CALIFORNIA
HEALTH BENEFITS REVIEW PROGRAM

EXECUTIVE SUMMARY
Analysis of Senate Bill 92: Health Care Reform

A Report to the 2009-2010 California Legislature
April 13, 2009

CHBRP 09-06

The California Health Benefits Review Program (CHBRP) responds to requests from the State Legislature to provide independent analyses of the medical, financial, and public health impacts of proposed health insurance benefit mandates and proposed repeals of health insurance benefit mandates. In 2002, CHBRP was established to implement the provisions of Assembly Bill 1996 (California Health and Safety Code, Section 127660, et seq.) and was reauthorized by Senate Bill 1704 in 2006 (Chapter 684, Statutes of 2006). The statute defines a health insurance benefit mandate as a requirement that a health insurer or managed care health plan (1) permit covered individuals to obtain health care treatment or services from a particular type of health care provider; (2) offer or provide coverage for the screening, diagnosis, or treatment of a particular disease or condition; or (3) offer or provide coverage of a particular type of health care treatment or service, or of medical equipment, medical supplies, or drugs used in connection with a health care treatment or service.

A small analytic staff in the University of California's Office of the President supports a task force of faculty from several campuses of the University of California, as well as Loma Linda University, the University of Southern California, and Stanford University, to complete each analysis within a 60-day period, usually before the Legislature begins formal consideration of a mandate bill. A certified, independent actuary helps estimate the financial impacts, and a strict conflict-of-interest policy ensures that the analyses are undertaken without financial or other interests that could bias the results. A National Advisory Council, drawn from experts from outside the state of California and designed to provide balanced representation among groups with an interest in health insurance benefit mandates, reviews draft studies to ensure their quality before they are transmitted to the Legislature. Each report summarizes scientific evidence relevant to the proposed mandate, or proposed mandate repeal, but does not make recommendations, deferring policy decision making to the Legislature. The State funds this work through a small annual assessment on health plans and insurers in California. All CHBRP reports and information about current requests from the California Legislature are available at the CHBRP Web site, www.chbrp.org.

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EXECUTIVE SUMMARY

California Health Benefits Review Program Analysis of Senate Bill 92: Health Care Reform

Senate Bill (SB) 92: Health Care Reform, introduced by Senator Sam Aanestad on January 21, 2009, is a legislative proposal with numerous provisions to reform the system of health care delivery in California. Among the many provisions in this 126-page omnibus bill, there are four that fall within the purview of CHBRP for review. These four provisions—Sections 8 and 18 (adding sections 1349.3 and 1399.830 to the Health and Safety Code) and Sections 19 and 29 (adding Sections 699.6 and 10920 to the California Insurance Code)—would do the following:

- Allow a carrier domiciled in another state to offer, sell, or renew a health insurance policy in California without holding a license issued by the Department of Managed Health Care (DMHC) or a certificate of authority issued by the California Department of Insurance (CDI). The bill would exempt the carrier's plan contract or policy from requirements otherwise applicable to plans and insurers providing health care coverage in California if the plan contract or policy complies with the domiciliary state's requirements, and the carrier is lawfully authorized to issue the plan contract or policy in that state and to transact business there.

- Authorize in-state carriers to offer, market, and sell a health care service plan or health insurance policy that does not include all of the benefits mandated under California state law to individuals with incomes below 350% of the federal poverty level (FPL) if the individual waives those benefits, as specified, and the plan contract or insurance policy is approved by the DMHC or the CDI.

- For in-state carrier product offerings, SB 92 requires the DMHC and CDI to prepare a disclosure form prior to July 1, 2010, that is easily understood and that summarizes the state-mandated benefits a health care service plan/health insurer is required to include in its plan/policy. Before a limited-benefit health insurance product is issued, individuals are required to sign a disclosure form specifying the benefits they are waiving, indicating that the plan/insurer has explained the contents of the disclosure and that they understand those contents. The expectation is that the DMHC and CDI would use their enforcement authority to ensure that plans and insurers provide sufficient written information about what mandated benefits are included and what mandated benefits and offerings are excluded so that the purchaser understands they are agreeing to waive mandated benefits.

California has two regulatory agencies that provide oversight of health insurance products sold in California. The DMHC has as its primary focus the oversight of health maintenance organizations (HMOs) and some preferred provider organization (PPO) plans. The CDI has broad regulatory authority over all other health insurance products. Under current law, carriers may only sell health insurance policies to employers and individuals who reside or work in California if the carrier (or its subsidiary) holds a license from the DMHC or a certificate of authority from the CDI. SB 92 would relax this requirement by allowing a carrier domiciled

(based) and licensed in another state to sell health insurance policies in California without obtaining a license (or certificate of authority) from the DMHC or CDI, as long as the carrier complied with the regulations of the state where it was domiciled and licensed. Currently, about two-thirds of the private health insurance products sold in California are underwritten by in-state carriers—carriers domiciled and licensed in California.

