

California Health Benefits Review Program

Implementation of Assembly Bill 1540: **Analysis of Legislation Mandating or Repealing Health Care Benefits and Services**

A Report to the California State Governor and Legislature October 4, 2013





The California Health Benefits Review Program (CHBRP) was established in 2002 to respond to requests from the California Legislature to provide an independent analysis of the medical, financial, and public health impacts of proposed health insurance benefit mandates and repeals per its authorizing statute.¹ The program was reauthorized in 2006 and again in 2009. CHBRP's authorizing statute defines legislation proposing to mandate or proposing to repeal an existing health insurance benefit as a proposal that would mandate or repeal a requirement that a health care service plan or health insurer: (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; (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; and/or (4) specify terms (limits, timeframes, copayments, deductibles, coinsurance, etc.) for any of the other categories.

An analytic staff in the University of California's Office of the President supports a task force of faculty and staff from several campuses of the University of California to complete each analysis within a 60-day period, usually before the Legislature begins formal consideration of a mandate or repeal bill. A certified, independent actuary helps estimate the financial impacts. 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, provides balanced representation among groups with an interest in health insurance benefit mandates or repeals, and 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 an annual assessment on health plans and insurers in California. All CHBRP reports and information about current requests from the California Legislature are available on the CHBRP website, www.chbrp.org.

¹ Available at: www.chbrp.org/documents/authorizing_statute.pdf.

A Report to the 2013–2014 California State Governor and Legislature

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October 4, 2013

**California Health Benefits Review Program
1111 Franklin Street, 11th Floor
Oakland, CA 94607-5200
Tel: 510-287-3876
Fax: 510-763-4253
www.chbrp.org**

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

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TABLE OF CONTENTS

LIST OF TABLES AND FIGURES.....	5
EXECUTIVE SUMMARY	6
Adapting to a New National and State Policy Context: The Affordable Care Act.....	7
CHBRP’s Charge: Analyses and Approach.....	9
Academic Rigor on Demand.....	11
Fulfilling CHBRP’s Mission	14
INTRODUCTION	15
History and Trends in Benefit Mandate Legislation.....	15
Adapting to a New National and State Policy Context: The Affordable Care Act.....	17
CHBRP’S CHARGE: ANALYSES AND APPROACH	21
CHBRP’s Initial Objectives and Charge.....	21
CHBRP Reports	22
Other Publications.....	27
Legislative Outreach and Briefings	29
Disseminating Knowledge Obtained Through CHBRP’s Experiences	29
Continuous Quality Improvement.....	32
Challenges Inherent to CHBRP’s Analytic Process	34
ACADEMIC RIGOR ON DEMAND	37
Overall Structure.....	37
Process and Workflow	42
Analytic Methods.....	47
Fulfilling CHBRP’s Mission	64
REFERENCES	65
APPENDICES	66

LIST OF TABLES AND FIGURES

Table 1. Multiple Facets of Bills Analyzed by CHBRP in 2013	11
Table 2. 2013 California Mandate Bills and Essential Health Benefits.....	18
Table 3. CHBRP Analyzed Bills: Topics Addressed and Final Bill Status, 2009–2013	23
Table 4. CHBRP Reports Formally Referenced by Other States, 2010–2012.....	27
Table 5. Citations of CHBRP’s Work by External Parties, 2009–2012.	30
Table 6. Domains in Which Medical Effectiveness Ranks Studies	48
Table 7. CHBRP Estimates of Sources of Health Insurance in California, 2014	56
Figure 1. Benefit Mandate and Repeal Bills and Applicable Benefit Floors by Year	8
Figure 2. Process Flow of a CHBRP Analysis.....	38
Figure 3. 60-Day Timeline.....	46
Figure 4. Health Insurance by Regulatory Authority in California, 2014	57
Figure 5. Health Insurance by Funding Type in California, 2014	58

EXECUTIVE SUMMARY

Over the past decade, the California Health Benefits Review Program (CHBRP) has supported consideration of health insurance benefit mandate and repeal bills through independent, academically rigorous, and unbiased analysis. Stakeholders have consistently reported that CHBRP's analyses inform and elevate discourse by bringing an objective and widely-respected analytical perspective to the policymaking process.

Currently set to sunset on June 30, 2015, CHBRP was established by Assembly Bill (AB) 1996 (Thomson, 2002), which "requested the University of California (UC) to assess legislation proposing mandated health care benefits to be provided by health care service plans and health insurers." In California, more than 40 health insurance benefit mandates had been enacted by the close of 2001. In response to concerns about benefit mandates serving their intended purposes without creating unintended consequences (including, but not limited to, large premium increases), by the end of 2002, California and 16 other states passed laws requiring benefit mandate evaluation. Since then, 12 additional states have formalized benefit mandate evaluation, bringing the total to 29 as of 2013.²

The annual number of benefit mandate bills introduced in California's Legislature remained steady between 2002 and 2006, and the Legislature deemed it valuable to continue requesting evaluations of mandate bills (SBFI Committee, 2006). As a result, CHBRP was reauthorized by Senate Bill (SB) 1704 (Kuehl, 2006) and again by AB 1540 (Assembly Health Committee, 2009). Since 2006, the number of introduced benefit mandate bills remained relatively steady, until passage of the Affordable Care Act (ACA).³ Perhaps in response to the ACA, the California Legislature saw the number of introduced benefit mandate bills swell to 15 in 2011 and then fall to 3 in 2012, before rising back to 9 in 2013.⁴

Since it was established, CHBRP has responded to the Legislature's requests for analysis with reports that have been consistently utilized by Legislators and committee staff, as well as bill advocates and opponents, providing all parties with an objective resource intended to serve as a reliable basis for discussion of proposed benefit mandate legislation.

CHBRP's most recent reauthorization, AB 1540, requested a report be submitted to the Governor and the Legislature by January 1, 2014, describing implementation of the bill as enacted. This report is provided in response to that request, and describes how CHBRP has fulfilled the mission outlined in its authorizing statute⁵ during the years 2009 through 2013.

² For further details on other states' benefit mandate review programs, please see Appendix 22.

³ Although jointly referred to as the Affordable Care Act, the law is actually a product of the Patient Protection and Affordable Care Act (P.L.111-148) and the Health Care and Education Reconciliation Act (H.R.4872), both passed in 2010.

⁴ Although CHBRP was only asked to analyze eight benefit mandate bills in 2013, Senator Hernandez, Chair of the Senate Health Committee, has testified that nine were introduced. See the Senate Health Committee analysis of SB 18. Available at: www.leginfo.ca.gov/pub/13-14/bill/sen/sb_0001-0050/sb_18_cfa_20130430_093208_sen_comm.html.

⁵ Available at: www.chbrp.org/docs/authorizing_statute.pdf.

Adapting to a New National and State Policy Context: The Affordable Care Act

The continuing introduction of benefit mandate bills by legislators, interest in repeal bills, and ongoing changes in both health care delivery and California's health insurance markets have shaped the context within which CHBRP performs its work. To be effective in meeting the Legislature's charge, CHBRP has continuously adapted its analytic efforts to this changing health care landscape. Most recently, and arguably most challenging, has been the 2010 passage of the ACA and subsequent need to refine CHBRP's methods, including the need to account for the possibility of interaction between state-level benefit mandates and the federal law. To accommodate these changes and to provide the most complete, accurate, and relevant information possible to the Legislature and other stakeholders, CHBRP has, among other efforts:

- Adapted its method of projecting enrollment and premiums;
- Considered the impact of benefit coverage floors required by the ACA; and
- Established a means of identifying state-level benefit mandates that may exceed the ACA's essential health benefits (EHBs).

California Cost and Coverage Model

A significant challenge posed by health reform has been the need to update CHBRP's California Cost and Coverage Model (CCM) to accommodate ACA-influenced changes in baseline enrollments and premiums. The CCM is an actuarial model that CHBRP updates annually with information from multiple sources, including data gathered through surveys and informal discussions with the seven largest insurance health plans and insurers in California (whose combined enrollment represents roughly 97.5% of persons with health insurance subject to state mandates). After considering multiple options, CHBRP chose to adapt the CCM by incorporating 2014 enrollment projections developed by the California Simulation of Health Insurance Markets (CalSIM). CalSIM is the most California-specific of available projections and is being used by Covered California, the state's health insurance exchange. Incorporation of the CalSIM projections allowed CHBRP to provide quantitative estimates of the impact of health reform on premiums and enrollment and to assess the marginal impacts of benefit mandates introduced in 2013 (which would be in effect in 2014). CHBRP's future annual updates of the CCM will reflect the continuing impacts of the ACA as various portions of the law are implemented, and as more evidence on its impact becomes available.⁶

Benefit Floors and Essential Health Benefits

CHBRP's analyses have always considered a bill's possible interactions with numerous benefit floors, as they now also consider possible interactions with the benefit floor represented by the ACA's requirement to provide coverage for EHBs. As Figure 1 illustrates, in addition to the benefit floors established by mandates already in law,⁷ CHBRP has always considered interactions with the floor represented by "basic health care services," a mix of law and

⁶ More specific information on the CCM can be found in the "Analytic Methods" section of this report.

⁷ CHBRP maintains a list of mandates applicable in California, available at http://www.chbrp.org/other_publications/index.php

regulation applicable to health care service plans regulated by the California Department of Managed Health Care (DMHC). More recent CHBRP analyses have also examined possible interactions with benefit floors newly established by the ACA. Since 2010, a number of DMHC-regulated plans, as well as a number of health insurance policies regulated by the California Department of Insurance (CDI) have been required to meet the benefit floor established by the ACA’s requirements regarding federally specified preventive services.⁸ For this reason, beginning in 2011, CHBRP analyses have addressed possible interactions with the federally specified preventive services benefit floor. Similarly, for recent analyses of bills that would go in effect in 2014, CHBRP has included consideration of possible interactions with the ACA’s EHB benefit floor.

Figure 1. Benefit Mandate and Repeal Bills and Applicable Benefit Floors by Year

Year	Analyzed Bills	California Mandate Bill Topics (Partial List)
2013	8	Acquired Brain Injury, Autism, Colorectal Cancer & Genetic Testing, Fertility Preservation, Infertility, Oral Cancer Drugs, Prescription Drugs, Wellness Programs
2012	3	Cancer Treatment, Immunizations for Children, Prescription Drugs, Tobacco Cessation
2011	15	Acupuncture, Autism, Breast Cancer, Child Health Assessments, Mammography, Maternity Services, Mental Health Services, Prescription Drugs, Tobacco Cessation
2010	9	Chemotherapy, Diabetes, Durable Medical Equipment, Mammography, Maternity Services, Mental Health Services, Tobacco Cessation
2009	10	Breast Feeding, Chemotherapy, Durable Medical Equipment, Human Papillomavirus Vaccination, Mammography, Maternity Services, Mental Health Services

Source: California Health Benefits Review Program, 2013.

Key: BHCS=Basic Health Care Services; EHBs=Essential Health Benefits; FPS=Federally Specified Preventive Services.

For the 2013 analytic cycle, CHBRP also developed an analytically rigorous approach to evaluate whether a state-level benefit mandate might exceed EHBs, a situation that would require California to defray related costs for enrollees in products sold by Covered California. For this

⁸ Affordable Care Act Section 1001, modifying Section 2713 of the Public Health Service Act; California Health and Safety Code 1367.002; California Insurance Code Section 10112.2.

purpose, CHBRP reviewed, for each bill, federal law and regulation (pending as well as final), state law and regulation, and the benefit coverage offered by California's benchmark plan. For benefit mandate bills analyzed in 2013, CHBRP identified the following:

- Five mandates would not exceed EHBs,
- Two mandates would have an unknown interaction with EHBs, and
- One might exceed EHBs.

Although not conclusive, these evaluations sought to provide policymakers with as much relevant context and analysis as possible.

CHBRP's Charge: Analyses and Approach

CHBRP's impartial reports analyze the medical effectiveness of the tests, treatments, and services relevant to a proposed benefit mandate or repeal bill, and estimate the likely impact of the bill on benefit coverage, utilization, cost, and public health. In response to requests from the Legislature, CHBRP has analyzed 94 bills in total, including 47 from 2009 through 2013. Upon completion, each report is posted to CHBRP's website,⁹ where it is retained for review by legislators and stakeholders, as well as other interested parties.

CHBRP Analyses During the Legislative Process

CHBRP's reports support and help inform decision making throughout the Legislature's deliberative process regarding benefit mandate bills.

- **Legislative Committee Staff** consistently draw findings and data from CHBRP reports for inclusion in the policy and fiscal committee analyses.
- **Legislators on Committees** and **Bill Authors** routinely quote from CHBRP reports during hearing remarks and testimony.
- **Health Insurance Stakeholders**, both bill advocates and opponents, including advocacy organizations, health plans/insurers, trade associations, and consumer groups, regularly use CHBRP reports to make cases in support of, or in opposition to, the passage of mandate bills.

Consistently, those involved with the Legislature's consideration of benefit mandate and repeal bills report that they rely on CHBRP's analyses because they are useful, comprehensive, rigorous, and impartial. Stakeholders frequently state that CHBRP analyses serve as the baseline for discussion around benefit mandate bills, particularly around fiscal impacts. Additionally, legislative and agency staff have indicated that the analyses aid them in their internal consideration of whether a bill avoids unintended consequences and whether it adequately addresses the problem it seeks to resolve.

⁹ See CHBRP's website at www.chbrp.org.

CHBRP Analyses Beyond the Legislative Cycle

Highlighting the strength of CHBRP's contributions, the analyses remain relevant as references even beyond the legislative process. For example, health insurers and regulators report having used CHBRP analyses in discussion of appropriate rate increases when analyzed bills have passed into law and health plans also report using CHBRP's medical effectiveness analysis to evaluate their benefit coverage offerings. Outside of California, a report¹⁰ by the Center for Consumer Information and Insurance Oversight (CCIIO) cited a CHBRP analysis' estimate regarding the marginal cost of covering applied behavioral analysis as an EHB (CCIIO, 2011), and the Institute of Medicine (IOM) recommended that CHBRP's approach serve as a guide for further defining EHBs in the future (IOM, 2011).¹¹ Academics in California and beyond, as well as state governments across the country often cite CHBRP analyses when considering similar legislation.

Benefit Mandates as Multifaceted Instruments

CHBRP's reports also provide value with their careful consideration of multifaceted aspects of benefit mandate bills. As defined by CHBRP's authorizing statute, a benefit mandate bill requires health insurance products to comply with any of the following:

- Provision of coverage for screening, diagnosis, and/or treatment of a specific disease or condition;
- Provision of coverage for one or more health care tests, treatments, or services;
- Provision of coverage for services by one or more specific types of health care providers;
- Compliance with specified terms when benefit coverage is provided (such as a prohibition on prior authorization requirements or limits regarding cost-sharing).

In practice, introduced benefit mandate bills touch many of these dimensions. The bills are made more complex because they often intend to place multifaceted requirements on subsets of state-regulated health insurance products, necessitating detailed information on premiums, benefits, and benefit coverage of market sub-segments are required in order to analyze them.

Some valuable elements of CHBRP's analytic approach include the ability to identify possible interactions with one or more benefit floors, the current state of relevant benefit coverage in state-regulated health insurance products, and the current health of enrollees in health insurance that would be subject to the proposed mandate. Considering the bills CHBRP analyzed in 2013, Table 1 demonstrates the range of dimensions and requirements that proposed benefit mandates would impose.

¹⁰ CCIIO, 2011, *Essential Health Benefits Bulletin*. Available at: www.cms.gov/CCIIO/Resources/Files/Downloads/essential_health_benefits_bulletin.pdf.

¹¹ IOM, 2011. *Essential Health Benefits: Balancing Coverage and Cost*. Available at: www.iom.edu/Reports/2011/Essential-Health-Benefits-Balancing-Coverage-and-Cost.aspx.

Table 1. Multiple Facets of Bills Analyzed by CHBRP in 2013

2013 Bills	Proposed Benefit Mandate's Requirements					
	Benefit Coverage				Limits	
	Specified Disease or Condition (a)	Specified Tests, Treatments, or Services (b)	Specified Providers	Specified Benefit Design	Specified Market Segments (c)	Specified Enrollees (d)
AB 219 (Perea) Oral Anticancer Medications				X		
AB 460 (Ammiano) Infertility		X			X	X
AB 889 (Frazier) Prescription Drug Benefits		X		X		
AB 912 (Quirk-Silva) Fertility Preservation		X		X	X	X
SB 126 (Steinberg) PDD or Autism		X	X	X	X	
SB 189 (Monning) Wellness Programs				X	X	
SB 320 (Beall) Acquired Brain Injury	X		X	X		
SB 799 (Calderon) Colorectal Cancer	X	X				X

Source: California Health Benefits Review Program, 2013.

Notes: (a) Bills often address multiple conditions/diseases. For example, SB 799 addressed Lynch syndrome and colorectal cancer.

(b) Bills often address multiple tests/treatments/services. For example, AB 460 addressed several infertility procedures.

(c) Bills often limit applicability broadly, such as an exemption for the individual market or for particular purchasers—such as the California Public Employees' Retirement System or the California Department of Health Care Services.

(d) Bills often limit applicability based on enrollee characteristics, because SB 799 would have required colorectal cancer screening coverage only for Lynch syndrome–positive enrollees.

Academic Rigor on Demand

As per its authorizing statute, CHBRP, utilizes the funds made available to it to secure relevant data and faculty time in advance, and is then able to act immediately upon requests from the Legislature to organize robust and credible analyses for introduced benefit mandate and repeal bills. This arrangement is unique among states that have organized programs for reviewing benefit mandates in that it both analyzes the bill while it is under consideration, and also harnesses the intellectual effort of teams of faculty, staff, actuaries, and content experts. This combination of academic rigor with sufficient speed to inform deliberation makes CHBRP's efforts unique, objective, and timely.

Operating support for CHBRP is provided through a non-General Fund source, specifically, fees levied by the DMHC and CDI on health care service plans and health insurers, the total annual amount of which has been capped at \$2 million annually, or about \$0.0077 per member per month (in 2012 dollars) since 2003. Additional in-kind support has also been provided by UC.

Broad Multidisciplinary Expertise

CHBRP reports provide academically rigorous analysis of the medical, financial, and public health impacts of proposed health insurance benefit mandates and repeals utilizing broad, multidisciplinary expertise. CHBRP's work achieves its standard academic rigor through the involvement of faculty, researchers and staff within the UC system. This includes individuals with expertise in medicine, health economics, actuarial science, public health, and medical effectiveness evaluation. CHBRP's multidisciplinary Faculty Task Force (FTF) and contributors are drawn from:

- University of California, Berkeley
- University of California, Davis
- University of California, Irvine
- University of California, Los Angeles
- University of California, San Diego
- University of California, San Francisco

In addition to its FTF, CHBRP is administered by a small group of staff at the UC Office of the President (UCOP). CHBRP staff provides overall management, policy analysis expertise, project management for the analytic process, and liaison services for CHBRP's communications with the Legislature and other stakeholders. CHBRP staff also ensures that reports and the supporting methodology are transparent and accessible to all stakeholders.

To meet CHBRP's statutory requirement to include actuarial analysis in its reports, CHBRP contracted with Milliman, Inc. after a competitive bidding process in 2003. The program has periodically re-bid the actuarial contract since that time, but as of now Milliman is currently retained through the middle of 2014.

Unbiased and Neutral Analyses

CHBRP's reports are highly valued because they provide independent, unbiased, and accurate analysis. It is important to note that although CHBRP is administered by UC, the program functions independently from UC's institutional policy and program interests. Throughout an analysis, CHBRP is carefully mindful to avoid any conflict of interest. CHBRP faculty and potential content experts are rigorously vetted for potential conflicts. Participation in the analyses by a person with a material financial interest or a history of advocacy (for or against the mandate) is prohibited, and final reports express solely the findings of the multidisciplinary analytic team.

For each bill analysis, CHBRP assembles analytic teams with expertise in medical effectiveness, health economics, public health, and policy analysis. The analytic teams work with actuaries, librarians, content experts, and editors to collaboratively develop and complete a cohesive analysis within the 60-day time period.

