expenditures for individually purchased insurance	$5,992,795,000	$6,120,744,000	$127,949,000	2.14%
Premium expenditures by individuals with group insurance, CalPERS, Healthy Families, AIM or MRMIP (b)	$12,820,614,000	$12,821,969,000	$1,355,000	0.01%
CalPERS employer expenditures (c)	$3,267,842,000	$3,267,842,000	$0	0.00%
Medi-Cal state expenditures (d)	$4,015,596,000	$4,015,596,000	$0	0.00%
Healthy Families state expenditures	$910,306,000	$910,306,000	$0	0.00%
Individual out-of-pocket expenditures for covered benefits (deductibles, copayments, etc.)	$5,961,186,000	$5,993,528,000	$32,342,000	0.54%
Out-of-pocket expenditures for noncovered benefits (e)	$116,951,000	$0	−$116,951,000	−100.00%
Total Annual Expenditures	$76,604,614,000	$76,653,689,000	$49,075,000	0.06%

Source: California Health Benefits Review Program, 2010.

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

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

(c) Of the CalPERS employer expenditures, about 58% would be state expenditures for CalPERS members who are state employees. However, given that SB 890 would not affect CalPERS the increase is attributed to premiums expenditures by individuals with CDI-regulated group policies.

(d) Healthy Families Program state expenditures include expenditures for approximately 7,000 enrollees covered by the Major Risk Medical Insurance Program (MRMIP) and 7,000 enrollees covered by the Access for Infants and Mothers (AIM) program. SB 890 would not affect these publicly purchased programs.

(e) This includes those expenditures for enrollees who do not have coverage for the mandated services but who obtain the mandated benefit either by self-pay or through other sources. For example, for enrollees who do not have coverage for adult vision exams through their health insurance, some may obtain vision exams by self-pay or through coverage through an employer sponsored vision-only policy.

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 Care; OT=occupational therapy; PT=physical therapy; ST=speech therapy.

Acknowledgements

The California Senate Committee on Health requested on February 22, 2010, that the California Health Benefits Review Program (CHBRP) conduct an evidence-based assessment of the medical, financial, and public health impacts of a proposed Senate Bill that would impose benefit mandates. Specifically the proposed legislation, SB 890, would require health policies regulated by the California Department of Insurance (CDI) to cover medically necessary "basic health care services." CHBRP undertook this analysis pursuant to the provisions of the program's authorizing statute.

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

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California Health Benefits Review Program Committees and Staff

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

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

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