According to the bill author, the subset of provisions analyzed in this report are intended to remedy the problem of costly state regulations, particularly legislatively imposed health insurance benefit mandates, that have reduced access to affordable health insurance by driving up the cost of premiums. The bill author maintains that the "state's idea of consumer protection does not match what is medically necessary or what consumers want."[1] According to the bill author, the provisions in this bill are also intended to help low-income individuals gain access to private health insurance products with larger provider networks than Medi-Cal, in light of physicians' unwillingness to treat Medi-Cal beneficiaries due to low rates of reimbursement.[2]

In 2007, CHBRP conducted two previous analyses of legislation substantially similar to SB 92. One bill, Assembly Bill (AB) 1214 (Emmerson), would have allowed in-state carriers to issue plans or policies to groups and individuals that omitted one or more of the currently mandated health insurance benefits. The other bill, SB 365 (McClintock), would have allowed health insurance policies to be offered to California residents without the carrier obtaining a license or certificate of authority from the DMHC or CDI, as long as the carrier complied with the regulations of the state where it was domiciled and licensed.

SB 92 includes provisions similar to those included in AB 1214 and SB 365. Both SB 365 and SB 92 would allow carriers to offer limited-mandate plans to any group or any individual, regardless of their level of income, without obtaining a license from the DMHC or CDI, as long as the carrier complies with the laws and regulations of the carrier's selected home state. AB 1214 would have allowed in-state carriers to offer limited-mandate plans to any group or individual, whereas SB 92 allows in-state carriers to offer limited-mandate plans only to individuals below 350% of the FPL.

CHBRP is charged to not only analyze bills that would add health benefit mandates, but also those that would repeal existing mandates. CHBRP has been asked to analyze the medical effectiveness and public health and cost impacts of SB 92 since it has been interpreted as a bill that would effectively repeal or relax a set of health benefit mandate requirements in current law.

Analytic Approach

This analysis and report is organized in two parts. Part I of the report focuses on the medical effectiveness and public health and cost impacts of allowing health insurance products to be sold to Californians that do not include state-mandated benefits. Part II of this report presents policy

[1] Pat McConahay, Republican Sen. *Aanestad Puts Forward Market-Based Plan to Rework Health Care in California*, California Healthline Special Report, March 18, 2009. Available at www.californiahealthline.org/Special-Reports/2009/Republican-Sen-Aanestad-Puts-Forward-MarketBased-Vision-for-Health-Care-Reform.aspx. Accessed March 26, 2009.

[2] Personal communication with L. Halderman, MD, Senior Policy Advisor for Senator Aanestad, February 13, 2009.

considerations of allowing insurance carriers to sell health insurance policies in California without obtaining a license or certificate of authority from the DMHC or CDI. This provision effectively exempts out-of-state carriers from California laws and regulations governing health insurance products.

To assess the medical effectiveness and the potential public health and cost impacts of SB 92, Part I of this report does the following:

- In the *Medical Effectiveness* section, CHBRP examines each of the benefits that may be excluded under SB 92 to determine whether the mandated benefit is considered to be medically effective based on existing evidence. Conclusions are drawn from the U.S. Preventive Services Task Force recommendations, CDC recommendations, NIH guidelines, and other authoritative sources. If a CHBRP analysis exists for a current benefit mandate, this report relies on that previous analysis. For example, the medical effectiveness analysis in the CHBRP report on AB 228 (2005) was used as evidence on the effectiveness of covering transplantation services for persons with HIV.
- The *Potential Cost Impacts s*ection addresses the issue of the added cost of California health insurance benefit mandates on the entire market by summarizing the existing literature and expert opinion on the premium savings associated with limited-mandate plans sold across state lines. Specifically, this report present analyses of two hypothetical scenarios:
    - **Scenario 1: Maximum Impact.** This extreme hypothetical scenario assumes that limited-mandate plans would be purchased by all currently insured Californians in lieu of their current plans. Buyers in all market segments (large group, small group, and individual) and all insurance products (high-deductible, low-deductible, and no-deductible policies) would respond to the lower premiums offered by limited-mandate policies, and would switch to those policies in response to a lower-cost alternative. This scenario projects the impacts of all currently insured persons purchasing policies that are otherwise identical to their current policies, except without a subset of the benefit mandates.
    - **Scenario 2: Low Impact.** Because of evidence that employees in the group market prefer generous benefits, and because there is evidence that those in the individual market are the most price-sensitive, this scenario assumes that limited-mandate policies would only have an impact on the individual market. This scenario also assumes that all those currently insured in this market segment with incomes below 350% of the FPL ($39,905 for a single person, $77,175 for a family of four) currently own HDHP policies in the CDI-regulated segment of the market since they are the least expensive policies currently available. This assumption is based on data from CHIS 2007 indicating that about 1/3 of those insured in the individual market have incomes below 350% of the FPL and CHBRP's estimates that about 1/3 of the total individual market consists of HDHP policies in the CDI-regulated segment of the market.
- The *Potential Cost Impacts* section also estimates the short-term impacts on those currently uninsured in California under each of the scenarios described above.