Prior to submission to the Legislature, each analysis is subject to internal peer review by members of CHBRP's FTF and CHBRP's Director, and subject to external review by members of CHBRP's National Advisory Council (NAC). The NAC consists of experts from outside California selected to provide balanced representation among groups with an interest in health insurance benefit mandates and repeals, including providers, purchasers, consumers, health policy experts, and health plans. The NAC is an advisory body rather than a governance board, and a subset of the NAC reviews each draft bill analysis for accuracy, balance, clarity, and responsiveness to the Legislature's request.

Within days of beginning an analysis, CHBRP also retains content experts for each analytic team. Content experts are individuals with specialized clinical, health services research, or other expertise pertaining to the specific benefits and topics addressed by the mandate or repeal bill. These individuals are generally drawn from the UC system or from other reputable educational or research institutions.

Unique Information in a CHBRP Report

CHBRP's process provides not only academic rigor, but also a number of unique data points that are useful to stakeholders considering a benefit mandate or repeal bill. CHBRP's annually updated CCM provides the baselines from which a mandate's marginal impacts on utilization and cost can be estimated. For each CHBRP analysis, the CCM provides:

- Enrollment estimates of the sources of health insurance for all Californians
- Estimates of annualized premiums paid for Californians enrolled in health insurance products subject to regulation by CDI or DMHC, including estimates for DMHC-regulated plans associated with:
 - The California Public Employees' Retirement System (CalPERS)
 - The California Department of Health Care Services (DHCS) on behalf of Medi-Cal beneficiaries
 - Covered California, the state's health insurance exchange
- Estimates of the age and sex distribution of Californians enrolled in health insurance market segments subject to state-level regulation and mandates

All of CHBRP's analyses are informed by regularly updated lists of applicable health insurance benefit mandates already in state or federal law.¹² CHBRP's list of mandates relevant to DMHC-regulated plans and CDI-regulated policies is important in establishing benefit floors relevant to a mandate or repeal bill. It is also useful to interested parties throughout the year, as it is the only comprehensive list of mandates enforced by either DMHC or CDI.

¹² For the full list of existing mandates in California, see Appendix 19.

In addition to the review of possible interactions with EHBs and other benefit floors and existing mandates in California law, each CHBRP report also continues to provide the Legislature with other unique information, including:

- Identification of which health insurance market segments would be subject to the mandate and current, California-specific estimates of enrollment in those segments.
- Identification of mandate relevant conditions and disorders and estimates of the number of enrollees whose health insurance would be subject to the mandate.
- Identification of mandate relevant tests, treatments, and services and analysis of their effect on health outcomes
- California-specific estimates of current figures and the bill's likely marginal impacts on:
 - Benefit coverage and utilization of mandate relevant tests, treatments, and services
 - Costs (estimated as premiums and related enrollee expenses)
 - Public health (estimated as morbidity, mortality, health behaviors, person-level financial obligation, and other measures significant to the bill being analyzed)

Summary of CHBRP Report Findings

For CHBRP reports produced between 2009 and 2013, approximately 70% found that the analyzed mandate for tests, treatments, or services was generally considered effective. Approximately 75% of CHBRP's reports estimated an incremental increase in total health care expenditures due to the mandate. The remaining reports estimated no overall increase, usually because the benefit was already widely covered or because utilization was unlikely to be affected. Additionally, more than half of the reports estimated a positive public health impact as a result of the mandate.

Fulfilling CHBRP's Mission

For a decade, CHBRP has provided rigorous and impartial analysis of benefit mandate legislation. Since its inception, the program has adapted to changing circumstances, including revisions to its authorizing statute and charge, changes to state health programs, and larger reforms of the health care system such as the ACA. Amidst these changes, CHBRP's work continues to be widely used in the legislative process, and has also been helpful to numerous stakeholders considering benefit mandate bills. The academic rigor the program provides directly to the Legislature through a multidisciplinary set of academic experts is unique to California, and provides policymakers with credible, robust, and independent analysis on demand.

From 2009 through 2013, as well as during the prior cycle of CHBRP's authorization, legislators and parties involved in health insurance have reported that they rely on CHBRP's reports and other products to support policy decision-making, because they are timely, objective, thorough, and high quality—thus effectively achieving the mission described in CHBRP's authorizing statute.

INTRODUCTION

Over the past decade, the California Health Benefits Review Program (CHBRP) has supported consideration of health insurance benefit mandate and repeal bills through independent, academically rigorous, and unbiased analysis. Stakeholders have consistently reported that CHBRP's analyses inform and elevate discourse by bringing an objective and widely respected analytical perspective to the policymaking process.

Currently set to sunset on June 30, 2015, CHBRP was established by Assembly Bill (AB) 1996 (Thompson, 2002) which "requested the University of California (UC) to assess legislation proposing mandated health care benefits to be provided by health care service plans and health insurers." The provisions of AB 1996, originally set to sunset on January 1, 2007, were extended by Senate Bill (SB) 1704 (Kuehl, 2006) and further extended by AB 1540 (Assembly Health Committee, 2009). SB 1704 added a provision that requested the University of California (UC), through CHBRP, analyze legislation that would repeal existing benefit mandates, and AB 1540 extends those provisions. AB 1540 also requested that UC to submit a report to the Governor and the Legislature describing the implementation of the program's authorizing statute by January 1, 2014.¹³ This implementation report is written in response to that request, and describes how the program has fulfilled the mission outlined in its authorizing statute¹⁴ during the years 2009 through 2013.

History and Trends in Benefit Mandate Legislation

A period of increasing passage of health insurance benefit mandate laws led to the establishment of CHBRP and the continuing introduction of benefit mandate bills by legislators has led to two subsequent reauthorizations of the program. In addition, interest in repeal bills and in the possibility of interaction between state-level benefit mandates and the Affordable Care Act (ACA)¹⁵ have added to CHBRP's analytic responsibilities over the past several years.

In the late 1990s, state-mandated health benefit laws were proliferating in states across the nation. Researchers attribute the proliferation of mandated benefit laws to several factors. First, these laws were a product of the managed care "backlash" of the 1990s. Specifically, the rise of health maintenance organizations (HMOs), and their willingness to use utilization and network controls led interest groups and elected officials to believe that legislation was necessary to curtail health plans' ability to deny services or limit access to certain provider types (Blendon et al., 1998; Laugesen et al., 2006). Second, political factors combined to make these types of bills more likely to be enacted since the costs are relatively small and diffused over a large population while the benefits are concentrated on a small group of stakeholders who have a strong interest in actively advocating for the legislation (Oliver and Singer, 2006; Schauffler, 2000; Wilson, 1980).

¹³ CHBRP provided similar reports to the Legislature and Governor in compliance with AB 1996 on December 22, 2005, and in compliance with SB 1704 on December 22, 2009. Both of those reports can be found at www.chbrp.org.

¹⁴ Available at: www.chbrp.org/docs/authorizing_statute.pdf.

¹⁵ Although jointly referred to as the Affordable Care Act, the law is actually a product of the Patient Protection and Affordable Care Act (P.L.111-148) and the Health Care and Education Reconciliation Act (H.R.4872), both passed in 2010.

In California, more than 40 mandated benefits had been enacted into state law by the close of 2001, and during the 2001–2002 session, 10 benefit mandate bills were introduced. At that time, concerns arose regarding cost containment and whether well-intended mandates actually served their intended purposes. In response, 17 states, including California, passed laws requiring the evaluation of health benefits mandates during 2001–2002.¹⁶

Between 2002 and 2006, the number of benefit mandate bills introduced in the California Legislature remained steady. Given this stability, the California Legislature deemed it valuable to continue obtaining evaluations of such legislative proposals (SBFI Committee, 2006). In addition, CHBRP's reports provided by 2005 were deemed useful by a variety of stakeholder groups who supported extending CHBRP's sunset date, including stakeholder groups who were both proponents and opponents of benefit mandate bills, such as the California Department of Insurance (CDI), the California Medical Association (CMA), Health Access, and California Association of Health Underwriters (CAHU) (Senate Rules Committee, 2006). According to the SB 1704 bill author, the analyses produced by CHBRP provided "a valuable resource to the Legislature and other policymakers by providing objective information about the real-world impact of health benefit mandates". In addition, the author and supporters wrote that there was "broad agreement among consumer groups, plans, insurers, and other observers that the CHBRP process has successfully brought objective, quantitative analysis to benefit mandate proposals", and that CHBRP's analyses had "helped inform the debate over the costs and health advantages of particular mandates" (SBFI Committee, 2006).

At the time of CHBRP's first reauthorization, the California Legislature deemed it valuable to evaluate the impacts of repeal legislation, including this in CHBRP's charge under SB 1704. Between 2007 and 2009, the average number of introduced benefit mandate bills considered by the California legislature again remained steady, which led to CHBRP's second reauthorization in 2009 by AB 1540, extending the program's sunset date to June 30, 2015.

From 2009 to now, the average number of introduced benefit mandate bills in California, has remained steady (see Figure 1 in the *Executive Summary*), although 2011 and 2012 deviated from the norm. Perhaps in response to the ACA, California's legislature saw the number of introduced benefit mandate bills swell to 15 in 2011 and fall to 3 in 2012, before rising back to 9 in 2013.

During the most recent period of reauthorization, as in prior years, CHBRP has responded to requests for analysis with reports that have been consistently utilized by Legislators and committee staff, as well as bill advocates and opponents, providing all parties with a reliable basis for discussion of benefit mandate legislation. In response to requests from the Legislature, CHBRP has analyzed 94 bills in total, including 47 since 2009.

¹⁶ Since 2002, legislatures across the country have continued to consider benefit mandate bills and many have been passed into law (BCBSA, 2012). In California, another 20 have been enacted in the last 11 years. The presence of programs dedicated to analysis of benefit mandates may have limited the trend of increase, and certainly more state legislatures have become interested in having close analysis of benefit mandates. As of 2013, 29 states had systematic programs or processes in place to study benefit mandates. However, many of them are not independent of their state government, and they often require more than 60 days to produce their analyses.

Adapting to a New National and State Policy Context: The Affordable Care Act

In March 2010, the federal government passed the ACA¹⁷, enacting health care reform laws that dramatically impacted California's health insurance markets and its regulatory environment. The ACA included a number of provisions, such as the expansion of Medicaid, the establishment of private health insurance exchanges, and the requirement to provide essential health benefits (EHBs), that impacted California health insurance benefit coverage, as well as directly and indirectly prompted changes to health care delivery and finance.

CHBRP has also seen its work impacted by these changes, and its faculty and staff have adapted the program's analytic approach to address the new health care landscape. Since 2010, CHBRP has focused on understanding how changes initiated by the ACA would influence the state-regulated health insurance markets. Some examples of this include ACA requirements related to medical-loss ratios for health insurers, new cost-sharing limits on health plans, and the division of health plans/policies into grandfathered and nongrandfathered categories, all of which are elements that were incorporated into CHBRP's analytic approach starting in 2011. Since the passage of the ACA, the program has also focused on understanding how subsequent federal regulations and state laws that provide clarity on aspects of the ACA would impact CHBRP's work, such as the state's selection of a benchmark plan that clarified EHBs, and federal guidance around EHBs. CHBRP engaged in these efforts in order to adapt its model and analytic approach to provide the most complete, accurate, and relevant information possible to the Legislature and other stakeholders.

Amidst these changes, a particular topic of interest to the Legislature and other stakeholders has been the question of how EHBs might interact with state-level benefit mandates. To address this concern, for both the complete bill analysis reports and through supplemental issue briefs, CHBRP has conducted a thorough analysis of the interaction of proposed benefit mandate bills with EHBs. For the 2013 analytic cycle, CHBRP also developed an approach to evaluate whether a state level benefit mandate might exceed EHBs, a situation which would require California to defray related costs for enrollees in products sold by Covered California. To do this, CHBRP reviewed, for each bill, federal law and regulation (pending as well as final), state law and regulation, and the benefit coverage offered by California's benchmark plan. The results of this approach are illustrated in Table 2 below. Although not conclusive, these evaluations provide more clarity for the discussion of mandate bills by indicating whether a mandate probably would not exceed EHBs, might exceed EHBs, or would have an unclear interaction with EHBs.

¹⁷ Although jointly referred to as the Affordable Care Act, the law is actually a product of the Patient Protection and Affordable Care Act (P.L.111-148) and the Health Care and Education Reconciliation Act (H.R.4872), both passed in 2010.

Table 2. 2013 California Mandate Bills and Essential Health Benefits

2013 Bill	Proposed Benefit Mandate	EHB Interaction	Discussion
AB 219 (Perea) Oral Anticancer Medications	Would limit cost sharing	Would not exceed	Cost-sharing requirements, such as those AB 219 would create, are not considered state-required benefits that could exceed EHBs.
AB 460 (Ammiano) Infertility	Would prohibit discrimination	Would not exceed	AB 460 would not change the current infertility mandate from a “mandate to <i>offer</i> ” to a “mandate to <i>cover</i> ,” and so the mandate would still not be a state-required benefit that could exceed EHBs.
AB 889 (Frazier) Prescription Drug Benefits	Would prohibit requiring trial of more than two drugs before covering a third	Would not exceed	Restrictions on benefit design, such as those AB 889 would impose, are not considered state-required benefits that could exceed EHBs.
AB 912 (Quirk-Silva) Fertility Preservation	Would require coverage for fertility preservation	May exceed ¹⁸	Fertility preservation services are not included in California’s benchmark plan, are not part of required coverage under basic health care services, and meet the federal definition of a state benefit mandate that can exceed EHBs. AB 912 (as written on February 22, 2013) may require benefit coverage that exceed EHBs.
SB 126 (Steinberg) Autism	Would require coverage for autism	Would not exceed	The existing state benefit mandate, which SB 126 would extend, was enacted before December 31, 2011, and so its requirements (and the extension of them that SB 126 would enact) are within California’s EHBs.
SB 189 (Monning) Wellness Programs	Would prohibit alteration of premiums or cost-sharing due to wellness program activity	Would not exceed	Restrictions on benefit design, such as those SB 189 would impose, are not considered state-required benefits that could exceed EHBs.
SB 320 (Beall) Acquired Brain Injury	Would require coverage for ABI rehabilitation services	Unknown	Determination of whether each type of ABI rehabilitation service is provided at listed facilities is needed to determine whether required coverage would exceed EHBs.
SB 799 (Calderon) Colorectal Cancer	Would require coverage of genetic testing for LS and annual CRC screening	Unknown	Determination of whether genetic testing for LS and annual (as opposed to biennial) CRC screening are medically accepted cancer screening tests is needed to determine whether the required coverage would exceed EHBs.

Source: California Health Benefits Review Program, 2013.

Key: ABI=acquired brain injury; CRC=colorectal cancer; EHB=essential health benefit; LS=Lynch syndrome.

As the Legislature and other public and private organizations representing different facets of the health care industry rapidly adapt their operations to confront changes to the health care system

¹⁸ Amendments taken after CHBRP’s analysis was complete would exempt the small-group and individual markets from compliance, so later versions of AB 912 would not exceed EHBs in 2014 or 2015.

due to health reform, CHBRP's scientific expertise and rigorous analysis of proposed benefit mandate legislation continues to provide value and insight into the interaction between federal health reform and state law and regulation. In order to provide maximum value to the Legislature and other stakeholders, CHBRP has disseminated information on how these two sets of laws and regulations interact through its formal reports, supplemental products, and through briefings and presentations at the State Capitol.

Additional ways in which CHBRP has adapted its analyses in light of the ACA include the following:

- **Interaction between benefit mandates and the ACA:** In advance of further clarity from the federal government on specific provisions of the reform laws, CHBRP was able to provide preliminary analysis of the potential effects of health reform in each of its 2010–2013 bill analysis reports, including details on how a proposed benefit mandate might interact with specific provisions of the ACA.
- **Stakeholder impact:** After passage of the ACA, CHBRP queried a wide variety of stakeholders about its effects, including legislative and executive agency staff, regulators, health plans and insurers, consumer and advocacy organizations, trade associations, and employer and business groups. This allowed CHBRP to gather input from diverse stakeholders on the potential impacts of the ACA on California, particularly focused on 2012–2013, including: the availability of coverage and enrollment data, interpretation and compliance approaches, and potential interactions with existing state law.
- **Quantitative Estimates:** CHBRP updated its California Cost and Coverage Model (CCM) using projections of health insurance premiums developed by the California Simulation of Health Insurance Markets (CalSIM), and developed an approach for projecting premiums and enrollment post-2014. This allowed for an assessment of the marginal impact of benefit mandates introduced in 2013 that would go into effect in 2014. CHBRP also continues to provide quantitative estimates of the impact of health reform on premiums and enrollment in the state-regulated health insurance markets. This data is gathered through surveys and informal discussions with the seven largest insurance carriers in California. CHBRP's CCM will continue to be updated each year to reflect the impacts of the ACA as it is implemented, and as more evidence on its impact becomes available.¹⁹
- **Health Policy Research:** CHBRP faculty and researchers reside in multiple health policy centers that house health reform experts and produce cutting-edge analysis for policymakers throughout the state of California. The ongoing efforts of CHBRP contributes to this larger knowledge base, by providing indirect funding opportunities, student internships, and other efforts that supports collaboration. CHBRP seeks to further leverage its work with these health policy research centers in the future, and to help the Legislature keep up to date on the most recent developments in federal and state law that relate to health insurance benefit mandates and other related facets of health reform implementation.

¹⁹ More specific information on changes to the CCM can be found in the “Analytic Methods” section of this report.

- **Resources and Policy/Issue Briefs:** Since passage of the ACA, CHBRP has substantively revised resources and has issued supplemental publications discussing specific provisions of the health reform law. Full descriptions of each of these products can be found in the “Other Publications” section of this report, but brief summaries are provided below.
 - Resources:
 - *Estimates of the Sources of Health Insurance:* Updated projections of health insurance enrollment for California’s population, including changes related to the ACA such as the establishment of Covered California.
 - *Health Insurance Benefit Mandates in California State Law:* A comprehensive list of the existing health insurance benefit mandates that are currently in law in California, including federal mandates required by the ACA.
 - *Federal Preventive Services Benefit Mandate and California Benefit Mandates:* An analysis of the interaction between state-level benefit mandates and the ACA’s requirement to cover some preventive services without cost-sharing.
 - Policy and Issue Briefs:
 - *California's State Benefit Mandates and the Affordable Care Act's “Essential Health Benefits”:* An issue brief that provides background on federal EHB requirements, and context for potential interaction effects between these requirements and state-level benefit mandates.
 - *Immunization Mandates, Benchmark Plan Choices, and Essential Health Benefits:* An analysis of how state benefit mandates could exceed EHBs.
 - *Mammography Mandates, Benchmark Plan Choices, and Essential Health Benefits:* An analysis of how state benefit mandates could exceed EHBs.
 - *Pediatric Dental and Pediatric Vision Essential Health Benefits:* A brief on unresolved policy and technical questions related to the selection of benefits, eligibility requirements, and cost-sharing issues around the pediatric dental and pediatric vision EHBs.

CHBRP'S CHARGE: ANALYSES AND APPROACH

Since its inception, the California Health Benefits Review Program (CHBRP) has provided the legislature with a standardized, impartial approach for evaluating health insurance mandates in an ever changing health policy landscape.

This section summarizes CHBRP reports' findings, provides an overview of supplemental publications, reviews CHBRP's continuous quality improvement efforts and responsiveness to legislative requests, and briefly describes some challenges to CHBRP's analytic approach.

CHBRP's Initial Objectives and Charge

AB 1996, CHBRP's initial authorizing statute,²⁰ outlined the program's initial objectives and charge. Due to the Legislature's concern about the increasing trend of benefit mandate proposals, interest in assessing their health outcomes, and concern about their cost and affordability, the Legislature commissioned the University of California (UC) to conduct a systematic review of proposed benefit mandate legislation.