- The *Potential Public Health Impacts* section discusses the potential health benefits and harms associated with allowing limited-mandate plans to be marketed in California. In particular, the public health impacts section evaluates these scaled-back benefit packages from the perspective that having health insurance is better for one's health and well-being than being uninsured, and having comprehensive coverage is preferable to having less coverage under limited-mandate plans. The report also offers general conclusions regarding the public health impact of excluding a particular benefit mandate based on the findings presented in the *Medical Effectiveness* section and the number of insured Californians that may be affected by the health condition.

Part I. The Impact of Allowing Limited-Mandate Plans to Compete in the California Market

By exempting out-of-state carriers from licensure by the DMHC or CDI, SB 92 would open the group and individual market to insurance policies sold by out-of-state carriers that do not include the health insurance benefits mandated under California law or regulation. SB 92 would also allow in-state carriers to offer health insurance products that do not include California benefit mandates, as long as the income of those potential individual beneficiaries is below 350% of the FPL.

Medical Effectiveness of Current Mandates: Summary of Evidence

Limited-mandate plans are those health care service plan contracts and health insurance policies that do not include all of the 46 benefits mandated under California law.

CHBRP reviewed evidence regarding the medical effectiveness of 31 of the 46 mandates to which SB 92 would apply for its previous report on AB 1214, and summarized findings from CHBRP reports on two new mandates that were enacted since the AB 1214 report was published. Thirteen mandates were not analyzed because they do not require coverage for specific diseases or health care services, require coverage for a vaccination that has yet to be approved by the Food and Drug Administration (i.e., AIDS vaccine), or apply to such a large number of diseases that the evidence cannot be summarized briefly (e.g., off-label use of prescription drugs).

For this analysis, CHBRP relied primarily on meta-analyses, systematic reviews, and evidence-based practice guidelines, because these types of studies synthesize findings from multiple studies. Previous CHBRP reports were reviewed where applicable. Individual studies were examined only if meta-analyses, systematic reviews, or evidence-based practice guidelines were not available or if no such syntheses had been published recently. If no studies had been published, CHBRP relied on clinical practice guidelines based on expert opinion.

The amount and strength of the evidence regarding the medical effectiveness of the services for which coverage may be excluded under SB 92 varies. The outcomes that are most important for assessing effectiveness also differ.

Nevertheless, many of the mandates and mandated offerings addressed by SB 92 require health insurance products to provide coverage for health care services for which there is strong evidence of effectiveness.

Findings regarding the medical effectiveness of specific health care services for which coverage could be excluded under SB 92 are as follows:

- There is *clear and convincing evidence* from multiple, well-designed randomized controlled trials (RCTs) that the following tests and treatments *are medically effective*: cancer screening tests for breast, cervical, and colorectal cancers; screening tests for the human immunodeficiency virus (HIV); diagnostic procedures and treatments for breast cancer; diabetes management medications, services, and supplies; services for the diagnosis and treatment of osteoporosis; medication and psychosocial treatments for severe mental illness and alcoholism; some preventive services for children and adolescents; prescription contraceptive devices; diagnosis and treatment of infertility; and home care services for elderly and disabled adults.

- A *preponderance of evidence* from nonrandomized studies and/or RCTs with major weaknesses indicates that the following tests and treatments *are medically effective*: liver and kidney transplantation services for persons with HIV; medical formulas and foods for persons with phenylketonuria; prosthetic devices; orthotic devices for some conditions; special footwear for persons with rheumatoid arthritis; acupuncture; pain management medication for persons with terminal illnesses; pediatric asthma management; prenatal diagnosis of genetic disorders; expanded alpha-fetoprotein screening; and surgery for the jawbone and associated bone joints.

- The evidence of the effectiveness is *ambiguous* for prosthetic devices used by persons who have had a laryngectomy; special footwear for persons with diabetes; breast reconstruction surgery following mastectomy; and hospice care.

- There is *insufficient evidence* to determine whether the following tests and treatments are effective: tests for screening and diagnosis of lung cancer, oral cancer, and skin cancer; orthotic devices for some conditions; general anesthesia for dental procedures; screening the blood lead levels of children at increased risk for lead poisoning; reconstructive surgery for clubfoot and craniofacial abnormalities; and home care for children.

- There is *insufficient evidence* to determine whether longer lengths of inpatient stays are associated with better outcomes for females who have a mastectomy or lymph node dissection, or whether prohibiting insurers from excluding coverage for illnesses or injuries due to an insured being intoxicated or under the influence of a controlled substance (unless prescribed by a physician) increases the provision of screening and counseling for alcohol and substance abuse.

- A *preponderance of evidence* from nonrandomized observational studies indicate that screening for bladder cancer, ovarian cancer, pancreatic cancer, and testicular cancer, and screening the blood lead levels of children at average risk for lead poisoning are *not medically effective*.

- Findings from two recently published RCTs suggest that using the prostate specific antigen test (PSA) to screen asymptomatic men for prostate cancer *may not be medically effective*.

Potential Cost Impacts

- Limited-mandate plans would be expected to exclude coverage for some benefits required by California state law. While individual benefit mandates typically raise premiums by less than 1%, the cumulative annual cost of state's mandated benefits is between 5% and 19% of the total premium for the health insurance product. Studies of the *marginal* cost of benefit mandates (i.e., the cost of the benefit minus the cost of the benefit that would be covered in the absence of the legal requirement imposed by the mandate) indicate that the marginal costs are lower than the total cumulative annual costs, ranging from 2% to 4% of premiums.

- Potential market responses include the following:

    - Carriers currently domiciled and licensed in California (in-state carriers) would be expected to continue to offer state-regulated health insurance products in the individual market. It would be likely that they would develop limited-mandate policies targeted to individuals with incomes less than 350% FPL. In-state carriers may move their base or "domicile" to another state if they considered it advantageous to compete with other carriers that offer products not subject to California regulations in the group market. It is not clear how quickly California's largest insurers, which are for-profit (with the exception of Kaiser Foundation Health Plan and Blue Shield of California), might establish out-of-state domiciles in order to offer limited-mandate policies in California. Blues Plans, for example, are not allowed to compete in the same market

    - Out-of-state carriers who hold a license from the DMHC or certificate of authority from the CDI would be able to sell their limited-mandate policies after the passage of SB 92. These carriers would likely choose to sell products in California that would be most competitive in the small employer group market and the individual market. Policies by out-of-state carriers would tend to be lower in cost than policies by in-state carriers because presumably carriers would elect to be domiciled in a state with minimal insurance requirements, regulatory review, or oversight. Out-of-state carriers that currently have a presence in California (i.e., currently have contracts with providers and already have a share of enrollment) would be well-positioned to develop, market, and sell out-of-state policies under SB 92.

    - Out-of-state carriers not currently licensed in California would be permitted to sell limited-mandate policies after the passage of SB 92. These carriers may not have the same market presence and ability to obtain advantageously priced contracts with providers in the same way carriers that already have a presence in California are able to, especially for managed care products, which tend to offer comprehensive benefits with defined provider networks. In-state carriers are able to negotiate

substantial discounts with provider networks because of such factors as the number of beneficiaries they may bring to the providers, their experience in negotiating with specific provider networks and vice versa, and because of economies of scale in administration of arrangements between health plans and provider networks.

Two hypothetical scenarios presenting a potential maximum and low-impact cost estimate are provided because of the uncertainty of how insurers would respond were the bill to be enacted. In this analysis, Scenario 1 assumes that out-of-state carriers would have an immediate impact on all market segments, whereas Scenario 2 assumes that out-of-state carriers would have a more limited impact on those under 350% of the FPL and enrolled in the individual market only. Using these two scenarios, CHBRP estimates that the potential impact of SB 92 would be:

<u>Scenario 1 Findings: All Currently Insured Switch Their Current Insurance to a Limited-Mandate Version of the Same Plan or Policy</u>

- Under this scenario, total expenditures among the currently insured population would decline by $2.214 billion, a reduction of 2.63%. This overall reduction in expenditures includes a shift in costs from insurer to insured of $1.675 billion for benefits currently mandated that would no longer be covered but would still be utilized, and a reduction in costs of $1.675 billion due to members reducing their utilization of services that are no longer covered.

- An estimated 99,000 Californians would become insured as a result of the reduced premiums in this scenario, representing a 2.04% decrease in the number of uninsured. These newly insured individuals would account for an increase in overall expenditures of $228.676 million.

- Therefore, the combined effect on overall health expenditures of this scenario would be a net savings of $1.985 billion, or 2.12%.

<u>Scenario 2 Findings: Only Currently Insured With HDHPs and Incomes below 350% FPL in the CDI-Regulated Individual Market Switch to Limited-Mandate Policies</u>

- Under this scenario, total expenditures among the currently insured population would decline by $74.134 million, a reduction of 0.09%. This overall reduction in expenditures includes a shift in costs from insurer to insured of $42.314 million for currently mandated services that would no longer be covered.

- An estimated 5,000 Californians would become insured as a result of the reduced premiums in this scenario, representing a 0.1% decrease in the number of uninsured. These newly insured individuals would account for an increase in overall expenditures of $2.552 million.

- Therefore, the combined effect on overall health expenditures of this scenario would be a net savings of $71.582 million, or 0.08%.