AB 1996 went on to specify the analytic questions that were to be addressed by UC's reviews; these specific provisions were also extended under SB 1704 and AB 1540 (California Health and Safety Code, Sections 127660–127664). As discussed previously, SB 1704 added the analysis of benefit mandate repeals to CHBRP's charge. The following lists the provisions of CHBRP's current enabling statute:

1. UC is requested to establish CHBRP.
2. Legislation proposing to mandate (or repeal) a benefit or service is defined as a proposed statute that requires (or repeals the requirement on) a health care service plan and/or health insurer to:
 - a. Permit an enrollee to obtain health care treatment or services from a particular type of health care provider;
 - b. Offer or provide coverage for the screening, diagnosis, or treatment of a particular disease or condition; or
 - c. 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.
3. All legislation proposing or repealing a "mandated benefit or service" is to be analyzed by UC and a written analysis is to be prepared with relevant data on the legislation's public health, medical, and financial impacts, as defined
4. Support for UC to conduct these analyses is to be provided through a non-General Fund source, specifically fees levied by the Department of Managed Health Care (DMHC) and

²⁰ For a full description of CHBRP's Authorizing Statute, see Appendix 1.

the California Department of Insurance (CDI) on health care service plans and health insurers, respectively, the total annual amount of which shall not exceed \$2 million.

5. Legislative requests to UC are to be made by an appropriate policy or fiscal committee chairperson or legislative leadership.
6. UC is to submit analyses of proposed health insurance mandate bills to the appropriate committee no later than 60 days after receiving a request from the Legislature.
7. UC is to develop and implement conflict-of-interest provisions to prohibit participation in the analyses by a person with a material financial conflict of interest, including a person who has a consulting or other agreement with an entity that would be affected by the legislation.
8. UC is to use a certified actuary or other person with relevant knowledge and expertise to determine the financial impact of a given bill.
9. UC is to post all analyses on the Internet and make them available to the public on request.
10. UC was to provide the Governor and Legislature with a report on the implementation of SB 1704 by January 1, 2010. The current enabling statute moves this report date to January 1, 2014. The established “sunset date” for the program is extended to June 30, 2015, unless a later enacted statute extends or repeals that date.

CHBRP Reports

As described in statute above, CHBRP is charged with supporting the California Legislature through independent, academically rigorous, and unbiased reports that analyze the medical effectiveness of the tests, treatments, and services relevant to a proposed mandate or repeal bill; and estimate the likely impact of the bill on benefit coverage, utilization, cost, and public health. Since the program’s inception, CHBRP has issued 94 completed bill reports and 13 follow-up letters, as well as 4 issue/policy briefs and several other resources. All CHBRP publications are available at www.chbrp.org.

Topics of Bills Analyzed

The list of bills CHBRP has analyzed, their relevant topics, and their final status is included in Table 3 below. Because of the range of issues addressed by mandate bills, CHBRP faculty and staff must be sophisticated generalists, capable of obtaining the knowledge base necessary to effectively develop an appropriate bill-specific analytic approach quickly. CHBRP also retains content experts who serve as subject matter experts and help to identify key literature. Different services and benefits may have specific analytic questions that are relevant to the Legislature’s deliberation of the bill. CHBRP has developed a methodology that is attuned to these questions and aims to deliver a robust analysis that addresses the potential questions the Legislature might face in its deliberation.

Table 3. CHBRP Analyzed Bills: Topics Addressed and Final Bill Status, 2009–2013²¹

Analyzed Legislation	Author	Topic	Status
2009			
AB 56	Portantino	Mammography	Vetoed by Governor
AB 98	De La Torre	Maternity services	Vetoed by Governor
AB 163	Emmerson	Amino acid–based elemental formulas	Failed passage out of Legislature
AB 214	Chesbro	Durable medical equipment	Failed passage out of Legislature
AB 244	Beall	Mental health services	Vetoed by Governor
AB 259	Skinner	Certified nurse midwives: Direct access	Failed passage out of Legislature
AB 513	de Leon	Breast-feeding	Vetoed by Governor
AB 786	Jones	Coverage choice categories	Failed passage out of Legislature
SB 92	Aanestad	Health care reform	Failed passage out of Legislature
SB 158	Wiggins	Human papillomavirus vaccination	Vetoed by Governor
SB 161	Wright	Chemotherapy treatment	Vetoed by Governor
2010			
AB 113	Portantino	Mammography	Vetoed by Governor
AB 754	Chesbro	Durable medical equipment	Failed passage out of Legislature
AB 1600	Beall	Mental health services	Vetoed by Governor
AB 1825	De La Torre	Maternity services	Vetoed by Governor
AB 1826	Huffman	Pain prescriptions	Failed passage out of Legislature
AB 1904	Villines	Out-of-state carriers	Failed passage out of Legislature
AB 2587	Berryhill	Benefit mandates	Failed passage out of Legislature
SB 220	Yee	Tobacco cessation services	Vetoed by Governor
SB 890	Alquist	Basic health care services	Vetoed by Governor
SB 961	Wright	Cancer treatment	Vetoed by Governor
SB 1104	Cedillo	Diabetes-related complications	Failed passage out of Legislature
2011			
AB 72	Eng	Acupuncture	Failed passage out of Legislature
AB 137	Portantino	Mammography services	Signed into law
AB 154	Beall	Mental health services	Failed passage out of Legislature
AB 171	Beall	Autism	Failed passage out of Legislature
AB 185	Hernandez	Maternity services	Failed passage out of Legislature
AB 310	Ma	Prescription drugs	Failed passage out of Legislature
AB 369	Huffman	Pain prescriptions	Vetoed by Governor
AB 428	Portantino	Fertility preservation	Failed passage out of Legislature
AB 652	Mitchell	Child health assessments	Failed passage out of Legislature
AB 1000	Perea	Cancer treatment	Vetoed by Governor
SB 136	Yee	Tobacco cessation	Ceased being a benefit mandate bill
SB 155	Evans	Maternity services	Failed passage out of Legislature
SB 173	Simitian	Mammograms	Failed passage out of Legislature
SB 255	Pavley	Breast cancer	Signed into law
SB 770	Steinberg and Evans	Autism	Failed passage out of Legislature
SB-TBD 1	Steinberg	Mental illness: autism	Signed into law

Source: California Health Benefits Review Program, 2013.

²¹ For full details on each of the bills CHBRP analyzed during this period, please see Appendix 9.

Table 3. CHBRP Analyzed Bills: Topics Addressed and Final Bill Status, 2009–2013 (Cont.)

Analyzed Legislation	Author	Topic	Status
2012			
AB 1000	Perea	Cancer treatment	Vetoed by Governor
AB 1738	Huffman	Tobacco-cessation services	Failed passage out of Legislature
AB 1800	Ma	Health care coverage	Failed passage out of Legislature
AB 2064	Perez	Immunizations for children	Failed passage out of Legislature
2013			
AB 219	Perea	Oral anticancer medications	Active, ordered to third reading
AB 460	Ammiano	Infertility	Active, ordered to third reading
AB 889	Frazier	Prescription drug benefits	Placed on suspense file
AB 912	Quirk-Silva	Fertility preservation	Placed on suspense file
SB 126	Steinberg	Pervasive developmental disorder or autism	Active
SB 189	Monning	Wellness programs	Failed passage out of Legislature
SB 320	Beall	Acquired brain injury	Held in committee
SB 799	Calderon	Colorectal cancer: genetic testing and screening	Set for hearing

Source: California Health Benefits Review Program, 2013.

Summary of CHBRP Reports

During the years 2009 through 2013, at the request of the California Legislature, CHBRP analyzed 47 bills, and issued 45 reports and 2 issue analyses. During this period, CHBRP also answered the Legislature’s requests for clarification with 7 letters regarding one or another of the 45 reports, generally with a much shorter turnaround. CHBRP reports consider: (1) the medical effectiveness of a proposed mandated benefit or service in terms of clinical outcomes; (2) the projected cost impacts of the mandate in terms of per member per month premiums and total expenditures; and (3) the estimated public health impacts in terms of the population and by public health outcomes.²² CHBRP’s issue analyses are less uniform in approach, instead providing a summarization of key policy considerations when the language of a bill is too ambiguous for CHBRP’s standard analytic process to be feasible. Below is a summary of some of the key findings from CHBRP’s analyses between 2009 and 2013.

Medical effectiveness

- In 31 of 34 reports, the medical effectiveness analyses determined that the bills were mandating coverage for tests, treatments, or services considered to be effective. The majority of those determinations were based on well-designed studies.
- In 14 reports, the medical effectiveness analyses concluded that the evidence was either mixed or insufficient to deem the test, treatment, or service effective.

²² For full details on the analytic methods used for CHBRP’s medical effectiveness, cost, and public health impacts analyses, see Appendices 10, 11, and 12.

Cost impact

- In 34 of 45 reports, the cost impact analysis estimated that the bill would incrementally increase total health care expenditures.
- In 11 reports, the cost impact analysis estimated no overall increase in total health care expenditures as a result of the bill, usually because the benefit was widely covered or there was no estimated increase in utilization associated with the mandate.

Public health impacts

- In 23 of 45 reports, the public health impact analysis estimated a directional positive impact to public health as a result of the bill, due either to improved health outcomes or decreased financial and administrative burden.
- In 12 reports, where the benefit was widely covered or there was no estimated increase in utilization associated with the bill, the public health impact analysis estimated no impact on the public's health.
- In 10 reports, the public health impact analysis concluded that due to incomplete, inconclusive, or mixed evidence, the impact of the bill on the health of the public was unknown.

Use of CHBRP's Reports

Consistently, those involved with the Legislature's consideration of benefit mandate and repeal bills report that they rely on CHBRP's analyses because they are useful, comprehensive, rigorous, and impartial. Stakeholders frequently state that CHBRP analyses serve as the baseline for discussion around benefit mandate bills, particularly around fiscal impacts. Additionally, legislative and agency staff have frequently indicated that the analyses aid them in their internal consideration of whether a bill avoids unintended consequences and whether it adequately addresses the problem it seeks to resolve.

CHBRP analyses during the legislative process

CHBRP's reports are widely used to support decision making throughout the Legislature's deliberative process regarding benefit mandate bills.

- **Legislative Committee Staff** consistently draw analysis from CHBRP reports for inclusion in the policy and fiscal committee analyses.
- **Legislators on Committees** and **Bill Authors** routinely quote from CHBRP reports during hearing remarks and testimony.
- **Health Insurance Stakeholders**, both bill advocates and opponents, including advocacy organizations, health plans/insurers, trade associations, and consumer groups, regularly use CHBRP reports to make cases in support of, or in opposition to, the passage of mandate bills.

Additionally, sometimes information cited in CHBRP reports is used when considering another California bill on a related topic. Such a situation occurred with CHBRP's analyses of AB 171 (Beall, 2011), a bill that would have required health plans and insurers to cover test, treatments, and services related to Pervasive Developmental Disorders and Autism (PDD/A). The medical effectiveness analysis section of CHBRP's AB 171 report, as well as the fiscal impact estimates, were used to examine two related bills, SB 770 (Steinberg and Evans, 2011) and SB 946²³ (Steinberg, 2011), both of which also addressed coverage for PDD/A. The latter of the two eventually became a health insurance benefit mandate law.

CHBRP's analyses are sometimes used by California Public Employees' Retirement System (CalPERS). For example, this occurred with CHBRP's analysis of AB 912 (Quirk-Silva, 2013), a bill that would have required health plans and insurers to cover medically necessary expenses for fertility preservation services when a necessary medical treatment might cause infertility to an enrollee. CHBRP's analysis of AB 912 was used by CalPERS's internal medical effectiveness consultants as they considered benefits, coverage, and associated costs for their employees, retirees, and dependents.

Opponents and advocates of health insurance benefit mandate bills have regularly used CHBRP's reports to make a case for or against a mandate bill's passage. In committee hearings, bill authors and sponsors regularly quote from CHBRP's reports, as do representatives of Health Access and the California Association of Health Plans (CAHP), two stakeholder groups that frequently testify regarding benefit mandate bills.

CHBRP analyses beyond the legislative cycle

CHBRP's analyses remain relevant as references even beyond the legislative process. For example, insurance regulators report having used CHBRP analyses in discussion of appropriate rate increases when analyzed bills have passed into law. Health plans also report using CHBRP's medical effectiveness analysis to evaluate their benefit coverage offerings.

Outside of California, a recent federal report²⁴ cited a CHBRP analysis's estimate regarding the marginal cost of covering applied behavioral analysis as an EHB, and the Institute of Medicine (IOM) also recommended that CHBRP's approach serve as a guide for further defining EHBs in the future.²⁵ Other states considering their own benefit mandate bills have also utilized CHBRP's analyses. Several recent instances appear in Table 4, although the list is certainly an undercount, given that CHBRP is not always made aware of such citations.

²³ SBD 946 was originally known as SB TBD-1.

²⁴ Center for Medicare & Medicaid Services, Center for Consumer Information and Insurance Oversight, *Essential Health Benefits Bulletin*. December 16, 2011. Available at: www.cms.gov/CCIIO/Resources/Files/Downloads/essential_health_benefits_bulletin.pdf.

²⁵ IOM, 2011. *Essential Health Benefits: Balancing Coverage and Cost*. Available at: www.iom.edu/Reports/2011/Essential-Health-Benefits-Balancing-Coverage-and-Cost.aspx.

Table 4. CHBRP Reports Formally Referenced by Other States, 2010–2012.

Year	Document Title	State Agency	Referenced CHBRP Report
2012	<i>Review and Evaluation of Certain Health Benefit Mandates in Connecticut</i>	University of Connecticut	<ul style="list-style-type: none"> • AB 171 (2011) Autism • SB 749 (2010) Health Care Coverage: Diagnosis of Autism • SB 173 (2011) Mammograms
2011	<i>Annual Mandated Health Insurance Services Evaluation</i>	Maryland Health Care Commission	<ul style="list-style-type: none"> • SB 161 (2009) Chemotherapy Treatment
2011	<i>Prosthetics and Orthotics Coverage Mandated Benefit Sunrise Review</i>	Washington State Department of Public Health	<ul style="list-style-type: none"> • AB 1212 (2006) Orthotic & Prosthetic Devices • AB 1212 (2006) Orthotic & Prosthetic Devices (Amended)
2010	<i>Connecticut Mandated Health Insurance Benefits Reviews 2010, Volume II</i>	University of Connecticut	<ul style="list-style-type: none"> • AB 56 (2009) Mammography • AB 8 (2005) Health Care Coverage: Mastectomies and Lymph Node Dissections
2010	<i>Oral Chemotherapy Drug Coverage Mandated Benefit Sunrise Review</i>	Washington State Department of Public Health	<ul style="list-style-type: none"> • SB 961 (2010) Cancer Treatment
2010	<i>Patient Cost Disparity Between Orally and Intravenously Administered Chemotherapies</i>	Texas Department of Insurance	<ul style="list-style-type: none"> • SB 161 (2009) Chemotherapy Treatment
2010	<i>Review and Evaluation of Proposed Legislation Entitled: An Act to Provide Coverage for Hearing Aids, House Bill 3598</i>	Massachusetts Division of Health Care Finance and Policy	<ul style="list-style-type: none"> • AB 368 (2007) Mandate to Offer Coverage for Hearing Aids for Children

Other Publications

In addition to analyzing benefit mandate bills, CHBRP utilizes faculty and staff expertise to generate a number of other publications that provide value to the Legislature. These products generally address issues that are broadly relevant to benefit mandates or aspects of federal health reform relevant to CHBRP’s work. A description of each publication is provided below.

Resources

Estimates of the Sources of Health Insurance

This annually updated resource presents projections of health insurance enrollment for California’s population that may be subject to state-level benefit mandates and the number enrolled in other types of health insurance. The resource also estimates the portion of enrollees associated with the CalPERS or the California Department of Health Care Services (DHCS) whose health insurance may be affected by a state-level benefit mandate law.

Health Insurance Benefit Mandates in California State Law

This annually updated resource provides a comprehensive list of the existing health insurance benefit mandates that are currently in law in California, including both the laws that are enforced by DMHC and CDI, as well as applicable federal law. This alerts CHBRP's stakeholders of existing laws that may interact with a state-level health insurance benefit mandate or repeal bill.

Federal Preventive Services Benefit Mandate and California Benefit Mandates

This resource identifies potential overlap between the ACA requirement to cover some preventive services, without cost-sharing, and California's state benefit mandates. The resource provides a comprehensive list of relevant preventive services through analysis of the sources referenced by the ACA, including: the United States Preventive Services Task Force (USPSTF) A and B recommendations; guidelines supported by the Health Resources and Services Administration (HRSA) for women, children, and newborns; and Advisory Committee on Immunization Practices (ACIP) recommendations.

Policy and Issue Briefs

California's State Benefit Mandates and the Affordable Care Act's "Essential Health Benefits"

The focus of this issue brief is on the ACA's 2014 requirement of coverage of EHBs by most health insurance products sold in the individual and small group markets, including but not limited to those associated with Covered California, the state's health insurance exchange. The brief provides background on federal EHB requirements, as well as context for potential interaction effects between those requirements and state level benefit mandate bills.

Immunization Mandates, Benchmark Plan Choices, and Essential Health Benefits

This brief provides a detailed analysis of California's immunization mandates as an example of how state benefit mandates could exceed EHBs and how evidence-based analysis may inform discussions of whether to keep or repeal state benefit mandates that exceed EHBs.

Mammography Mandates, Benchmark Plan Choices, and Essential Health Benefits

This brief provides a detailed analysis of California's mammography mandates to illustrate how state benefit mandates could exceed EHBs and how evidence-based analysis may inform discussions of whether to keep or repeal state benefit mandates that exceed EHBs.

Pediatric Dental and Pediatric Vision Essential Health Benefits

This brief raises a number of unresolved policy and technical questions related to the ACA's requirement of coverage for pediatric dental and vision benefits. All of the questions posed analytic challenges for CHBRP, even when considering bills unrelated to the subject matter, so the brief was issued to begin raising those questions with external policymakers and stakeholders. Since its publication, the brief was revised to address ways in which some of these questions have been answered by subsequent federal and state law and regulation.

Legislative Outreach and Briefings

In order to promote better understanding of CHBRP's role and the nature of health benefit mandates, CHBRP has regularly provided pre-session briefings for legislative staff and other interested parties. Each January, before the bill introduction deadline, CHBRP provides a briefing that outlines the program's process and methodology.

CHBRP has also consistently taken steps to ensure that reports are understood by legislators and staff from author's offices and policy committees throughout the legislative process. Immediately after a report is submitted, CHBRP schedules calls with staff from the requesting health committee, with calls also offered to the bill author's office and to the staff of each health and appropriations committee that considers the bill. CHBRP staff members remain available to answer the questions of any interested party throughout the legislative process, and routinely attend health committee hearings as well as appropriations hearings. At hearings, CHBRP staff members have occasionally been called upon by committee members to further explain report details and methodology.

Disseminating Knowledge Obtained Through CHBRP's Experiences

In tandem with their analytic work, CHBRP faculty, staff, librarians, and actuaries have attended select conferences, made presentations, and published materials to share the methods they have developed with fellow researchers and health policy experts. Such additional work helps to disseminate sound analytic methods to other analytic and academic organizations, and ensures that staff and faculty also are kept abreast of other new introduced methods or approaches that might inform CHBRP's work. In addition, by subjecting the methods to scrutiny by peers in the policy and academic communities, CHBRP stands to benefit over the longer term by continuous quality improvement of its analytic methods. Since passage of the ACA, CHBRP has also dedicated efforts to understanding the interaction between state benefit mandates and federal health reform, and has disseminated that information through briefings and presentations at the State Capitol and at other health policy forums and conferences.²⁶ Some examples include:

- Presentation: *Essential Health Benefits and State-level Mandates*. December 8, 2011. National Academy for State Health Policy (NASHP) Webinar. CHBRP's detailed its approach to analyzing the interaction of EHBs and benefit mandates to a community of national policymakers.
- Conference: *Putting it all Together: Evidence-Based Health Research and Policymaking in California*. September, 2012. Vancouver, BC. CHBRP's experience was presented to an international audience at a conference of the International Society on Health Care Priorities.
- Conference: *Essential Health Benefits and State Mandates*. October, 2012. Miami, FL. CHBRP's work in California was shared with a national audience at the Milliman HealthCare Symposium.