Table 1. Potential Cost Impacts of SB 92 Under Scenario 1—Limited-Mandate Benefit Plans Offered to and Taken Up by Everyone in All Market Segments

	Before Enactment of SB 92	After Enactment of SB 92	Increase/ Decrease	% Change After Enactment
Coverage				
Number of individuals whose insurance products are subject to state regulation (a)	21,340,000	21,439,000	99,000	0.46%
Number of individuals whose insurance products are subject to SB 92	18,100,000	18,199,000	99,000	0.55%
Number of individuals who retain current insurance	18,100,000	0	-18,100,000	-100.00%
Number of individuals who purchase limited-mandate policies	0	18,199,000	18,199,000	0.000%
Number of uninsured individuals	4,847,000	4,748,000	-99,000	-2.04%
Total number of individuals	26,187,000	26,187,000	0	0.00%
Expenditures				
For the currently insured				
Premium expenditures by private employers for group insurance	$50,546,207,000	$48,065,626,000	-$2,480,581,000	-4.91%
Premium expenditures for individually purchased insurance	$5,944,229,000	$5,659,537,000	-$284,692,000	-4.79%
Premium expenditures by individuals with group insurance, CalPERS, Healthy Families, AIM, or MRMIP (b)	$13,475,994,000	$12,817,625,000	-$658,369,000	-4.89%
CalPERS employer expenditures (c)	$3,161,160,000	$3,001,961,000	-$159,199,000	-5.04%
Medi-Cal state expenditures (d)	$4,112,865,000	$4,112,865,000	$0	0.00%
Healthy Families state expenditures	$643,247,000	$643,247,000	$0	0.00%
Individual out-of-pocket expenditures for covered benefits (deductibles, copayments, etc.)	$6,384,077,000	$6,078,188,000	-$305,889,000	-4.79%
Out-of-pocket expenditures for non-covered benefits	$0	$1,674,782,000	$1,674,782,000	0.00%
Total annual expenditures for members currently insured	$84,267,779,000	$82,053,831,000	-$2,213,948,000	-2.63%
For newly insured members				
Premium expenditures by private employers for group insurance	$0	$259,426,000	$259,426,000	NA
Premium expenditures for individually purchased insurance	$0	$29,606,000	$29,606,000	NA
Premium expenditures by individuals with group insurance, CalPERS, Healthy Families, AIM or MRMIP (b)	$0	$68,849,000	$68,849,000	NA
CalPERS employer expenditures (c)	$0	$16,630,000	$16,630,000	NA

	Before Enactment of SB 92	After Enactment of SB 92	Increase/ Decrease	% Change After Enactment
Medi-Cal state expenditures	$0	$0	$0	NA
Healthy Families state expenditures	$0	$0	$0	NA
Individual out-of-pocket expenditures for covered benefits (deductibles, copayments, etc.)	$0	$31,968,000	$31,968,000	NA
Out-of-pocket expenditures for non-covered benefits	$186,967,000	$9,164,000	-$177,803,000	-95.10%
Total annual expenditures for newly insured members	$186,967,000	$415,643,000	$228,676,000	122.31%
For the uninsured				
Total annual expenditures for the uninsured	$9,008,803,000	$9,008,803,000	$0	0.00%
Total annual expenditures	$93,463,549,000	$91,478,277,000	-$1,985,272,000	-2.12%

Source: California Health Benefits Review Program, 2009.
Notes: (a) This population includes privately insured (group and individual) and publicly insured (e.g., CalPERS, Medi-Cal, Healthy Families, AIM, MRMIP) individuals enrolled in 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. Beneficiaries of public insurance programs for the low-income and uninsured (e.g. MRMIB and Medi-Cal Managed Care) are assumed to be exempt from the SB 92 because the administering state agencies require participating contractors to follow the scope of benefits in the DMHC-regulated plans.
(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 59% or $1.78 billion would be state expenditures for CalPERS members who are state employees.
Key: CalPERS = California Public Employees' Retirement System; AIM = Aid to Infants and Mothers; MRMIP = Major Risk Medical Insurance Plan.

Table 2. Potential Cost Impacts of SB 92 Under Scenario 2—Limited-Mandate Benefit Plans Offered to and Taken Up by Everyone in the Individual Market With Incomes <350% FPL