²⁶ A full list of presentations and publication can be found in Appendix 8.

- Presentation: *Overview of Health Insurance “101.”* January, 2013. Sacramento, CA. CHBRP provided a presentation on the basics of health insurance to the State Legislature and other California stakeholders.

CHBRP has repeatedly received attention from and been recognized as a resource by experts and stakeholders outside of California. In addition to the already mentioned use of CHBRP’s reports by other states considering mandates (noted earlier in Table 4), CHBRP is aware of instances in which CHBRP’s work supported broader policy discussions. Several examples are listed in Table 5, though the list is likely to be a lower threshold, since CHBRP is not always alerted when its work is referenced.²⁷

Table 5. Citations of CHBRP’s Work by External Parties, 2009–2012

Year	Document Title	Publisher	Referenced to CHBRP
2013	<i>Research Highlight: Estimated Sources of Health Insurance in California in 2014</i>	California Association of Health Plans	Estimates of Sources of Health Insurance in California, 2012 & 2014
2013	<i>Issue Brief: Private Coverage Under California’s Affordable Care Act: Benefit and Cost-Sharing Requirements Affecting Children and Adolescents With Special Health Care Needs</i>	Lucile Packard Foundation for Children’s Health	Issue Brief: Interaction between California State Benefit Mandates and the Affordable Care Act’s “Essential Health Benefits” (2012)
2012	<i>Protecting High-Risk, High-Cost Patients: “Essential Health Benefits,” “Actuarial Value,” and Other Tools in the Affordable Care Act</i>	Robert Wood Johnson Foundation and Urban Institute	SB 161 (2009) Chemotherapy Treatment
2012	<i>RIDER 55 REPORT: Report on Telemonitoring in the Texas Medicaid Program</i>	Texas Health and Human Services Commission	SB TBD 1 (2011) Autism
2012	“The Value of Federalism in Defining Essential Health Benefits”	<i>The New England Journal of Medicine</i>	ISSUE BRIEF: California’s State Benefit Mandates and the Affordable Care Act’s “Essential Health Benefits” (2011)
2011	<i>California’s Individual and Small Group Markets on the Eve of Reform</i>	California HealthCare Foundation	Estimates of Sources of Health Insurance in California, 2011
2011	<i>Essential Health Benefits: Balancing Coverage and Cost</i>	Institute of Medicine	CHBRP on Public Health Impact Analysis; CHBRP’s 2011 report on benefit mandate analysis programs in other states

²⁷ A full list of citations of CHBRP’s work in the media and in the published literature can be found in Appendices 20 and 21.

Table 5. Citations of CHBRP’s Work by External Parties, 2009–2012 (Cont.)

Year	Document Title	Publisher	Referenced to CHBRP
2011	<i>Essential Health Benefits Bulletin</i>	Center for Consumer Information and Insurance Oversight	SB TBD 1 (2011) Autism
2011	“Lessons From California on Essential Benefits...”	Health Access Blog	CHBRP is referenced as giving testimony in this article.
2011	<i>Statement on Essential Health Benefits</i>	America’s Health Insurance Plans	CHBRP is referenced as a program that analyzes mandate and repeal bills.
2010	<i>California Health Care Almanac: California Health Plans and Insurers</i>	California HealthCare Foundation	Table 1: Health Insurance Coverage of Californians, 2008
2010	<i>Medical Governance: Values, Expertise, and Interests in Organ Transplantation</i>	Georgetown University Press	CHBRP is referenced as a program that analyzes mandate and repeal bills.
2010	“Satisfaction and Expectations of the Women Participants and Not Participants in the Breast Cancer Screening Programme in Barcelona After 10 Years of Operation”	<i>Revista Española de Salud Pública</i> (Spanish Journal of Public Health)	AB 56 (2009) Mammography
2009	“Designing Health Insurance Market Constructs for Shared Responsibility: Insights From California”	<i>Health Affairs (Millwood)</i>	Broken link referencing “Table 1: Insurance Coverage of Californians, 2006.”
2009	<i>Impact of the Patient Protection and Affordable Care Act on Costs in the Individual and Small-Employer Health Insurance Markets</i>	Marsh, Mercer, Kroll, Guy Carpenter, Oliver Wyman	SB 1198 (2008) Health Care Coverage: Durable Medical Equipment
2009	“IOM Likes Its CER List; Others Might if It Suits Them”	<i>Managed Care</i>	CHBRP is referenced as a program that analyzes mandate and repeal bills.
2009	Len Nichols Explains Why Cadillac Health Care Plans Aren’t the Cause Of Rising Insurance Costs	ThinkProgress	Refers to CHBRP’s analyses indicating “...that eliminating all 44 of California’s mandates would reduce premiums by no more than 4.8 percent.”
2009	“Research Topics Underpin Comparative Effectiveness”	<i>Managed Care</i>	CHBRP is referenced as a program that analyzes mandate and repeal bills.
2009	<i>The True Effects of Comprehensive Coverage: Examining State Health Insurance Mandates</i>	Baton Rouge Area Chamber	CHBRP is briefly mentioned for its review criteria in this article.

CHBRP has been recognized as an acknowledged model for benefit mandate review programs in other states. In 2006, the Virginia General Assembly directed their Joint Legislative Audit and Review Commission (JLARC), the investigative arm of the General Assembly, to begin providing staff assistance to Virginia’s Special Advisory Commission on Mandated Health

Insurance Benefits (SACMHIB). In particular, JLARC's charge was to assess, analyze, and evaluate the social and economic costs and benefits of any proposed mandated health insurance benefit or mandated provider. In developing JLARC's methods to fulfill its new charge, their staff interviewed CHBRP staff and reviewed CHBRP's methodology and processes. Although the law authorizing Virginia's SACHMHIB has been repealed, the benefit mandate review program is being absorbed into Virginia's new Health Insurance Reform Commission (HIRC), which is charged with establishing the state's health insurance exchange, deciding Virginia's EHBs package, and providing assessments of existing and proposed mandate legislation. At this time, the transition is still in progress but a continued focus on benefit mandate analysis is expected.

Another notable example of CHBRP serving as a model occurred in Connecticut. In 2009, the Connecticut General Assembly passed legislation establishing a mandate evaluation program similar in both structure and analytic focus to CHBRP. According to key staff involved in the policymaking process, legislators modeled the new program largely on CHBRP and California's experience. The legislation directs the Commissioner of Insurance to contract with the University of Connecticut's Center for Public Health and Health Policy (CPHHP) to analyze bills annually upon request. The program evaluates the social and financial impacts of benefit mandates along a number of discrete lines, including an analysis of medical effectiveness in addition to utilization and premium impacts. Similar to CHBRP, CPHHP is funded through a tax on health carriers. Since 2009, CPHHP has evaluated numerous mandates, and is currently working on four proposed mandates for 2013.

Continuous Quality Improvement

UC and CHBRP continuously evaluate the products, processes, and policies of CHBRP to ensure that the program is in compliance with the requirements of its authorizing statute, that it is responsive to legislative requests, and that it has processes in place to maintain quality assurance and make continuous quality improvements.

On an annual basis, CHBRP interviews legislative staff, agency staff, and stakeholder groups to understand how CHBRP reports were used, how reports can be improved, and how CHBRP's process can continue to be responsive to its legislative mandate. This stakeholder meeting process ensures that CHBRP's stakeholders have the opportunity to voice their comments and concerns directly to CHBRP staff, so that their feedback can be incorporated into the analytic approach for the next legislative cycle.

As part of CHBRP's annual stakeholder process, the following groups are contacted:

- Legislative staff, including the Health and Appropriations committee chairs, and staff from the Republican caucus in both chambers. Personal staff of Senators or Assembly members who served as the primary bill authors for benefit mandate or repeal bills are also contacted.
- Agency staff, including individuals at DMHC, CDI, Department of Health Care Services (DHCS), Covered California, and CalPERS.

- Health plans, insurers, and their trade associations, including the California Association of Health Plans (CAHP), the Association of California Life & Health Insurance Companies (ACLHIC)
- Advocacy groups such as Disability Rights of California and Health Access
- Labor groups such as the AFL-CIO and the California Federation of Labor
- Small business groups, including the National Federation of Independent Businesses (NFIB) and Small Business California (SBC)
- Provider groups such as the American College of Obstetrics and Gynecology (ACOG)

The following sections summarize the relevant concerns discussed in CHBRP’s stakeholder process, how CHBRP has responded to these issue areas, and how CHBRP continues to evaluate ways in which it can be responsive to demands on its reports while staying within its legislative mandate.

Readability, Reliability, and Content of the Reports

Legislative staff, agency staff, and stakeholder groups consider CHBRP’s reports to be both reliable and impartial. Stakeholders often remark that CHBRP’s reports serve as the “baseline” for discussion of the fiscal impact of mandate bills. Legislative staff report that they utilize CHBRP’s analyses and find the reports responsive, comprehensive, and useful. Committee staff have stated that CHBRP reports provide the essential technical information the Legislature needs to make decisions regarding health insurance benefit mandates, and particularly appreciate that the executive summaries are helpful in locating essential data for the legislative analyses.

Consumer groups and sponsors or proponents of certain mandate bills have also expressed high regard and utility for CHBRP’s work. They appreciate the fact that cost impacts are broken down by out-of-pocket expenditures and employee/employer premiums and have stated that such information is useful to communicate all sides of the story, and particularly valuable in discussions regarding the overall affordability of health insurance. One provider group representative stated that the reports “do a good job of outlining the key issues, a feature especially important for new legislators.” Another provider group representative noted that the quantitative data are sometimes difficult to parse out if one does not have an actuarial background. They emphasized the need to “translate” the figures presented in the tables into useful bulleted points, and since then, CHBRP has provided abbreviated bulleted explanations to help clarify understanding of these often complex figures.

Health plans and insurer representatives and their associations echo the sentiment that CHBRP is seen as a “credible source” for information. One plan stated that they conduct an internal analysis for some mandate bills, and their findings are generally consistent with CHBRP’s premium impact analysis. Insurers have also stated they appreciated that administrative costs are also discussed in CHBRP reports, especially for those bills that would primarily shift out-of-pocket costs from the enrollee to the insurer.

Overall, CHBRP has received a great deal of positive feedback on its reports, and has focused over the past five years in particular at trying to present findings with greater clarity and brevity. Some ways in which this has been done is to include summary boxes that provide the main points of each section of the report, and to shorten the length of the Executive Summary to try and makes the salient report findings easier to digest for CHBRP’s stakeholders.

CHBRP’s Analytic and Research Translation Process

Committee and bill author staff appreciate having a dialogue with CHBRP staff to understand the key background issues a bill author may identify, any issues related to bill language (in terms of its potential interpretation), and the verbal briefing of the report by CHBRP’s lead analyst, after the analysis has been submitted to the Legislature.

CHBRP’s adherence to its academic and rigorous methods is greatly appreciated and adds to the credibility of its work. However, stakeholders note that its high standards are sometimes not completely congruent with the goal of assisting the Legislature in determining whether the bill is ultimately a policy option worth pursuing. CHBRP acknowledges this challenge and notes that CHBRP’s authorizing legislation does not allow for the making of overall recommendations. To better draw readers to conclusions and caveats presented in the medical effectiveness, cost, and public health impacts sections, CHBRP staff has routinely followed up with legislative staff to provide detailed briefings. In addition, the reports have been revised to more clearly state the overall conclusions in terms of medical effectiveness. CHBRP is committed to addressing any concerns and taking further strides to ensure that its analytic work is even more accessible and useful to busy legislative staff operating under tight timelines.

Certain legislative staff and some stakeholders noted that it would be helpful if a CHBRP-like process were available for other types of bills such as mandates on insurers (e.g., related to eligibility, underwriting) or mandates on providers (e.g., hospital- or medical group–related mandates).

Challenges Inherent to CHBRP’s Analytic Process

The overarching challenge CHBRP faces in its analytic process is the delivery of a scientific, rigorous, high-quality analysis within the constraints posed by the 60-day timeframe required by statute. More specifically, key process challenges include identifying mandate or repeal bills in time for CHBRP analysis and ensuring smooth workflow. Some of CHBRP’s analytic challenges include projecting public health impacts with data limitations, and dealing with the applicability and limitations of the medical literature. More detail on each of these challenges is provided below.

Identifying Mandate Bills

The Assembly Health and the Senate Health Committees play an active role in communicating with members’ offices so that they are notified of potential mandate or repeal bills. On an annual basis, both the Assembly Health Committee and the Senate Health Committee send a memorandum to all Assembly Members and Senators discussing CHBRP’s process, the

deadlines for the legislative year, and the requirement for a CHBRP analysis. CHBRP's briefings and workshops have also helped bill authors to become aware of the timelines and to notify committee staff of potential bills early in the process.

The second year of each 2-year legislative session presents additional challenges due to an accelerated hearing calendar. Approximately 30 days are allotted from the point of bill introduction to the time it must pass out of the policy committees in the house of origin. To address this issue and provide CHBRP the statutory 60-day time period, CHBRP works with committee staff to be notified of bills and receive requests before the bill introduction deadline. These deadlines are communicated with Assembly Member and Senators office at the beginning of the legislative session.

Workflow and Timing

CHBRP must have sufficient capacity to do multiple (e.g., eight or more) analyses on simultaneous 60-day timelines. CHBRP faculty, actuaries, librarians, reviewers, and staff must produce and review multiple drafts on multiple bills in a very compressed timeframe. To address this concern, CHBRP has built additional capacity among CHBRP librarians, and with faculty and research staff.

When the Legislature is not in session, CHBRP undertakes numerous projects to meet the workload of the coming year, and improve the quality and transparency of its process and products. For example, CHBRP's medical effectiveness and public health teams may develop guidelines or criteria to address specific research questions that are likely to be presented by future bills. CHBRP updates its Cost and Coverage Model (CCM) annually, during the fourth quarter of the calendar year. The cost team supplies updated California Health Insurance Survey (CHIS) and California Health Care Foundation/National Opinion Research Center (CHCF/NORC) data, as described later in the "Analytic Methods" section of this report. In addition, CHBRP's staff and cost team incorporate, update, and validate the model based on information collected from health plans and insurers, DHCS, and CalPERS.

Estimating Public Health Projections With Data Limitations

CHBRP has responded to requests from legislative staff, agency staff, and other stakeholders to provide quantitative estimates of public health benefits where possible. In an effort to provide more information about impact on health disparities, CHBRP has done preliminary analyses examining the distribution of gender, age, and race/ethnicity in different insurance markets. Because health insurance benefit mandates sometimes have differential impacts on different elements of the health insurance market, such an understanding can provide some information about the potential for benefit mandates to enhance access to certain kinds of care. In addition, because most public health impacts occur in a longer time frame than the typical 1 year CHBRP typically estimates, staff and faculty are developing a new section on long-term health impacts of health benefit mandates that will be incorporated to reports in the upcoming legislative season.

Applicability and Limitations of the Medical Literature

CHBRP's medical effectiveness team has encountered three specific challenges in conducting its analysis. First, some mandate bills address topics for which few well-designed studies have been completed. Secondly, for medical effectiveness analyses, some mandate bills would require coverage for multiple interventions or services, such as bills regarding coverage for maternity services or durable medical equipment. Many studies focus on a single intervention or service, and their findings are not applicable to all of the interventions or services proposed in a bill. Studies that examine multiple services often do not compare the same bundle of interventions or services, which makes it difficult to compare findings across studies. The third challenge arises with the bills that address parity in coverage for treatment of a disease or condition rather than coverage of specific services, such as bills on parity in coverage for mental health and substance abuse services. Such bills are difficult to analyze because they implicitly assume that parity in coverage will remove financial barriers for accessing services which will, in turn, increase use of appropriate and effective services and thus improve health outcomes. The available medical literature often does not enable the medical effectiveness team to make these causal links. In each of these cases, CHBRP reports on both what the literature is able to convey and its limitations. To the extent possible, CHBRP also provides supplemental explanatory sections when the traditional medical effectiveness analytic framework does not lend itself to the particular bill. For example, CHBRP's analysis of AB 1600 (Beall, 2010) provided a section on the effects of California's previously enacted mental health parity law.

ACADEMIC RIGOR ON DEMAND

As per its authorizing statute, the California Health Benefits Review Program (CHBRP) utilizes the funds made available to it to secure key data and faculty time in advance, and is then able to act instantly upon requests from the Legislature to organize robust and credible analyses for introduced benefit mandate and repeal bills. This arrangement is unique among states that have organized programs for reviewing benefit mandates in that it both analyzes while the bill is under consideration, and also harnesses the intellectual effort of teams of faculty, staff, actuaries, and content experts. This combination of academic rigor with sufficient speed to inform deliberation makes CHBRP's efforts unique, robust, and timely.

Since CHBRP was reauthorized under SB 1704 in 2006, the program has made several structural, process, and methodological improvements to strengthen its analytic methods. This section will briefly review the infrastructure, process, and methods used by CHBRP and then highlight changes made since 2009.

Overall Structure

Operating support for CHBRP is provided through a non-General Fund source, specifically, fees levied by the California Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI) on health care service plans and health insurers, the total annual amount of which has been capped at \$2 million annually, or about \$0.0077 per member per month (in 2012 dollars) since 2003.²⁸ Additional in-kind support has also been provided by UC.

Broad Multidisciplinary Expertise

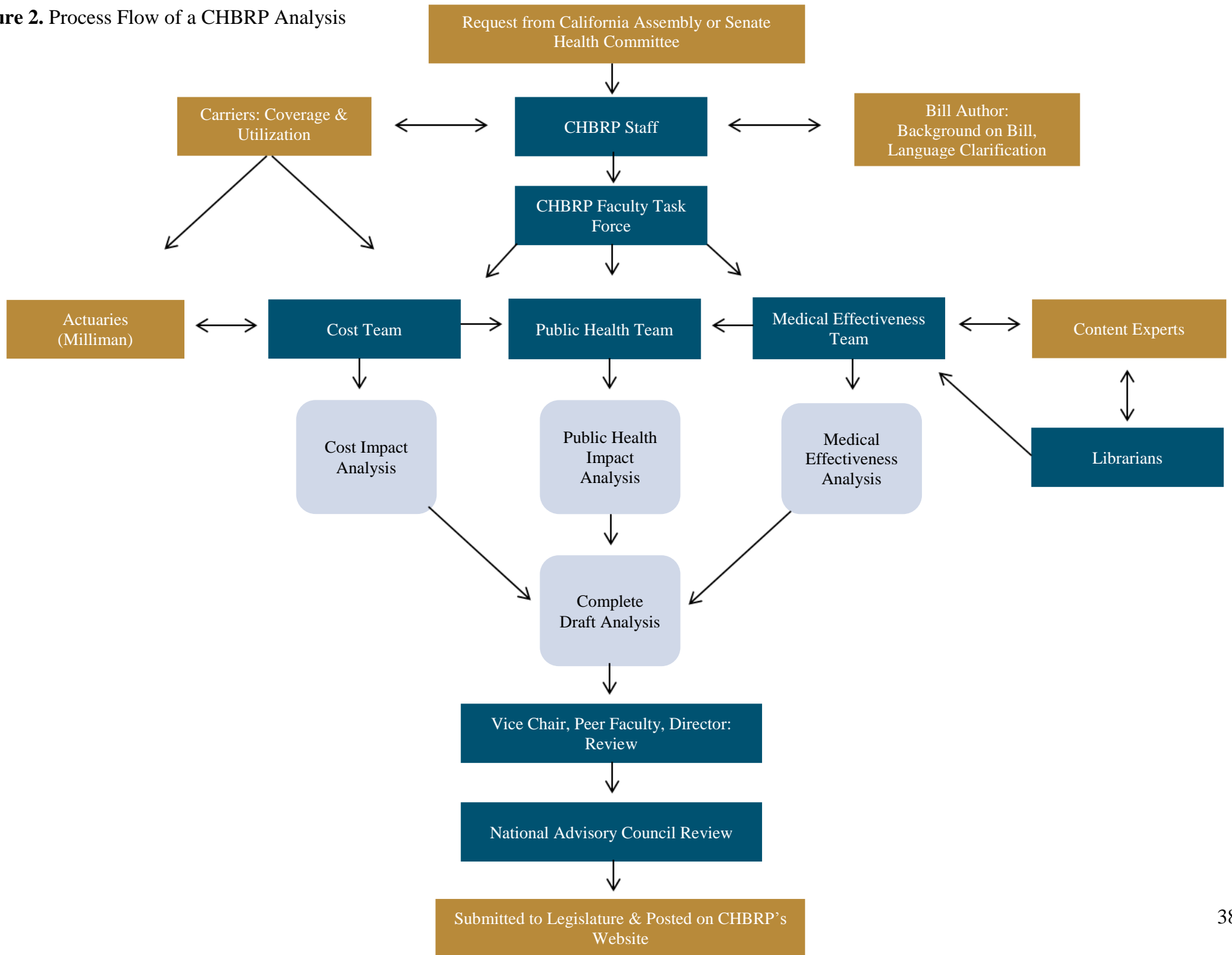
CHBRP reports provide academically rigorous analysis utilizing broad, multidisciplinary expertise. CHBRP's work achieves its standard academic rigor through the involvement of faculty, researchers and staff attached to the UC system. This includes individuals with expertise in medicine, health economics, actuarial science, public health, and medical effectiveness evaluation. CHBRP's multidisciplinary contributors are drawn from:

- University of California, Berkeley
- University of California, Davis
- University of California, Irvine
- University of California, Los Angeles
- University of California, San Diego
- University of California, San Francisco

The analytic teams work with librarians, content experts, and editors to collaboratively develop and complete a cohesive analysis within the 60-day time period. As demonstrated in Figure 2 below, the work is interdependent and cumulative.

²⁸ Additional information about CHBRP's funding process can be found in Appendix 7.

Figure 2. Process Flow of a CHBRP Analysis



Full descriptions of all of CHBRP’s contributors follow in the sections below.

Research capacity and expertise: faculty task force

During the years following the passage of AB 1996, UC considered various structural options for building the program. After consideration and discussions with faculty from various campuses, UC decided to implement a hybrid model in which the administration and some analytic work would occur at the UC Office of the President (UCOP), but the bulk of the writing and analysis would fall to the designated campuses. This model has proven to be an effective approach from UC’s perspective because (1) the quality of CHBRP reports is enhanced by an internal peer-review process; (2) the quality of CHBRP reports is enhanced by using faculty who are experts in their field, and (3) faculty, junior faculty, and graduate students derive benefits in terms of collaborative research opportunities.

Prominent researchers have been selected periodically from various campuses to serve as CHBRP’s vice-chairs. The vice-chairs coordinate the three statutorily required components of each bill analysis. As of 2013, the University of California at San Francisco (UCSF) leads the medical effectiveness review, the University of California at Los Angeles (UCLA) leads analysis of benefit coverage, utilization, and cost impacts, and the University of California at Davis (UC Davis) leads analysis on public health impacts. The University of California at San Diego (UCSD) also plays a key role, regularly providing either medical effectiveness or public health analyses. Additional prominent researchers from these and other UC campuses, including the University of Berkeley (UC Berkeley) and the University of California at Irvine (UC Irvine), also serve as members of the FTF to ensure broad expertise. The FTF’s expertise reflects the evaluation criteria set forth in CHBRP’s authorizing statute—the inclusion of experts in health services research and health policy, public health, economics, pharmacology political science, and clinical medicine. Appointments on the FTF have remained fairly stable over time, but have changed periodically based on availability and the needs of the program.²⁹

One of the ongoing challenges of ensuring adequate research capacity is the uncertainty of the workload from year to year. In addition, because the legislative calendar dictates the workflow, multiple bills need to be analyzed simultaneously, often during the same 60-day time period. To address these issues as well as the workload challenges previously discussed, CHBRP has built additional capacity at specific campuses to handle overflow. Since 2009, all four of the campuses that lead analytic efforts, UCSF, UCLA, UC Davis, and UCSD have brought on additional faculty and staff to handle the spikes in the number of mandate bills that may arise from year to year and to take on a specific analysis if another researcher has a potential conflict of interest.

CHBRP also makes a concerted effort to enhance its analytic model by periodically incorporating new faculty to provide fresh, unique perspectives and understanding of new research approaches. In the past, CHBRP has also had prominent academics “audit” its analytic approach, in order to gain insight into changes and improvements that might be made from an academic perspective so that all salient information is captured in the bill analysis reports submitted to the Legislature.

²⁹ For a complete list of current FTF members, see Appendix 3.

Additionally, many of CHBRP's faculty and researchers work at public research centers throughout the UC system as health reform experts, producing cutting edge research for policymakers throughout California. Participation in CHBRP provides these contributors with indirect funding opportunities as well as ongoing expertise in changes to state and federal law, which helps support their wider research efforts.

Professional analytic and administrative staff

In addition to its FTF, CHBRP is administered by a small group of staff at UCOP. The staff provides overall management, policy analysis expertise, project management for the analytic process, and liaison services for CHBRP's communications with the Legislature and other stakeholders. The staff also ensures that reports and the supporting methodology are transparent and accessible to all stakeholders via CHBRP's website. CHBRP staff consists of a director, an associate director, three analysts, an administrative/program specialist, and a graduate intern.³⁰

Actuarial analysis

To meet CHBRP's statutory requirement to include actuarial analysis in its reports, CHBRP contracted with Milliman, Inc. after a competitive bidding process in 2003. The program has periodically re-bid the actuarial contract since that time, but as of now Milliman is currently retained through the middle of 2014.

Milliman's senior actuaries have been heavily involved in developing and annually updating CHBRP's Cost and Coverage Model (CCM) and developing the methodological approach for each bill analysis. They support the cost team at UCLA in analyzing coverage, cost, and utilization impacts, and support the public health team at UC Davis by providing utilization data analyses for specific populations when available. Milliman's access to proprietary aggregate claims data enables CHBRP to obtain baseline cost and utilization data and project financial impacts that would result from enactment of a mandated benefit.³¹

National Advisory Council: internal review

CHBRP's NAC consists of experts from outside California selected to provide balanced representation among groups with an interest in health insurance benefit mandates and repeals. The NAC is an advisory body rather than a governance board. Its membership changes based on availability and program needs, with a focus on maintaining a balanced group of stakeholders from key constituencies, including providers, purchasers, consumers, health policy experts, and health plans.³²

The NAC reviews CHBRP's draft bill analyses for accuracy, balance, clarity, and responsiveness to the Legislature's request before the reports are transmitted to the Legislature.³³ During the 60-day time period, NAC reviews occur over five days within the final two weeks. The NAC review enhances CHBRP's ability to produce balanced, impartial analyses by providing feedback on early draft analyses from different stakeholder groups. For each analysis, CHBRP staff selects a

³⁰ For a full list of CHBRP's current staff, see Appendix 2.

³¹ Further information regarding CHBRP's contracting actuaries is included in Appendix 5.

³² For a full list of the current National Advisory Council membership, see Appendix 4.

³³ See Appendix 16, NAC Review Criteria and Guidelines.

subcommittee—generally three to five members—of the NAC membership to serve as reviewers. NAC reviewers provide input when a particular draft explanation, method, or underlying assumption may be perceived as leading to biased results. In addition, the NAC members’ input enhances the overall quality of the product by: (1) reviewing and providing comments on the methods, assumptions, and data sources used in the analyses; (2) identifying sections that warrant further explanation, clarification, or citation; and (3) noting text that may need to be reworded to be more accessible to a lay audience. Since 2009, NAC members have completed a total of 120 separate reviews. In addition to its annual meeting and review of draft reports, individual NAC members have also provided advice to CHBRP staff on particular issues as they have arise.

Content experts: timely guidance to identify key literature and data sources

Within days of beginning an analysis, CHBRP also retains content experts for each analytic team.³⁴ Content experts are individuals with specialized clinical, health services research, or other expertise pertaining to the specific benefits and topics addressed by the mandate or repeal bill. These individuals are generally drawn from the UC system or from other reputable educational or research institutions. Content experts are asked to help identify literature and/or data and provide advice to the analytic teams on the following:

- Identification of individual or bundled sets of mandate-relevant tests, treatments, and services and the associated billing codes that allow estimates of utilization;
- Search criteria for the literature review that informs the medical effectiveness analysis (e.g., medical conditions and outcomes) to assure that the team is using the appropriate search terms to identify key articles;
- Expert knowledge regarding:
 - Clinical care management, any controversies in practice, specialty society positions and guidelines;
 - Research in progress that could affect the final conclusions of the medical effectiveness analysis;
 - Potential changes in utilization due to coverage for the mandated benefit; and
 - Potential effects of the mandate on clinician practice patterns.

Throughout an analysis, CHBRP is also carefully mindful to avoid any conflict of interest in its use of content experts. Potential content experts are carefully screened by CHBRP’s director, who is charged with maintaining and acting upon conflict-of-interest policies to prohibit participation in the analyses by any person with a material financial conflict of interest or who has advocated for or against the benefit mandate being analyzed. CHBRP applies this prohibition broadly, to content experts as well as to faculty and staff participating on the analytic team, and NAC members reviewing analyses, carefully screening and carefully documenting the absence of any possible conflicts of interest.

³⁴ For full details on the protocol for selecting CHBRP content experts, see Appendix 14.

Librarians: timely and relevant literature searches

CHBRP's work requires resource-intensive, systematic literature reviews to be conducted within the first three weeks of the analytic process. To accomplish this, several librarians with Masters in Library and Information Science from across the UC System are brought in to conduct in-depth literature searches during CHBRP's analytic cycle.³⁵ Having a team of librarians with expertise in health insurance benefit mandate terminology and search criteria has enhanced the timing of internal deliverables and the development of medical effectiveness analyses. The librarians: (1) develop search strategies specific to the mandated benefit or repeal; (2) conduct the literature search given inclusion/exclusion criteria developed by the medical effectiveness team, the cost team, the public health team, content experts, and CHBRP staff; (3) forward relevant abstracts of peer-reviewed literature to the medical effectiveness team for researchers' review and selection; and (4) conduct literature searches of the grey literature and forward relevant abstracts to the other members of the analytic teams as needed.

Process and Workflow

Since inception, CHBRP has established policies and procedures to streamline activities, to ensure the production of unbiased and thorough analyses, and ensure continuous quality improvement activities are sought out and implemented.

Conflict-of-Interest Policy

CHBRP's authorizing statute specifically requests that UC develop and implement conflict-of-interest provisions to prohibit an individual from participating in an analysis or review in which the individual knows, or has reason to know, that he or she has a material financial interest, including but not limited to a consulting or other agreement that would be affected by the mandate benefit proposal or repeal.

To comply with this provision and to systematically review potential conflicts, CHBRP continues the process established by UC in 2004. Specifically, CHBRP uses a detailed conflict-of-interest disclosure form for the NAC and a separate form for use by all others (faculty, content experts, Milliman, and staff) who contribute to CHBRP analyses.³⁶ These forms were modeled closely on a background and conflict-of-interest disclosure form designed by the National Academies of Sciences (NAS) for use with respect to studies relating to government regulation.³⁷

It is essential that the work of the participants in CHBRP activities not be compromised by any material conflict of interest. All who participate in the development of CHBRP's analyses are required to complete and submit the disclosure form and to update it annually or whenever compelled by a change of circumstance (e.g., a new investment, equity interest, change of employment, or the specific nature of a given item of legislation for review). The completed forms are recorded and reviewed by CHBRP's Director and UCOP administrative personnel who

³⁵ For a complete list of CHBRP's current librarians, see Appendix 6.

³⁶ See Appendix 15, CHBRP Conflict-of-Interest Policies, General Disclosure Form, and NAC Disclosure Form.

³⁷ The UC and CHBRP are grateful to the NAS for extending its permission to use the NAS form.

monitor potential conflicts and, as appropriate, request recusals where actual or perceived conflicts of interest arise in relation to a given bill.

FTF members are encouraged to publish their research results in peer-reviewed journals; however, they are expected to avoid legislative testimony or lobbying related to the findings of CHBRP studies while serving on the FTF.

Recusals are noted in CHBRP's bill analyses. In the past, CHBRP faculty have recused themselves from three separate analyses due to potential conflicts of interest. In these cases, other CHBRP researchers, including other members of the FTF, have stepped in to conduct the relevant analysis.

Clarifying Bill Language

Legislative language in benefit mandate and repeal proposals is sometimes vague and difficult to interpret. It is important for CHBRP to interpret bills reasonably and correctly since the interpretation can often alter the scope of an analysis or the accuracy of impact estimates. Examples of potential questions include: (1) whether the mandate applies to all insurance markets (e.g., large group, small group, and individual); (2) whether the mandate applies to all populations (adults and children); and (3) whether the mandate restricts utilization management or impacts physician referral requirements.

CHBRP's general approach is to interpret the bill language by considering only the bill "as written." Regulatory staff from DMHC have told CHBRP that they refer to secondary sources for legislative intent only if the law was not clear on its face or was ambiguous. For this reason, CHBRP focuses on the bill "as written" whenever possible. However, in order to address instances of ambiguous language, CHBRP developed a protocol that allows analytic teams to request clarification of intent directly from the bill author's office. As part of this protocol, CHBRP conducts an interview with the bill author's staff shortly after each bill request is received. Using a standardized questionnaire, CHBRP staff works with the bill author's office to confirm mutual understanding of both the intent of the bill and the likely interpretations of the bill as written.³⁸ CHBRP's analysis then proceeds based on the agreed upon interpretation of the bill as written.

CHBRP's standard questionnaire allows staff, in plain language, to clarify a number of elements crucial to providing useful reports. The process identifies the issue or problem being addressed and the solution that the bill (or repeal) seeks to create. The process also identifies the populations for which the bill (or repeal) may affect health benefit coverage, and whether any populations are purposefully excluded. It also gives CHBRP staff an opportunity to ask for copies of any studies, standards of care, or other documents that the author's office finds relevant. CHBRP staff also uses this process to ask whether similar bills have been introduced previously in California or in any other state.

³⁸ For the full questionnaire, see Appendix 17.

Obtaining Data From Health Plans

CHBRP must obtain accurate and timely data from health plans and insurers to conduct its cost impact analyses. Since the program's establishment, CHBRP has worked with the California Association of Health Plans (CAHP) and the Association of California Life & Health Insurance Companies (ACLHIC) to obtain contact information from the seven largest health plans and insurers in the state (Enrollment in plans or policies offered by these insurers represent an estimated 97.5% of persons with health insurance subject to state mandates).³⁹ CHBRP has routinely collected data from health plans and insurers to obtain information about what proportion of the insured population has coverage for the mandated benefit.

Since CHBRP was reauthorized under SB 1704, CHBRP has made changes to improve the processes and enhance the content of the data collected by plans and insurers. Specifically, instead of asking for the "baseline" information several times a year, CHBRP now conducts an Annual Enrollment and Premium Survey of each health plan and insurer. In addition, CHBRP continues to collect data via a coverage survey for each proposed benefit mandate. Details on these surveys are provided below.

Annual Enrollment and Premium Survey

Before the legislative session, CHBRP collects enrollment and premium data through a survey of health plans and insurers. These data are used: (1) to identify the population in health plans and insurance policies subject to state mandated benefits (i.e., health plans and insurance policies regulated by the DMHC and the CDI); and (2) to categorize enrollment by type of purchaser: small-group (2–50 employees), large-group (51+ employees), and individual (non-group) purchasers. In the individual market, the data are further broken down by age and gender. These data are limited to the population enrolled in privately purchased health plans and insurance policies because enrollment and premium data are available from public sources for publicly purchased health insurance.

The Annual Enrollment and Premium Survey has been refined in two ways since 2006. First, the annual survey was expanded to obtain information on enrollment by deductible (i.e., low- or high-deductible), so that the cost analysis could project estimates for bills that specifically address high-deductible health plans. Secondly, in 2012, in anticipation of the 2013 analytic cycle, CHBRP began collecting data breaking out enrollment in terms of grandfathered and nongrandfathered plans as outlined in the ACA. This was necessary because CHBRP anticipated that benefit mandates would have differential impacts on nongrandfathered plans that included EHBs and other ACA compliant features relative to grandfathered plans.

Bill-specific surveys

Following the receipt of a request for bill analysis from the California Legislature, CHBRP sends a bill-specific coverage survey to health plans and insurers that focuses on information necessary for CHBRP to conduct the analysis. Examples of data requested include: (1) existing (baseline) coverage for the proposed mandate; (2) cost sharing; (3) other benefit limits or rules (e.g., prior

³⁹ It is important to note that it is CHBRP's policy to mask plan-identifying information and to report data in aggregate in its analyses. For more information about this policy, see Appendix 18.

authorization, limitations based on specific clinical guidelines); (4) changes that might impact administrative costs; and (5) differential impacts between self-insured and fully insured products.

Obtaining Information From Consumer Groups and Other Stakeholders

CHBRP has established a process for obtaining information from interested parties for bills under analysis. “Interested parties” are defined by CHBRP as any member of the public, such as bill sponsors, disease-specific organizations, consumer advocate organizations, health plans, or health care industry interests. CHBRP announces each new legislative request on its website and via its mailing list.⁴⁰ All interested parties who believe they have scientific evidence relevant to CHBRP’s analysis of proposed health insurance benefit mandates are encouraged to provide that information to CHBRP’s staff. In order for CHBRP to meet its statutory 60-day deadline to complete its analyses, CHBRP requests interested parties to submit information within the first 14 days of the review cycle. Currently there are approximately 475 individuals signed up to receive such notices, including legislative staff, consumer and interest groups, health plan representatives, and state government agency employees from California and other states.

Once CHBRP receives information submitted by the public, that information is disseminated to the analytic teams and the actuaries. The respective teams (medical effectiveness, cost, and public health) then review the information to determine whether the evidence submitted is relevant to the analysis and meets the standard of rigor for inclusion. If the information is relevant and meets the inclusion criteria, the teams decide how to incorporate the information into the analysis. All publically submitted information is listed in an appendix in the relevant analysis.

60-Day Timeline

In order to address the evaluation criteria specified in CHBRP’s authorizing statute in a timely, transparent manner, CHBRP uses a 60-day timeline that details which activities occur on what day.⁴¹ The 60-day clock is initiated upon receipt of a request from the Senate Health Committee or the Assembly Health Committee. Figure 3 below provides a broad illustration of the tasks and responsibilities for each of the teams within the 60-day timeline.

⁴⁰ Any interested party may request that he or she be added to the mailing list, or may add themselves via the CHBRP website at www.chbrp.org.

⁴¹ For more detail on CHBRP’s 60-day timeline, see Appendix 13.