	Before Enactment of SB 92	After Enactment of SB 92	Increase/ Decrease	% Change After Enactment
Coverage				
Number of individuals whose insurance products are subject to state regulation (a)	21,340,000	21,345,000	5,000	0.02%
Number of individuals in insurance products subject to SB 92	18,100,0000	18,105,000	5,000	0.03%
Number of individuals who retain current insurance	18,100,000	17,434,000	-666,000	-3.68%
Number of individuals who purchase limited-mandate policies	0	671,000	671,000	0.00%
Number of uninsured individuals	4,847,000	4,842,000	-5,000	-0.10%
Total number of individuals	26,187,000	26,187,000	0	0.00%
Expenditures				
For the currently insured				
Premium expenditures by private employers for group insurance	$50,546,207,000	$50,546,207,000	$0	0.00%
Premium expenditures for individually purchased insurance	$5,944,229,000	$5,850,639,000	-$93,590,000	-1.57%
Premium expenditures by individuals with group insurance, CalPERS, Healthy Families, AIM, or MRMIP (b)	$13,475,994,000	$13,475,994,000	$0	0.00%
CalPERS employer expenditures (c)	$3,161,160,000	$3,161,160,000	$0	0.00%
Medi-Cal state expenditures	$4,112,865,000	$4,112,865,000	$0	0.00%
Healthy Families state expenditures	$643,247,000	$643,247,000	$0	0.00%
Individual out-of-pocket expenditures for covered benefits (deductibles, copayments, etc.)	$6,384,077,000	$6,361,219,000	-$22,858,000	-0.36%
Out-of-pocket expenditures for non-covered benefits	$0	$42,314,000	$42,314,000	0.00%
Total annual expenditures for members currently insured	$84,267,779,000	$84,193,645,000	-$74,134,000	-0.09%
For the newly insured members				
Premium expenditures by private employers for group insurance	$0	$0	$0	NA
Premium expenditures for individually purchased insurance	$0	$9,577,000	$9,577,000	NA
Premium expenditures by individuals with group insurance, CalPERS, Healthy Families, AIM, or MRMIP (b)	$0	$0	$0	NA
CalPERS employer expenditures (c)	$0	$0	$0	NA
Medi-Cal state expenditures	$0	$0	$0	NA
Healthy Families state expenditures	$0	$0	$0	NA
Individual out-of-pocket expenditures for covered benefits (deductibles, copayments, etc.)	$0	$2,339,000	$2,339,000	NA

	Before Enactment of SB 92	After Enactment of SB 92	Increase/ Decrease	% Change After Enactment
Out-of-pocket expenditures for non-covered benefits	$9,688,000	$324,000	-$9,364,000	-96.66%
Total annual expenditures for newly insured members	$9,688,000	$12,240,000	$2,552,000	26.34%
For the Uninsured				
Total annual expenditures for the uninsured	$9,186,082,000	$9,186,082,000	$0	0.00%
Total annual expenditures	$93,463,549,000	$93,391,967,000	-$71,582,000	-0.08%

Source: California Health Benefits Review Program, 2009.
Notes: (a) This population includes privately insured (group and individual) and publicly insured (e.g., CalPERS, Medi-Cal, Healthy Families, AIM, MRMIP) individuals enrolled in 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. Beneficiaries of public insurance programs for the low-income and uninsured (e.g. MRMIB and Medi-Cal Managed Care) are assumed to be exempt from the SB 92 because the administering state agencies require participating contractors to follow the scope of benefits in the DMHC-regulated plans.
(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 59%, or $1.865 billion, would be state expenditures for CalPERS members who are state employees; however, CHBRP estimates no impact of the mandate on CalPERS employer expenditures.
Key: CalPERS = California Public Employees' Retirement System; AIM = Aid to Infants and Mothers; MRMIP = Major Risk Medical Insurance Plan.

Potential Public Health Impacts: Effect of Allowing Carriers to Offer Limited-Mandate Plans

- Using the projections from the hypothetical scenarios discussed above, the primary health benefit of SB 92 could be an expansion of the insured population to an estimated 5,000 to 99,000 persons. Compared to the insured, uninsured individuals obtain less preventive, diagnostic, and therapeutic care, are diagnosed at more advanced stages of illness, have a higher risk of death, and have worse self-reported health. In addition to the issues of health and health care access, the absence of health insurance can also cause substantial stress and worry due to lack of coverage as well as financial instability if health problems emerge. As a result, the 5,000 to 99,000 persons who are expected to no longer be uninsured due to SB 92 would likely realize improved health outcomes and reduced financial burden for medical expenses.

- The benefits of having health insurance are clear. Having less comprehensive or limited-mandate health insurance exposes individuals to the financial and health risks of becoming *underinsured* if insurers drop coverage for effective health services currently mandated in California. Using the projections from the hypothetical scenarios, SB 92, could result in 666,000 to 18,100,000 previously insured persons moving from a plan with mandated benefits to one where coverage of mandated benefits is no longer required. With out-of-pocket expenditures for benefits previously covered potentially increasing for this population to between $42 million and $1.7 billion, these insured have an increased risk of foregoing treatment for services no longer covered under limited-mandate policies. Additionally, it is possible that persons moving to limited-mandate plans could develop a preexisting medical condition that would exclude them from moving back to a plan with increased benefits.

- In order to assess the public health impact if coverage for a particular benefit was excluded from a plan, three criteria were used: the medical effectiveness findings, the scope of the public health problem (broad, moderate, or limited), and the type of public health problem (mortality or morbidity). Table 3 details the current California mandates that have expected public health impacts if coverage were dropped.