Figure 3. 60-Day Timeline

	Day 0	Day 10	Day 20	Day 30	Day 40	Day 50	Day 60
Vice Chairs & Team Leads	<ul style="list-style-type: none"> Identify analytic teams, faculty and staff leads, and reviewers Identify potential conflicts of interest Determine scope of services 	<ul style="list-style-type: none"> Review drafts (e.g., bibliography, baseline tables) 	<ul style="list-style-type: none"> Review drafts (e.g., medical effectiveness outcomes, impact tables) 	<ul style="list-style-type: none"> Complete 1st internal review of full report draft 	<p>National Advisory Council Review</p> <p>-----</p> <p>Medical effectiveness lead, cost lead, public health lead, and CHBRP staff revise draft report to address all comments from NAC review</p> <p>-----</p> <p>Editor reviews completed draft of report</p>	<p>Final review by VCs and SVP of UC Office of the President Health Sciences & Services</p> <p>-----</p> <p>Medical effectiveness lead, cost lead, public health lead, and CHBRP staff revise draft report to address any final comments by VCs and SVP</p> <p>-----</p> <p>Final production</p> <p>-----</p> <p>Report submitted to the Legislature and posted to CHBRP's website</p>	
CHBRP Staff	<ul style="list-style-type: none"> Post Legislature's request on website Clarify intent of legislation Send coverage survey to carriers 	<ul style="list-style-type: none"> Compile carrier coverage and data Compile relevant information from interested parties Compile public program coverage information 	<ul style="list-style-type: none"> Review drafts, coordinate both internal and NAC reviews 	<ul style="list-style-type: none"> Integrate all sections for the 1st full report draft 			
Medical Effectiveness Team and Librarians	<ul style="list-style-type: none"> Screen and select content experts Identify search terms and scope of literature search Librarians conduct literature search 	<ul style="list-style-type: none"> Librarians prepare final abstract database Medical effectiveness team analyzes literature & prepares draft medical outcomes 	<ul style="list-style-type: none"> Complete 1st draft of medical effectiveness summary and appendices 	<ul style="list-style-type: none"> Address all comments on 1st full report draft 			
Cost Team and Actuaries	<ul style="list-style-type: none"> Develop questions for coverage survey Conduct cost literature search Identify codes to assess utilization with claims data 	<ul style="list-style-type: none"> Develop baseline coverage & utilization tables Review evidence for projecting impacts (utilization assumptions, cost offsets, long term) 	<ul style="list-style-type: none"> Finalize approach to determine utilization & cost impacts Actuaries produce draft cost tables Complete 1st draft of cost section 	<ul style="list-style-type: none"> Finalize cost model/approach Actuaries produce draft cost tables Address all staff and VC comments on 1st full report draft 			
Public Health Team	<ul style="list-style-type: none"> Conduct public health literature search (on issues such as disease prevalence, racial disparities) 	<ul style="list-style-type: none"> Develop baseline public health tables and review evidence for projecting demographic impacts 	<ul style="list-style-type: none"> Finalize approach to determine public health impacts Draft postmandate impact section 	<ul style="list-style-type: none"> Address all staff and VC comments on 1st full report draft 			

Key: CHBRP=California Health Benefits Review Program; NAC=National Advisory Council; SVP=Senior Vice President; VC=Vice Chair; UC=University of California.

Disseminating CHBRP Reports

CHBRP electronically submits reports to the Chairs and Vice Chairs of the Senate and Assembly Health Committees and to other Chairs and Vice Chairs of Committees that are likely to hear CHBRP-analyzed bills (e.g., the Appropriations Committees.)

CHBRP's website, www.chbrp.org, provides full access to all CHBRP reports and the legislation analyzed in the reports, as required by statute. The website also announces new requests from the Legislature and provides instructions on how interested parties can provide CHBRP with evidence they believe should be considered in its analyses. Reference documents describing CHBRP's processes and methods are available on the website, as well as lists of individuals associated with CHBRP's work, including CHBRP's staff, FTF members and contributors, and NAC members.⁴² Lastly, the website serves as the primary medium for making announcements. In 2012, the CHBRP website was redesigned to promote greater accessibility and ease of use for CHBRP's many stakeholders, and to allow access to CHBRP's materials and analyses by web visitors using mobile web browsers (such as those found on "smartphones" and "tablets").

Analytic Methods

Medical Effectiveness Analysis

CHBRP's authorizing statute requires the program to analyze the following with regard to the analyses of medical effectiveness⁴³:

- The extent to which the benefit or service is generally recognized by the medical community as being effective in the screening, diagnosis, or treatment of a condition or disease;
- The current availability and utilization of a benefit or service by treating physicians;
- The contribution of the benefit or service to the health status of the population; and
- The extent to which mandating or repealing the benefits or services would not diminish or eliminate access to currently available health care benefits or services.

This section presents the current methods used by CHBRP to conduct the medical effectiveness analyses and highlights the refinements that have been made to these methods since 2009.

CHBRP's approach to medical effectiveness analysis

CHBRP's approach to medical effectiveness analysis is grounded in the principles of evidence-based medicine (EBM). CHBRP applies the principles of EBM to health insurance mandates by systematically reviewing the medical literature to assess the effectiveness of interventions (e.g., preventive services, diagnostic tests, treatments) addressed by proposed mandates.

⁴² For full lists of CHBRP staff and contributors, see Appendices 2, 3, and 4.

⁴³ For full details on CHBRP's medical effectiveness approach, see Appendix 10.

Once CHBRP receives a request from the State Legislature, the medical effectiveness team defines the parameters for a search of the medical literature in consultation with a medical librarian and an expert on the disease or condition to which the proposed mandate would apply. Once the literature search is completed, the medical effectiveness team selects studies for inclusion in the review based on a hierarchy of evidence that ranks studies by the strength of the evidence they present.

Team members systematically evaluate evidence across five domains, as illustrated in Table 6 below:

Table 6. Domains in Which Medical Effectiveness Ranks Studies

Domains	Description
Research design	Studies with strong research designs are more likely to yield accurate information about an intervention’s effects.
Statistical significance	Statistical significance indicates whether the association between an intervention and an outcome is stronger than that which might occur by chance.
Direction of effect	The direction of effect reveals whether the intervention is associated with better or poorer outcomes or has no effect on outcomes.
Size of effect	The size of effect suggests whether an intervention’s effect is sufficiently large to be clinically meaningful to patients and/or their caregivers.
Generalizability of results	Generalizability concerns the applicability of a study’s findings to the population to which a proposed mandate would apply. Many studies, for example, assess populations that are not as racially/ethnically diverse as California’s.

Source: California Health Benefits Review Program, 2013.

Conclusions regarding an intervention’s effects on outcomes are based on the strength of the evidence across the five domains described above.⁴⁴ Medical effectiveness findings may relate to any one of a number of types of outcomes including the following:

- Physiological (e.g., blood pressure);
- Behavioral (e.g., smoking cessation);
- Cognitive (e.g., improved short-term memory);
- Functional status (e.g., activities of daily living, such as bathing and dressing);
- Quality of life (e.g., overall sense of well-being);
- Morbidity (e.g., specific complications, progression of disease, restricted activity days);
- Mortality (e.g., years of life lost); and
- Health care utilization (e.g., emergency department visits).

If the language of a bill references specific outcomes, these outcomes will be included in the review. If the bill does not mention specific outcomes, the team and the content expert will identify the outcomes most relevant to the proposed mandate or repeal.

Content of the medical effectiveness sections of CHBRP reports

The medical effectiveness section of the main text includes information regarding:

- Services covered under the proposed mandate;
- Outcomes of interest;
- Methods used to gather evidence;
- Evidence for each outcome measure assessed; and
- Medical effectiveness team's conclusion regarding the effectiveness of the intervention.

All CHBRP reports contain a qualitative synthesis of the medical literature on the outcomes of interest. In some cases, the effectiveness team also produces quantitative estimates of effectiveness for select outcomes.

The reports also include a table that summarizes the findings for each outcome with regard to research design, statistical significance, direction of effect, size of effect, and generalizability, as well as CHBRP's conclusion regarding the intervention's effectiveness.

Further information about the effectiveness analysis is presented in two standard appendices in the reports. The first appendix describes the methods used to conduct the literature review. The second appendix consists of a table that lists the studies included in the medical effectiveness analysis and their major characteristics, such as the specific screening test, diagnostic test, or treatment assessed, the research design, the sample size, the population studied, and the location in which the study was conducted.

Enhancing the medical effectiveness analysis

Since CHBRP's reauthorization, the medical effectiveness team has worked to enhance the medical effectiveness analysis in three key areas: (1) developing criteria for using the grey literature; (2) developing criteria for using clinical practice guidelines; and (3) presenting the findings of the literature analysis.

Grey literature

The medical effectiveness team expanded the scope of its literature searches to include the grey literature, which consists of material that is not published commercially or indexed systematically in bibliographic databases. The grey literature is primarily composed of technical reports, working papers, dissertations, theses, business documents, and conference proceedings. The medical effectiveness team decided to incorporate grey literature into CHBRP's literature searches due to concerns that bias could arise if only peer-reviewed sources for literature were evaluated for inclusion in its reviews. For example, medical journals have a subtle bias against publishing negative findings. CHBRP's hierarchy of evidence is applied in a consistent fashion to both the peer-reviewed literature and the grey literature.

Clinical practice guidelines

Clinical practice guidelines are statements about appropriate health care for specific diseases or conditions that are intended to help clinicians and patients make decisions regarding screening, diagnostic testing, or treatment (IOM, 1990). CHBRP developed the following criteria to standardize the use of guidelines in medical effectiveness analyses. In cases where a bill would mandate coverage for an intervention that is “consistent with national guidelines” or where a guideline is specified in a bill or is an obvious source of bill language, the medical effectiveness team constructs a table that summarizes pertinent guidelines and rates the transparency of the guideline’s development process and the strength of the evidence on which they are based. In cases where a bill does not reference any guidelines, the medical effectiveness team will apply the hierarchy of evidence and review guidelines only when little information is available from more highly ranked sources of evidence or when the information is conflicting.

Presentation of the findings of the medical effectiveness analysis

CHBRP received feedback that early CHBRP reports’ discussions of the findings of the medical effectiveness analysis were sometimes difficult to grasp. The medical effectiveness team therefore developed a method to present an overall conclusion for an outcome that captures all the factors in determining the quality of the available evidence (research design, statistical significance, direction of effect, size of effect, and generalizability). The conclusion is a statement that captures the strength and consistency of the evidence of an intervention’s effect on an outcome. The following terms are currently used to characterize the body of evidence regarding an outcome.

- Clear and convincing evidence with
 - Favorable effect
 - No effect
 - Unfavorable effect
- Preponderance of evidence with
 - Favorable effect
 - No effect
 - Unfavorable effect
- Ambiguous/conflicting evidence
- Insufficient evidence

Cost Impact Analysis

CHBRP’s authorizing statute requests that CHBRP provide two sets of financial information to assist the Legislature’s consideration of benefit proposed health benefit mandates: (1) current

coverage, utilization and cost (premandate); and (2) projected changes in coverage, utilization and costs after the implementation of a mandate (postmandate).⁴⁵

The specific information regarding current coverage requested by the California Legislature for each mandate includes:

- Existing coverage of the service in the current insurance market;
- Current utilization and cost of providing a benefit;
- Public demand for coverage among self-insured plans; and
- Current costs borne by insurers.

The specific information regarding post-mandate effects requested by the Legislature includes:

- Changes in utilization;
- Changes in the per-unit cost of providing the service;
- Administrative costs;
- Impact on total health care costs;
- Costs or savings for different types of insurers; and
- Impact on access and availability of services.

This section presents the current methods used by CHBRP to conduct the cost impact analysis of proposed mandated benefits as required and highlights the refinements that have been made to these methods since 2009, particularly adjustments that CHBRP has had to make to account for changes resulting from the ACA.

California Cost and Coverage Model

CHBRP developed the CCM to produce baseline and postmandate financial impacts requested by the Legislature. CHBRP's Cost Model is an actuarial forecasting model, using data from the CHBRP's annual enrollment and premium survey, administrative payer data, the California Health Interview Survey and the California Employer Health Benefits Survey. Each year, a team of economists and researchers from a number of UC campuses, along with actuaries from Milliman and CHBRP staff, update and refine the CCM.

Before CHBRP can measure an incremental change resulting from a proposed mandate, it must first establish a starting point, or baseline. This is a two-step process: first requiring CHBRP to estimate current overall health insurance coverage for California; and then, estimating current coverage for a specific proposed mandate.

⁴⁵ For full detail on CHBRP's cost approach, see Appendix 11.

Current coverage overall: To establish a baseline, CHBRP determines:

- **Enrollment:** Number of Californians currently enrolled in state-regulated health plans in relevant market segments (individual, small group, large group), CalPERS HMO plans, and Medi-Cal Managed Care;
- **Premiums:** Current premiums by market segment (split by DMHC-regulated or CDI-regulated Individual, Small Group, and Large Group).

A comprehensive list of CHBRP's sources for coverage and demographic data can be found in Appendix 11, but in short, CHBRP relies on both public administrative data, as well as an annual survey of the state's seven largest insurance carriers.

Baseline adjustments to account for the ACA: For the 2013 Legislative cycle, CHBRP made adjustments to its cost model in order to account for changes that would occur as a result of the ACA. Because ACA-induced market changes would not take place until January 1, 2014, CHBRP's 2013 cost model was constructed to make estimates for a market that did not yet exist. Key changes were made to:

- **Enrollment:** CHBRP relied on the California Simulation of Health Insurance Markets (CalSIM), a microsimulation model, in addition to its usual sources of enrollment data, to estimate how enrollment would change post-ACA implementation of the individual mandate and subsidies.
- **Premiums:** The 2012 CHBRP Annual Enrollment and Premium Survey asked the seven largest insurance carriers in California to provide their average premium rates separately for grandfathered and nongrandfathered plans. The ratios from the carrier survey data are then applied to a national survey of aggregate premium rates, to estimate premium rates for grandfathered and nongrandfathered plans that were consistent with the national premium results. The incremental impact of ACA on 2014 premiums was established as follows:
 - For nongrandfathered small-group and individual market segments, a 3% increase in medical costs is applied to reflect the total cost of requiring each plan to cover the essential health benefits.
 - For nongrandfathered small-group plans, a 5% increase in medical costs is applied to reflect the other additional costs of ACA (e.g., age rating, health status, increased premium taxes and fees, change in actuarial value, etc.).
 - For DMHC-regulated individual plans and CDI-regulated individual policies, an increase of 20% and 31%, respectively, in medical costs is applied to reflect the other additional costs of ACA.
- **Market segments:** The ACA imposes additional requirements on health insurance products created after March 23, 2010. These plans are considered "nongrandfathered." Health insurance that existed before that date is considered "grandfathered" and the ACA has limited authority over those plans. In order to determine enrollment and premium costs associated with enrollees in grandfathered vs. nongrandfathered health insurance, CHBRP's 2012 Annual Enrollment and Premium Survey asked the state's seven largest health plans to include that detail as part of its annual survey instrument.

Beyond grandfathered and nongrandfathered plans, the addition of a health insurance exchange (Covered California),⁴⁶ where Californians could purchase federally subsidized insurance, was also included as a market segment in the 2013 CHBRP Cost Model.

Mandate-specific baseline: Coverage: For each proposed mandate, CHBRP surveys each of the state's seven largest insurance carriers on specific tests, treatments, and services relevant to the mandate. These surveys provide CHBRP with baseline coverage for a proposed mandate (as opposed to baseline coverage for health insurance generally), which would change based on the details of proposed legislation.

Utilization and unit cost: CHBRP must also determine how frequently a treatment or service is currently used—whether or not an individual has benefit coverage—and how much each unit of the test, treatment, or service costs. This is determined using a variety of sources, including actuary Milliman's Health Cost Guidelines, academic literature related to health costs, guidance from content experts, and information from other sources.

Definitions/components of the Cost and Coverage Model

Cost: Cost is defined as the aggregate expenditures for health care services. (It is not the costs incurred by health care providers.) The rationale for this definition of "cost" is that legislators are ultimately interested in evaluating the financial impact of mandates on the major *payors* for health care services in the state.

In evaluating aggregate expenditures, CHBRP includes:

- Insurance premiums (paid by employers, government, and enrollees);
- Enrollee cost sharing (copayments, deductibles, coinsurance);
- Total cost of covered benefits (paid by insurer);
- Noncovered health expenses (paid by enrollees who have health insurance, but whose insurance does not cover specified services); and
- Total expenditures for health insurance premiums, enrollee cost sharing, and noncovered health expenses.

Utilization: Utilization is defined as the frequency or volume of use of a mandated service.

Coverage: Coverage is defined as the extent to which the mandated services are covered by state-regulated health insurance.

The model includes two types of health insurance plans or policies:

1. "Knox-Keene" plans: These include health maintenance organizations (HMO), point-of-service (POS) health plans, and certain preferred provider organization (PPO) health plans subject to the requirements of the Knox-Keene Health Care Service Plan Act of

⁴⁶ CHBRP estimated Covered California enrollment using CalSIM.

1975. These plans are regulated by the Department of Managed Health Care and are included in one category because they are similar in type and regulatory requirements.
2. “Insurance” policies: These include PPOs and fee-for-service (FFS) health insurance products subject to the California Insurance Code, which are regulated by the California Department of Insurance.

These plan types are divided into three market segments representing private purchaser categories:

- Large group (51 or more employees);
- Small group (2 to 50 employees); and
- Individual market (direct purchase).

Because some requirements of the ACA do not apply to “grandfathered” health insurance that existed before March 23, 2010, CHBRP’s California Cost and Coverage Model also makes a distinction between “grandfathered” and “nongrandfathered” plans.

Coverage and demographic data sources.

The following bullets provide an enumeration of all data sources in California’s Cost and Coverage Model:

- The California Simulation of Insurance Markets (CalSIM) is used to estimate health insurance status of Californians aged 64 and under in 2014. CalSIM is a microsimulation model that was created to project the effects of the Affordable Care Act on firms and individuals.⁴⁷ CalSIM relies on data from the Medical Expenditure Panel Survey (MEPS), the California Health Interview Survey (CHIS) 2009, analysis data from the California Employment Development Department, and the most recent California Employer Health Benefits Survey.
- The California Health Interview Survey (CHIS) is used to estimate the number of Californians aged 65 and older, and the number of Californians dually eligible for both Medi-Cal and Medicare coverage.⁴⁸ CHIS is a continuous survey collected annually that provides detailed information on demographics, health insurance coverage, health status, and access to care. Prior to 2011, CHIS was conducted every 2 years with a sample of over 40,000 households. Beginning in 2011, the CHIS is collected continuously, surveying over 20,000 households each year, and is conducted in multiple languages by the UCLA Center for Health Policy Research.
- The most recent California Health Care Foundation/National Opinion Research Center (CHCF/NORC) survey of California employers is used to obtain estimates of the

⁴⁷ UC Berkeley Center for Labor Research and Education and UCLA Center for Health Policy Research. *Methodology & Assumptions, California Simulation of Insurance Markets (CalSIM) Version 1.7*, June 2012. Available at www.healthpolicy.ucla.edu/pubs/files/calsim_methods.pdf. Accessed October 19, 2012.

⁴⁸ Although CHIS collects data on Californians of all ages, CHBRP’s analysis relies on it particularly for information on the population aged 65 years and over.

characteristics of the employment-based insurance market, including firm size, plan type, self-insured status, and premiums. The CHCF/NORC survey, collected annually since 2000, is based on a representative sample of California's employers.

- CalPERS premiums and enrollment are obtained annually from CalPERS administrative data for active state and local government public employees and their family members who receive their benefits through CalPERS. Enrollment information is provided for fully-funded, Knox-Keene licensed health care service plans covering non-Medicare beneficiaries, which comprise nearly 70%⁴⁹ of CalPERS total enrollment. CalPERS self-funded plans—approximately 25% of enrollment—are not subject to state mandates.
- The California Department of Health Care Services (DHCS) supplies CHBRP with the statewide average premiums negotiated for the Medi-Cal Managed Care Two-Plan Model and generic contracts with health plans participating in Medi-Cal Managed Care program. Administrative data for the Medicare program is obtained online from the federal agency the Centers for Medicare & Medicaid Services (CMS).
- CHBRP also conducts a survey of the seven largest health plans and insurers in California, whose enrollment together represents an estimated 97.5% of the persons with health insurance subject to state mandates. Although it is important to note that it is CHBRP's policy to mask plan/insurer identifying information and to report data in aggregate in its analyses,⁵⁰ the seven are: Aetna, Blue Cross of California, Blue Shield of California, CIGNA, Health Net, Kaiser Permanente, and UnitedHealth/PacifiCare. These surveys provide data to determine baseline enrollment in the non-group (individual) market, and distributions between grandfathered and nongrandfathered insurance plans.