Table 3. Summary of Public Health Scope and Type of Impact for Current California Mandates

Public Health Scope	Current California Mandated Benefits
Broad (1 in 20 persons or more)	Mandates with Mortality Impact • Cancer screening tests for breast, cervical, and colorectal cancers • Diagnostic tests and treatments for breast cancer • Diabetes management medications, services, and supplies • Medication and psychosocial treatments for severe mental illness and alcoholism • Preventive services for children and adolescents • Pediatric asthma management Mandates with Morbidity Impact • Prescription contraceptive devices (morbidity related to problems occurring from unplanned pregnancy)
Moderate (Fewer than 1 in 20 persons to 1 in 2,000 persons)	Mandates with Mortality Impact • HIV Testing • Services for the diagnosis and treatment of osteoporosis • Prenatal diagnosis of genetic disorders Mandates with Morbidity Impact • Prosthetic devices • Orthotic devices for some conditions • Special footwear for persons with rheumatoid arthritis • Pain management medication for persons with terminal illnesses • Acupuncture • General anesthesia for dental procedures • Diagnosis and treatment of infertility • Surgery for the jawbone and associated bone joints
Limited (1 in 2,000 persons or fewer)	Mandates with Mortality Impact • Medical formulas and foods for persons with phenylketonuria • Expanded alpha-fetoprotein screening Mandates with Morbidity Impact • Home care services for elderly and disabled adults • Hospice care

Source: California Health Benefits Review Program, 2009.

- One mandate with evidence of **no impact** on public health if coverage is dropped is screening the blood lead levels of children at average risk for lead poisoning. Additionally, a number of mandates have an **unknown impact** on public health if coverage is dropped, including tests for screening and diagnosis of prostate cancer, transplantation services for persons with HIV, the intoxication exclusion, prosthetic devices for persons who have had a laryngectomy, special footwear for persons with diabetes, reconstructive surgery for breast cancer, and reconstructive surgery for clubfoot and craniofacial abnormalities.

- Based on the prototype limited-mandate plans, the medically effective mandated benefits that are most likely to be dropped following SB 92 include: alcoholism treatments and parity in coverage for severe mental illness/coverage for mental and nervous disorders, phenylketonuria (PKU) treatment with medical formula and foods, expanded alpha-fetoprotein screening (AFP), prescription contraceptive devices, acupuncture, infertility treatments, jawbone or associated bone joint surgery, orthotics and prosthetics, special footwear for persons with rheumatoid arthritis, general anesthesia for dental procedures, and home care services for elderly and disabled adults.

- A number of mandates are associated with benefits primarily for females (e.g., breast/cervical cancer, maternity care-related mandates, and prescription contraceptives). Of the 666,000 to 18,100,000 previously insured persons that could move from a plan with mandated benefits to one where coverage of mandated benefits is no longer required, females would be at greater risk for underinsurance compared to males.

- In California, racial disparities in health insurance coverage are also important where racial and ethnic minorities are more likely to be low income and more likely to be uninsured compared to whites. As a result, among the 5,000 to 99,000 estimated newly insured, a larger proportion of minorities compared to whites could change from being uninsured to insured under SB 92. It is important to note, however, that coverage under SB 92 policies would likely attract low-risk enrollees rather than those uninsured with chronic or high-risk conditions.

Part II – Potential Impacts of SB 92 on the Health Insurance Market

Currently about about two-thirds of private health insurance products sold in California are underwritten by in-state carriers. The remaining one-third of health insurance products are underwritten by out-of-state carriers licensed in California. Four of the seven major carriers are currently domiciled and licensed outside California. These four carriers (or their subsidiaries) are also licensed by both the DMHC and CDI to sell health insurance policies in California.

To assess the outcomes of allowing out-of-state carriers to sell policies in California without obtaining a license from the DMHC or CDI, CHBRP reviewed evidence on group purchasing pools because certain types of purchasing pools have, at one point, been exempt from state requirements or have been proposed as legislative solutions to reduce premiums and increase choice. The research on group purchasing arrangements is also relevant to SB 92 because this bill relaxes the requirements for associations to gain the same legal status as "small employers."[3] Group purchasing arrangements bring different employers or individuals together for the purpose of purchasing health insurance or negotiating provider discounts on behalf of their members. Examples of group purchasing arrangements include purchasing cooperatives and alliances, multiple employer welfare arrangements (MEWAs), and association health plans (AHPs). Such arrangements need to be legally recognized by the state or federal government because, under state insurance regulation, multiple employers and individuals are prohibited from forming a group solely for the purpose of buying group insurance.

Based on a review of this literature and input from experts, CHBRP identified the following potential impacts of relaxing state requirements on health plans and insurers.