Utilization and expenditure data sources. The utilization and expenditure data for the California Cost and Coverage Model are drawn primarily from multiple sources of data used in producing the Milliman Health Cost Guidelines (HCGs). The HCGs are a health care pricing tool used by actuaries in many of the major health plans in the United States. The guidelines provide a flexible but consistent basis for estimating health care costs for a wide variety of commercial health insurance plans. The HCGs are used nationwide and by several California HMOs and insurance companies, including at least five of the largest plans. It is likely that these organizations would use the HCGs, among other tools, to determine the initial premium impact of any new mandate. Thus, in addition to producing accurate estimates of the costs of a mandate, the HCG-based values should also be reasonable estimates of the premium impact as estimated by the HMOs and insurance companies. The baseline analyses performed by Milliman start with PPOs in the large-group national market, which are then adjusted to account for differences by type of insurance, size of market, and geographic location.

The final estimates for California's population divided by market segments are given below in Table 7 and shown in graphic form in Figures 4 and 5.

⁴⁹ CalPERS enrollment as of September 30 of the previous year.

⁵⁰ For more information about this policy, see Appendix 18.

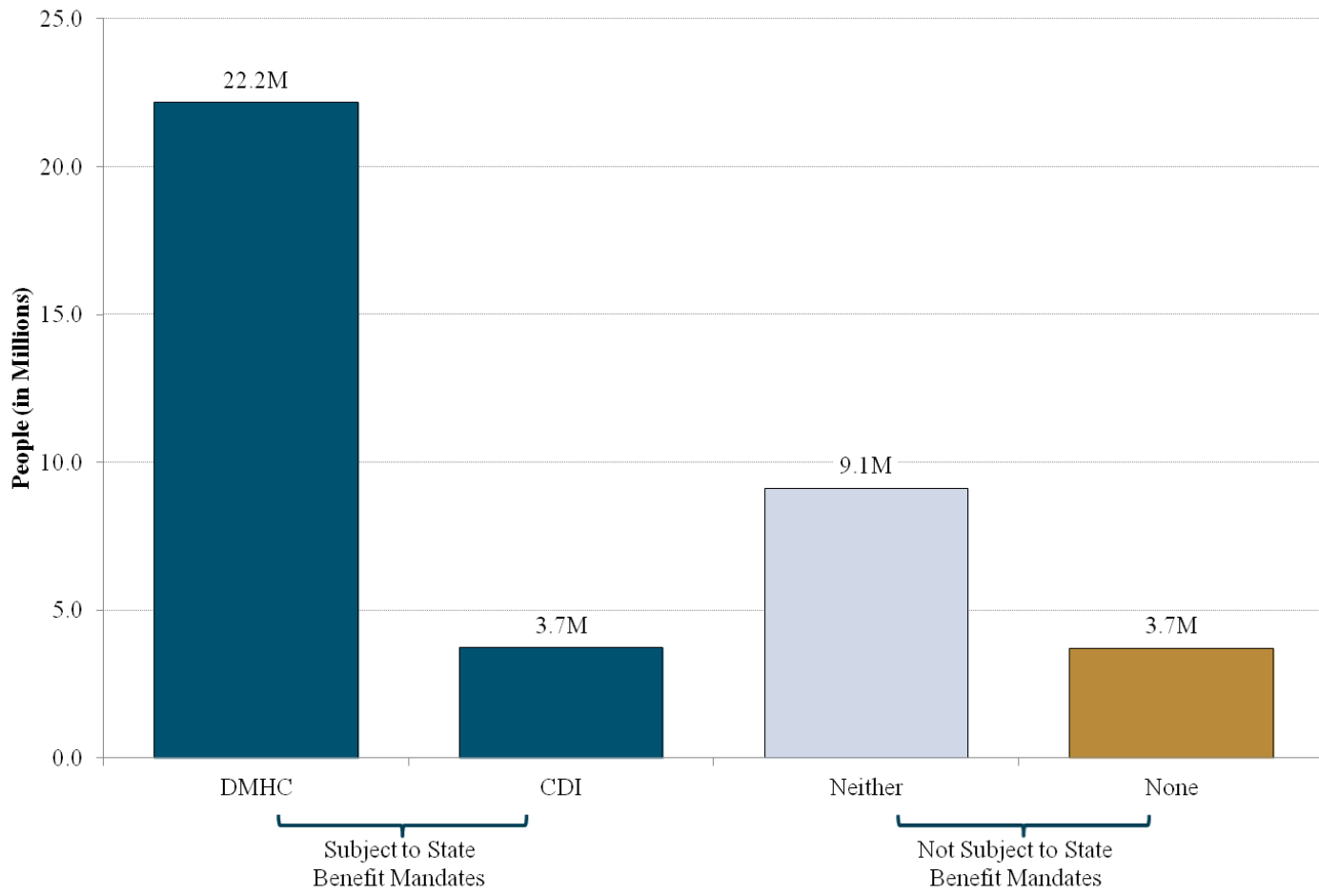
Table 7. CHBRP Estimates of Sources of Health Insurance in California, 2014

Publicly Funded Health Insurance						
	Age, Years	DMHC-Regulated	Not State-Regulated	Total		
Medi-Cal (non Medicare)	0–17	3,143,000	860,000	4,003,000		
	18–64	2,060,000	1,256,000	3,316,000		
	65+	17,000	32,000	49,000		
Medi-Cal, formerly Healthy Families	0–17	594,000	—	594,000		
	18–64	32,000	—	32,000		
Other public	All		259,000	259,000		
Dually eligible Medicare & Medi-Cal	All	671,000	387,000	1,058,000		
Medicare (non–Medi-Cal)	All		3,505,000	3,505,000		
CalPERS Small Firm	0–17	1,000	—	1,000		
	18–64	4,000	2,000	6,000		
	65+	—	—	—		
CalPERS Large Firm	0–17	202,000	62,000	264,000		
	18–64	629,000	229,000	858,000		
	65+	18,000	11,000	29,000		
Privately Funded Health Insurance						
		DMHC-Regulated		CDI-Regulated		
	Age, Years	Grand-fathered	Non-Grand-fathered	Grand-fathered	Non-Grand-fathered	Total
Self-insured	All					2,518,000
	0–17	—	20,000	—	48,000	68,000
	18–64	—	395,000	—	969,000	1,365,000
	65+	—	1,500	—	3,500	5,000
Individually purchased, Subsidized Exchange	0–17	54,000	23,000	72,000	57,000	207,000
	18–64	519,000	15,000	688,000	37,000	1,260,000
	65+	2,000	-	2,000	1,000	5,000
Individually purchased, Non- Subsidized Exchange and Outside Exchange	0–17	64,000	622,000	14,000	350,000	1,050,000
	18–64	165,000	1,609,000	37,000	904,000	2,715,000
	65+	2,000	17,000	—	10,000	29,000
Small group	0–17	637,000	2,487,000	9,000	140,000	3,273,000
	18–64	1,647,000	6,433,000	24,000	362,000	8,466,000
	65+	17,000	68,000	—	4,000	89,000
Large group						
Uninsured						
	Age, Years					Total
	0–17					457,000
	18–64					3,232,000
	65+					31,000
California's total population					38,744,000	

Source: California Health Benefits Review Program, 2013.

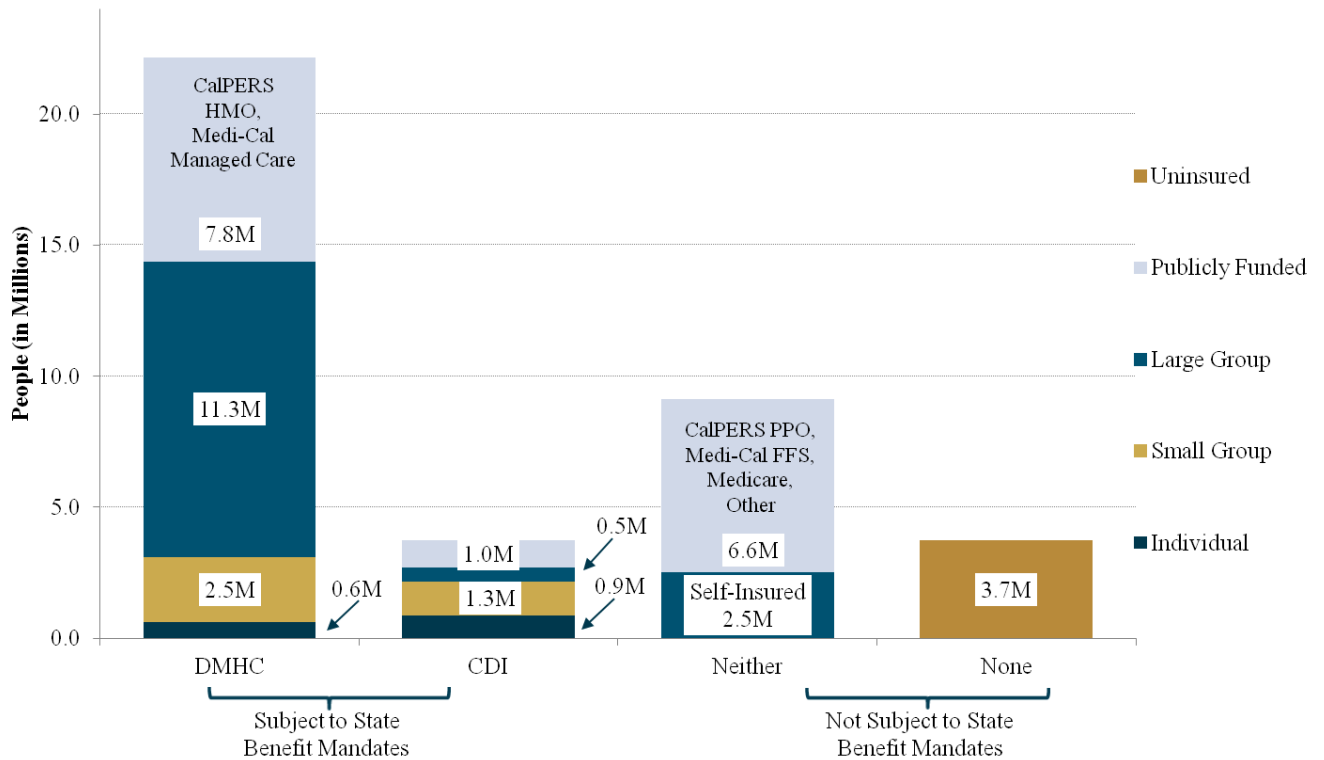
Key: CalPERS=California Public Employees' Retirement System; CDI=California Department of Insurance; DMHC=California Department of Managed Health Care.

Figure 4. Health Insurance by Regulatory Agency in California, 2014



California Health Benefits Review Program, 2013

Figure 5. Health Insurance by Funding Type in California, 2014



* Individuals with subsidized coverage in the exchange are counted in publicly funded. California Health Benefits Review Program, 2013

HMO = Health Maintenance Organization
PPO = Preferred Provider Organization
FFS = Fee-for-Service

Public Health Impact Analysis

The public health impact analyses capture the potential value of a proposed health benefit mandate—what health outcomes might be expected from implementation of the mandate. Short-term (1 year) costs and impacts are estimated quantitatively when possible. The analyses focus on the health outcomes of Californians with health insurance that may be subject to a health benefit mandate law passed at the state level.

This section describes the methodology and assumptions that CHBRP developed to conduct public health impact analyses of proposed health benefit mandates, as required by the program's authorizing statute.⁵¹

Health outcomes and data sources

Prior to collection of baseline public health data, the CHBRP public health team determines the relevant health outcomes related to the proposed health benefit mandate. These decisions are

⁵¹ For more detailed information about CHBRP's public health approach, see Appendix 12.

made in consultation with a content expert and the medical effectiveness team. Examples of health outcomes include reductions in morbidity; mortality; disability; days of hospitalization and emergency department visits; changes in self-reported health status; improvements in physiological measures of health such as blood pressure, cholesterol, weight, and forced expiratory volume; changes in health behaviors such as increased physical activity or quitting smoking; and improvements in the quality of life. Also, when possible, CHBRP presents an assessment of potential harms and financial burden related to the mandate. For each defined health outcome, baseline data on the incidence, prevalence, and health services utilization rates of associated conditions are collected. The public health team uses a five-tiered hierarchy of evidence to prioritize sources of incidence and prevalence data:

- Tier 1. Registries with California-specific census counts;
- Tier 2. Surveys with California-specific estimates;
- Tier 3. Surveys with national estimates only, peer-reviewed literature, or grey literature;
- Tier 4. Actuarial contractor database; and
- Tier 5. Content experts.

Examples of data sets used to conduct the public health impact analysis include the California Cancer Registry (Tier 1), the California Health Interview Survey (CHIS) (Tier 2), and California agency reports (Tier 3). Baseline data on prevalence/incidence for the disease/condition and relevant outcomes are presented in each report. This provides context for analyses in the medical effectiveness, cost and utilization, and public health sections.

Impact on public health

The data elements needed to estimate the short-term public health impact on the overall health of Californians with health insurance that may be subject to a health benefit mandate law passed at the state level include:

- Baseline incidence and health outcomes of the relevant condition(s);
- The medical effectiveness of the mandated health benefit; and
- The impact on coverage and utilization due to the mandate.

First, using registry- or survey-based datasets and/or literature, the public health team estimates baseline health status relevant to the health benefit mandate. This includes but is not limited to rates of morbidity (disease), mortality, premature death, disability, health behaviors, and other risk factors stratified by age, gender, race, and ethnicity. Second, the public health impacts section uses findings from the literature review in the medical effectiveness analysis. The literature review commonly includes meta-analyses and randomized controlled trials, which provide information on the effectiveness of the proposed benefit or service on specific health outcomes. Third, the public health impacts section uses estimated changes in benefit coverage and/or utilization of treatments or services relevant to the proposed legislation from the cost impact analysis section. Estimated changes in benefit coverage include the number of insured Californians who are presently covered for the proposed benefit and the number who would be newly covered if the mandate were enacted. The cost section also estimates changes in utilization

rates for insured Californians who are presently covered for the proposed benefit and for those who will be newly covered for the benefit, postmandate. Using these data elements, estimates are made regarding the impact of new utilization of the mandated benefit on specific health outcomes in the affected population (e.g., the effect of asthma self-management training on the reduction of hospitalizations for asthma). The results are compiled by the public health team to produce an overall mean estimate that can be used to calculate the predicted short-term (1 year) health effects of the benefit mandate.

Impact on gender and racial disparities

When possible, CHBRP reports detail differences in disease prevalence, health services utilization, and health outcomes by gender and race/ethnicity, preferably in the insured population. Four steps are used to assess whether disparities exist and whether the proposed mandate will have an impact on gender and/or racial disparities:

- Conduct a literature review;
- Review data sources for prevalence, utilization, and outcome data by race/ethnicity and gender;
- Determine whether a mandate will impact disparities; and
- Determine whether a change in disparities can be quantified.

Impact on premature death and economic loss

In addition, the public health team estimates the extent to which the proposed benefit would reduce premature death and the economic loss associated with conditions affected by the benefit mandate. In order to calculate an expected impact on premature death, mortality must be a relevant health outcome; the treatment or service must be medically effective at reducing mortality; and the mandate must increase coverage or utilization of the benefit. Where premature death is a relevant outcome, the public health team conducts a literature review to determine if societal costs of illness (indirect costs) have been established and uses the evidence to support one of four conclusions: disease/condition is not relevant to economic loss; impact of mandate on economic loss is unknown; mandate is not estimated to affect economic loss; or mandate is estimated to increase economic loss.

Long-term impacts

When the expected benefits may not be realized within the 1-year timeframe used in the cost and utilization analyses, the public health team also projects the long-term public health impacts (beyond 12 months) associated with a benefit mandate. In this case, the public health team generally relies on qualitative assessments based on longitudinal studies and other research about the long-term impacts of health interventions affected by the mandate. This type of analysis is especially relevant for preventive care and disease management programs where the benefits accrue over many years.

Analyzing Repeal Bills

As discussed previously, under SB 1704 CHBRP's statutory charge was expanded to include analysis of health benefit mandate repeals. The authorizing statute defines a "repeal" bill as a

proposed statute that, if enacted, would repeal an existing requirement that a health care service plan or a health insurer do any of the following:

- Permit a person insured or covered under the policy or contract to obtain health care treatment or services from a particular type of health care provider;
- Offer or provide coverage for the screening, diagnosis, or treatment of a particular disease or condition;
- 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.

Per discussions with legislative staff, the following types of bills would be considered a “repeal” bill and could trigger a request for CHBRP to conduct an analysis:

- A bill that would relax a mandate to *cover* a service and instead require carriers simply to *offer* that coverage;
- A bill that would allow carriers to develop products for a subset of the market, which would be exempt from a set of mandates, such as limited benefit plans for small employers; and
- A bill that would relax coverage level requirements; for example, repealing requirements to cover a certain set of services at “parity” levels or eliminating coverage requirements altogether.

In developing methodology for analyzing repeal bills, CHBRP considered what analytic questions within its charge were relevant for the Legislature’s consideration.

Overall approach

When determining the analytic approach to a repeal bill, CHBRP considers the scope of the benefits that would be affected. In 2007, CHBRP developed methods to anticipate the receipt of the various types of bills that would be considered a “repeal” bill, for example, a bill that would repeal a single benefit mandate or a bill that would affect benefit packages. CHBRP has thus far only received requests to analyze bills that would allow carriers to develop and sell products that are not subject to California benefit mandate laws.

Medical effectiveness analytic questions and approach. The analytic questions for medical effectiveness are essentially the same as for a mandate bill: 1) to what extent is the benefit or service generally recognized by the medical community as being effective; and 2) to what extent is the benefit or service generally available and utilized by treating physicians. However, given that the repeal bills CHBRP has analyzed to date sought to address the full range of benefit mandates authorized in law, the analytic approach applied to medical effectiveness has necessarily been modified.

As an example, AB 1904 (Villines, 2010) would have effectively permitted the waiver of California’s current health insurance benefit mandate and mandated offering statutes—statutes that address numerous health care services for a wide range of diseases and conditions. CHBRP reviewed evidence regarding the medical effectiveness of 34 of the mandates that could have

been waived under AB 1904. Nine mandates were not analyzed because they would not require coverage for specific diseases or health care services, but instead would require coverage for a vaccination that had yet to be approved by the Food and Drug Administration, or apply to such a large number of diseases that the evidence could not have been summarized briefly. CHBRP examined each of the 34 mandates to determine whether the mandated benefits were considered to be medically effective based on existing evidence. Conclusions were drawn from the U.S. Preventive Services Task Force recommendations, CDC recommendations, NIH guidelines, and other authoritative sources. A number of previous CHBRP reports, especially useful when studies or recommendations are limited or unavailable, were also utilized. For example, the medical effectiveness analysis in CHBRP's report on SB 1634 (Steinberg, 2008) was used regarding the effectiveness of orthodontic services for persons with oral clefts, a relatively rare service for which few studies have been completed. Similarly, the medical effectiveness analysis in CHBRP's report on SB 158 (Wiggins, 2009) was used regarding the effectiveness of immunization against human papillomavirus (HPV), a vaccine that was, at the time of CHBRP's report, still relatively new.

Cost impact analytic questions and approach: The cost impact analytic questions and approach used in analyzing repeal bills differs substantially from those used in the analysis of mandate bills. Currently, an analysis of mandates assumes that the post-mandate coverage levels would be 100%, essentially full and universal compliance with the bills' requirements. However, it would not be reasonable to assume that *all* coverage would be dropped following the effective date of a repeal bill because: (1) the benefit or service may be considered medically necessary per the professional standard of care; (2) employers and individuals may still demand the benefit; and (3) the associated premium decreases may be so minimal that the cost associated with the perception of taking away a benefit or service may seem more costly to the carrier or the purchaser than simply keeping the existing benefit coverage in place. Timing is also an issue of consideration. With a new mandate, carriers have had to comply by the effective date specified in the bill. With a repeal, carriers have the option to offer the newer products that exclude the repealed benefit mandate(s). Some carriers may respond right away, and others may delay in order to monitor what other carriers do and how the market responds. Collective bargaining and inertia could also delay employer response to new choices that become available in the market. CHBRP identified a series of analytic questions that would need to be addressed and data elements that would need to be identified for CHBRP to produce a reliable post-repeal estimate of premiums and health care expenditures. For example:

- Products available for purchase from carriers:
 - Would carriers continue to include the benefit in the “base” benefit package, move it to a “rider,” or not offer it at all?
 - If carriers continue to cover/offer the benefit, then with what levels of cost sharing and to what extent would the premium differential be passed down to the employer/individual?
- Employer/purchaser demand or offer rate:
 - What percentage of employers would demand that the benefit continue to be included in the benefit package they purchase? If employers no longer have to provide

- coverage for a service, how many will continue to offer that coverage to their employees?
- How would this vary by market segment—i.e., for large groups, small groups, and individual markets?
 - Employee/individual take-up rate:
 - How many employees would opt out of employer-based coverage if the mandate was repealed?
 - How many individual members would purchase a plan without coverage for the previously mandated benefit?