- Out-of-state carriers would be exempt from California-specific consumer protection and financial solvency requirements.
    - Enrollees in plans offered by such carriers would have to contact the insurance commissioner in the state of domicile to deal with denied claims or other disputes. Depending on the state, resource constraints such as time, number of employees, and budget may prevent regulators from providing assistance to out-of-state consumers and may prevent regulators from enforcing policies. In addition, some states' departments of insurance have taken the position that it is not in their jurisdiction to assist consumers who are out of state.
    - All states require insurance products to maintain adequate reserves to be financially solvent and be able to pay claims. However, these requirements and the capacity to monitor solvency of their carriers vary across states. In addition, funds that are set up to pay for claims if a carrier becomes insolvent may not cover out-of-state consumers or may not be adequate to pay for all eligible consumers (for example, if the carrier is domiciled in a small state with few insurers paying into the insolvency fund). Historically, less stringent solvency requirements have been associated with insolvency. Between 2001 and 2003, for example, four self-insured MEWAs became insolvent with

[3] Existing law defines "small employer" to include a guaranteed association that purchases health care coverage for its members. Existing law defines "guaranteed association" to mean a nonprofit organization of individuals or employers that meets certain requirements, including having been in active existence and having included health coverage as a membership benefit for at least 5 years prior to January 1, 1992, and covering at least 1,000 persons in that regard. SB 92 would delete the requirements for a guaranteed association to have been in active existence and to have included health care coverage as a membership benefit for at least 5 years prior to January 1, 1992. The bill would reduce the required number of persons covered by health coverage provided through the guaranteed association from 1,000 to 100. The bill would also define "small employer" to include an eligible association that purchases health care coverage for its members and would define an eligible association as a community or civic group or a charitable or religious organization.

66,000 individuals and small businesses losing coverage and about $48 million in unpaid claims.

  - If a claim is denied by a carrier not licensed in California, consumers would need to deal with the out-of-state carrier per their arbitration rules, and potentially the out-of-state regulatory agency if there are applicable external grievance processes in place.

- Out-of-state carriers would be exempt from California-specific requirements related to cost and availability of insurance.

  - Federal proposals to introduce group purchasing arrangements (AHP plans that were exempt from various state-level requirements) increased coverage rates slightly. Nationally, an estimated 330,000 would become newly insured—because 4.6 million individuals would enroll in these new plans while enrollment in state-regulated plans would drop by 4.3 million. When examining the projected impacts of similar federal proposals on the California market, researchers found that there was virtually no increase in insurance coverage resulting from the introduction into the market of plans exempt from state requirements. They projected a less than 1% increase in new coverage or "virtually no net change in insurance coverage resulting from the availability of this alternative insurance product."
  - California-specific and national analyses found that the introduction of AHPs in the market resulted in savings in premiums for those individuals who enrolled in the AHPs and an increase for those policyholders who stayed in the insured, state-regulated market. According to the California-specific study, the decrease in insurance premiums for AHP policyholders ranged from 13% to 14% and the increase for the policyholders in the insured, fully regulated market ranged from 2% to 5%. The savings in premiums for AHP policyholders is attributed to both exemption from state regulations as well as selection of better (low-cost) risk. Conversely, increased premiums in the state-regulated market are due to adverse selection of worse (high-cost) risk with fewer low-cost enrollees to spread the risk.
  - Prior research evaluated a federal proposal that is similar to SB 92. The Health Care Choice Act of 2005 (H.R. 2355) would have allowed individuals buying health insurance in the individual market to do so from an entity licensed in another state. The Congressional Budget Office estimated about 1 million small-group enrollees would lose health insurance coverage as a result. However, low-risk individuals who were uninsured would obtain low-cost, out-of-state individual policies, offsetting those who lost insurance. Although the characteristics of the insured population could change, with low-risk individuals gaining insurance coverage and high-risk individuals losing coverage, the net effect with respect to the number of insured would be insubstantial.
  - The development of AHPs and other proposals for the development and marketing of products exempt from state-specific requirement is projected to result in out-of-state policies attracting healthy, low-risk employees in the small-group and individual market. This selection of low-cost enrollees and risk segmentation could lead to a change in the composition of the market, leaving the high-risk individuals in the state-regulated market or uninsured.

- If fewer California-regulated products are offered in the commercial market as a result of SB 92, it is expected that over time, more large groups, and perhaps even mid-sized groups, might choose to self-insure rather than purchase an out-of-state policy. This would be likely to occur if the state-regulated products charged higher and higher premiums due to adverse selection. Out-of-state policies might not be an attractive alternative if they did not have the kind of generous benefit packages that large-groups tend to demand.
- Insurance requirements in the small-group market were intended to spread risk and ensure availability of coverage for otherwise uninsurable populations. AHPs and other arrangements exempt from state-specific requirement are likely to result in out-of-state carriers attracting healthy, low-risk employers and individuals. This favorable selection and risk segmentation could lead to change in the composition of the market. For example, in the small-group market, those with younger and healthier employees may choose more affordable out-of-state products while other small groups may drop coverage altogether. Small groups may face dramatic variations in premiums when California-specific rate protections do not apply. The CDI calculated projected premium impacts if S. 1955 were to pass and found that small-group employees of the same firm could face premium differentials of 67% (versus 22% in current California law) based on less stringent rate band requirements.

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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 the CHBRP authorizing legislation, UC contracts with a certified actuary, Milliman Inc. (Milliman), to assist in assessing the financial impact of each benefit mandate bill. Milliman also helped with the initial development of CHBRP methods for assessing that impact.

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