An actual estimate of post-repeal coverage (and utilization of benefits) was not ascertainable due to the significant uncertainties surrounding carriers' responses, purchasers' responses, and the take-up rate by the individual or employee. Therefore, to model cost impacts for repeal bills, CHBRP chose to develop hypothetical scenarios that would provide a range of potential cost impacts, given the range of possible market responses. For example, in its analysis of AB 1904 (Villines, 2010), CHBRP determined that the number of possible combinations of the current benefit mandates that insurers might offer, if they were no longer mandated, was practically limitless. For the cost impact analysis of AB 1904, CHBRP's analysis modeled the possible maximum short-term savings using the following three scenarios:

- **Scenario 1: Maximum Impact.** This extreme hypothetical scenario assumes that limited-mandate plans would be purchased by all (i.e., 100%) 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. This scenario represents the most extreme possible response and should be considered an absolute upper bound. The probability of this scenario occurring is small; therefore, the report offered two more scenarios.
- **Scenario 2: Low-Income 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 only on the price-sensitive segment of the individual market. However, in contrast to Scenario 1 where it is assumed that all plan participants will switch over, and based on actuarial experience demonstrating take-up by only part of the considered population, this scenario assumes that only 40% of all those insured in this market segment with incomes below 350% of the 2010 federal poverty level (FPL) would switch; thus this scenario assumes that about 16% of the individual market participants will switch to limited-mandate plans. This scenario falls within the range of possibility should AB 1904 be enacted.
- **Scenario 3: Very Low-Income Impact.** This scenario is similar to Scenario 2, and assumes that limited-mandate policies would only have an impact on the most price-

sensitive segment of individual and small-group markets. This scenario also assumes that 40% of all those currently insured in the individual market segment with incomes below 200% of the FPL who currently own DMHC- and CDI-regulated individual policies, and 20% of the small-group segment with incomes below 200% of the FPL, will purchase limited-mandate plans. This scenario also falls within the range of possibility should AB 1904 be enacted.

The multiple scenarios offered in the analysis of AB 1904 were considered useful because they show the maximum short-term savings that might be possible if there was broad acceptance of these policies. In its analysis of AB 1904, CHBRP also estimated the short-term impacts on those currently uninsured in California if AB 1904 were to pass and limited-mandate plans were to become available in the market. Finally, potential long-term impacts on the market, such as risk segmentation and possible interactions with the ACA, were qualitatively addressed.

Public health impact analytic questions and approach: The public health impact analytic questions for repeal analysis are essentially equivalent to CHBRP's standard mandate analysis: (1) what is the impact on the health of community; (2) what is the impact on disparities; and (3) what is the extent to which premature death and economic loss are impacted? Given the scope of repeal bills analyzed to date and the approach necessitated for the cost impact analysis, the public health impact analysis also uses multiple-scenario analysis to determine what the population impacts would be if a specific benefit were to be dropped or certain product types were taken up in the market.

Fulfilling CHBRP's Mission

For a decade, CHBRP has provided rigorous and impartial analysis of benefit mandate legislation for the Legislature and other interested stakeholders. Throughout that time, the program has adapted to changing circumstances, including revisions to its authorizing statute and charge, changes to state health programs, and larger reforms of the health care system such as the ACA. Amidst these changes, CHBRP's work continues to support the legislative process, and has also been helpful to numerous stakeholders in their internal consideration of the merits of benefit mandate bills. The academic rigor that the program provides directly to the Legislature through its use of multidisciplinary academic experts is unique to California, and provides policymakers with credible, independent analysis on demand.

From 2009 through 2013, as well as during the prior cycle of CHBRP's authorization, CHBRP's reports and other products have been regarded by the Legislature and parties involved in health insurance as credible sources of information that support policy decision making, thus effectively and carefully achieving the mission described in its authorizing statute.

With the program set to sunset on June 30th, 2015, CHBRP looks forward to working with the Legislature on reauthorization discussions in the coming year, and incorporating enhancements to CHBRP's model that enhances CHBRP's utility to both the Legislature and to other policymakers and stakeholders.

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APPENDICES

All of the appendices listed below are available on CHBRP's website at www.chbrp.org.

Appendix 1	Authorizing Legislation
Appendix 2	CHBRP Staff List
Appendix 3	Task Force Membership List
Appendix 4	National Advisory Council Membership List
Appendix 5	CHBRP Actuaries
Appendix 6	CHBRP Librarians
Appendix 7	CHBRP Funding Process and Operating Costs
Appendix 8	CHBRP List of Reports, Letters, and Products, 2009–Present
Appendix 9	Summary of CHBRP Completed Reports on Mandate Bills, 2009–2013
Appendix 10	Medical Effectiveness Analysis Research Approach
Appendix 11	The California Cost and Coverage Model: CHBRP's Analytic Tool for Examining the Financial Impacts of Benefit Mandates
Appendix 12	Public Health Impact Analysis and Research Approach
Appendix 13	60-Day Timeline of the Analytical Process
Appendix 14	Content Expert Identification, Screening, and Selection Protocol
Appendix 15	CHBRP's Conflict-of-Interest Policies: General Disclosure Form and NAC Disclosure Form
Appendix 16	NAC Review Criteria and Guidelines
Appendix 17	Clarification of Bill Language and Legislative Intent (Bill Author Questionnaire)
Appendix 18	Health Care Service Plans' and Health Insurers' Proprietary Data Retention and Destruction Policy
Appendix 19	Existing Mandates in California Law
Appendix 20	Media Citations of CHBRP or Its Work
Appendix 21	Published Literature Citations of CHBRP
Appendix 22	Other States' Health Benefit Review Programs, 2013

Acknowledgments

John Lewis, MPA, and Nimit Ruparel, MPP, of CHBRP staff prepared this report. Garen Corbett, MS, Hanh Kim Quach, Laura Grossmann, MPH, and Karla Wood of CHBRP staff reviewed this report for its accuracy, completeness, and clarity.

Additional review of this report was provided by Ed Yelin, PhD, Joy Melnikow, MD, MPH, Ninez Ponce, PhD, Theodore Ganiats, MD, Lauren LeRoy, PhD, and Angela Gilliard.

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

**California Health Benefits Review Program
University of California, Office of the President
Division of Health Sciences and Services
1111 Franklin Street, 11th Floor
Oakland, CA 94607-5200
Tel: 510-287-3876
Fax: 510-763-4253
www.chbrp.org**

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

Garen Corbett, MS
Director

California Health Benefits Review Program Committees and Staff

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

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

Faculty Task Force (as of 9/1/2013)

Ed Yelin, PhD, *Vice Chair, Medical Effectiveness*, University of California, San Francisco
Joy Melnikow, MD, MPH, *Vice Chair, Public Health*, University of California, Davis
Ninez Ponce, PhD, *Vice Chair, Cost*, University of California, Los Angeles
Susan L. Ettner, PhD, University of California, Los Angeles
Theodore Ganiats, MD, University of California, San Diego
Sheldon Greenfield, MD, University of California, Irvine
Sylvia Guendelman, PhD, LCSW, University of California, Berkeley

Task Force Contributors

Wade Aubry, MD, University of California, San Francisco
Janet Coffman, MPP, PhD, University of California, San Francisco
Gina Evans-Young, University of California, San Francisco
Margaret Fix, MPH, University of California, San Francisco
Ronald L. Fong, MD, MPH, University of California, Davis
Brent Fulton, PhD, University of California, Berkeley
Erik Groessl, PhD, University of California, San Diego
Shana Lavarreda, PhD, MPP, University of California, Los Angeles
Stephen McCurdy, MD, MPH, University of California, Davis
Sara McMenamain, PhD, University of California, San Diego
Ying-Yeng Meng, PhD, University of California, Los Angeles
Jack Needleman, PhD, University of California, Los Angeles
Nadereh Pourat, PhD, University of California, Los Angeles
Dominique Ritley, MPH, University of California, Davis
Dylan Roby, PhD, University of California, Los Angeles
Meghan Soulsby, MPH, University of California, Davis
Chris Tonner, MPH, University of California, San Francisco
Byung-Kwang (BK) Yoo, MD, MS, PhD, University of California, Davis

National Advisory Council

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

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

CHBRP Staff

Garen Corbett, MS, Director
John Lewis, MPA, Associate Director
Laura Grossmann, MPH, Principal Analyst
Chelsea Kelleher, Graduate Health Policy Intern
Hanh Kim Quach, Principal Analyst
Nimit Ruparel, MPP, Policy Analyst
Karla Wood, Program Specialist

California Health Benefits Review Program
University of California
Office of the President
1111 Franklin Street, 11th Floor
Oakland, CA 94607-5200
Tel: 510-287-3876 Fax: 510-763-4253
chbrpinfo@chbrp.org
www.chbrp.org

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



Appendix 1: Authorizing Legislation

Assembly Bill 1996 (2002)

On February 15, 2002, Assembly Bill (AB) 1996 was introduced by author Assembly Member Helen Thomson. On September 22, 2002, Governor Davis signed AB 1996 into law. (Chapter 795, Statutes of 2002).

Senate Bill 1704 (2006)

On February 24, 2006, Senate Bill (SB) 1704 was introduced by author Senator Sheila Kuehl. On September 29, 2006, Governor Schwarzenegger signed SB 1704 into law. (Chapter 684, Statutes of 2006).

Assembly Bill 1540 (2009)

On March 4, 2009, AB 1540 was introduced by the Assembly Committee on Health: Dave Jones (Chair), Anthony Adams, Tom Ammiano, Marty Block, Wilmer Carter, Hector De La Torre, Isadore Hall, Mary Hayashi, Edward Hernandez, Bonnie Lowenthal, Pedro Nava, V. Manuel Perez, and Mary Salas. On October 11, 2009, Governor Schwarzenegger signed AB 1540 into law. (Chapter 298, Statutes of 2009).

The chaptered bills and the relevant language follow.

Assembly Bill No. 1996

CHAPTER 795

An act to add and repeal Chapter 7 (commencing with Section 127660) of Part 2 of Division 107 of the Health and Safety Code, relating to health care.

[Approved by Governor September 22, 2002. Filed with Secretary of State September 22, 2002.]

LEGISLATIVE COUNSEL'S DIGEST

AB 1996, Thomson. University of California: analysis of legislation mandating health care benefits and services.

Existing law regulates the provision of health care benefits by a health care service plan and by a health insurer.

This bill would request the University of California to assess legislation proposing mandated health care benefits to be provided by health care service plans and health insurers, and to prepare a written analysis in accordance with specified criteria.

This bill would request the University of California to develop and implement conflict-of-interest provisions that would prohibit a person from participating in any analysis in which he or she knows or has reason to know he or she has a material financial interest.

This bill would provide funding for the University of California's work from fees imposed upon health care service plans and health insurers, which would not exceed a total of \$2,000,000. The fees would be deposited in the Health Care Benefits Fund, which would be created by the bill. Initial startup funding would be loaned to the Health Care Benefits Fund from the Managed Care Fund and the Insurance Fund.

This bill would request the University of California to submit a report to the Governor and the Legislature by January 1, 2006, on the implementation of the bill's provisions.

The bill's provisions would remain in effect until January 1, 2007.

The people of the State of California do enact as follows:

SECTION 1. The intent of the Legislature in enacting this act is:

(a) To promote the public interest to assure that all residents of this state have reasonable access to quality health care.

(b) To analyze the clinical efficacy and cost-effectiveness of legislative proposals for expanded health care benefits using clear criteria for evaluating each proposal.



(c) To facilitate the provision of quality, cost-effective health services by providing current, accurate data and information to the Governor and the Legislature for the purpose of determining health-related programs and policies in connection with proposed legislation.

(d) That the University of California publish a written analysis of the clinical efficacy and cost-effectiveness of each legislative proposal, including supporting expert data.

(e) The Legislature finds that there is an increasing number of proposals that mandate that certain health benefits be provided by health care service plans and health insurers as components of individual and group contracts. The Legislature further finds that many of these would potentially result in better health outcomes that would be in the public interest. However, the Legislature also recognizes that mandated benefits may contribute to the cost and affordability of health insurance premiums. Therefore, it is the intent of the Legislature that the University of California conduct a systematic review of proposed mandated or mandatorily offered health benefit mandates. This review will assist the Legislature in determining whether mandating a particular coverage is in the public interest.

SEC. 2. Chapter 7 (commencing with Section 127660) is added to Part 2 of Division 107 of the Health and Safety Code, to read:

CHAPTER 7. UNIVERSITY OF CALIFORNIA ASSESSMENT ON
LEGISLATION PROPOSING MANDATED BENEFITS OR SERVICES

127660. (a) The Legislature hereby requests the University of California to assess legislation proposing a mandated benefit or service, as defined in subdivision (d), and to prepare a written analysis with relevant data on the following:

(1) Public health impacts, including, but not limited to, all of the following:

(A) The impact on the health of the community, including the reduction of communicable disease and the benefits of prevention such as those provided by childhood immunizations and prenatal care.

(B) The impact on the health of the community, including diseases and conditions where gender and racial disparities in outcomes are established in peer-reviewed scientific and medical literature.

(C) The extent to which the proposed service reduces premature death and the economic loss associated with disease.

(2) Medical impacts, including, but not limited to, all of the following:

(A) The extent to which the benefit or service is generally recognized by the medical community as being effective in the screening, diagnosis,



or treatment of a condition or disease, as demonstrated by a review of scientific and peer reviewed medical literature.

(B) The extent to which the benefit or service is generally available and utilized by treating physicians.

(C) The contribution of the benefit or service to the health status of the population, including the results of any research demonstrating the efficacy of the benefit or service compared to alternatives, including not providing the benefit or service.

(D) The extent to which the proposed services do not diminish or eliminate access to currently available health care services.

(3) Financial impacts, including, but not limited to, all of the following:

(A) The extent to which the coverage will increase or decrease the benefit or cost of the service.

(B) The extent to which the coverage will increase the utilization of the benefit or service, or will be a substitute for, or affect the cost of, alternative services.

(C) The extent to which the coverage will increase or decrease the administrative expenses of health care service plans and health insurers and the premium and expenses of subscribers, enrollees, and policyholders.

(D) The impact of this coverage on the total cost of health care.

(E) The potential cost or savings to the private sector, including the impact on small employers as defined in paragraph (1) of subdivision (l) of Section 1357, the Public Employees' Retirement System, other retirement systems funded by the state or by a local government, individuals purchasing individual health insurance, and publicly funded state health insurance programs, including the Medi-Cal program and the Healthy Families Program.

(F) The extent to which costs resulting from lack of coverage are shifted to other payers, including both public and private entities.

(G) The extent to which the proposed benefit or service does not diminish or eliminate access to currently available health care services.

(H) The extent to which the benefit or service is generally utilized by a significant portion of the population.

(I) The extent to which health care coverage for the benefit or service is already generally available.

(J) The level of public demand for health care coverage for the benefit or service, including the level of interest of collective bargaining agents in negotiating privately for inclusion of this coverage in group contracts, and the extent to which the mandated benefit or service is covered by self-funded employer groups.



(K) In assessing and preparing a written analysis of the financial impact of a mandated benefit pursuant to this paragraph, the Legislature requests the University of California to use a certified actuary or other person with relevant knowledge and expertise to determine the financial impact.

(b) The Legislature requests that the University of California provide every analysis to the appropriate policy and fiscal committees of the Legislature not later than 60 days after receiving a request made pursuant to Section 127661. In addition, the Legislature requests that the university post every analysis on the Internet and make every analysis available to the public upon request.

(c) The Legislature requests that the University of California first analyze any of the following benefit mandates proposed in the 2001–02 Legislative Session, if introduced or proposed to be introduced at the start of the 2003–04 Legislative Session, and a request for an analysis is made by the author or the relevant policy committee chair:

- (1) Bone marrow testing for prospective donors.
- (2) Infertility treatment.
- (3) Specified ovarian cancer screening and diagnostic tests.
- (4) Medically necessary prescription drugs.
- (5) Wigs for patients who have undergone chemotherapy.
- (6) Bone mineral density testing for osteoporosis.
- (7) Hearing aids.
- (8) Hyperbaric oxygen therapy for an acute or chronic brain condition.
- (9) Substance-related disorders.
- (10) Genetic disease tests for certain populations.

(d) As used in this section, “mandated benefit or service” means a proposed statute that requires a health care service plan or a health insurer, or both, to do any of the following:

- (1) Permit a person insured or covered under the policy or contract 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.
- (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.

127661. A request pursuant to this chapter may be made by an appropriate policy or fiscal committee chairperson, the Speaker of the Assembly, or the President pro Tempore of the Senate, who shall forward the introduced bill to the University of California for assessment.



127662. (a) In order to effectively support the University of California and its work in implementing this chapter, there is hereby established in the State Treasury, the Health Care Benefits Fund. The university's work in providing the bill analyses shall be supported from the fund.

(b) For fiscal years 2002–03 to 2005–06, inclusive, each health care service plan, except a specialized health care service plan, and each health insurer, as defined in Section 106 of the Insurance Code, shall be assessed an annual fee in an amount determined through regulation. The amount of the fee shall be determined by the Department of Managed Health Care and the Department of Insurance in consultation with the university and shall be limited to the amount necessary to fund the actual and necessary expenses of the university and its work in implementing this chapter. The total annual assessment on health care service plans and health insurers shall not exceed two million dollars (\$2,000,000).

(c) The Department of Managed Health Care and the Department of Insurance, in coordination with the university, shall assess the health care service plans and health insurers, respectively, for the costs required to fund the university's activities pursuant to subdivision (b).

(1) Health care service plans shall be notified of the assessment on or before June 15 of each year with the annual assessment notice issued pursuant to Section 1356. The assessment pursuant to this section is separate and independent of the assessments in Section 1356.

(2) Health insurers shall be noticed of the assessment in accordance with the notice for the annual assessment or quarterly premium tax revenues.

(3) The assessed fees required pursuant to subdivision (b) shall be paid on an annual basis no later than August 1 of each year. The Department of Managed Health Care and the Department of Insurance shall forward the assessed fees to the Controller for deposit in the Health Care Benefits Fund immediately following their receipt.

(4) "Health insurance," as used in this subdivision, does not include Medicare supplement, vision-only, dental-only, or CHAMPUS supplement insurance, or hospital indemnity, accident-only, or specified disease insurance that does not pay benefits on a fixed benefit, cash payment only basis.

127663. In order to avoid conflicts of interest, the Legislature requests the University of California to develop and implement conflict-of-interest provisions to prohibit a person from participating in any analysis in which the person knows or has reason to know he or she has a material financial interest, including, but not limited to, a person who has a consulting or other agreement with a person or organization that would be affected by the legislation.



127664. The Legislature requests the University of California to submit a report to the Governor and the Legislature no later than January 1, 2006, regarding the implementation of this chapter. Initial startup funding for the university shall be loaned to the Health Care Benefits Fund from the Managed Care Fund created pursuant to Section 1341.4 and the Insurance Fund created pursuant to Section 12975.8 of the Insurance Code. The Health Care Benefits Fund shall reimburse the Managed Care Fund and the Insurance Fund by September 30, 2003, from the 2003–04 fiscal year assessments received under subdivision (b) of Section 127662. The annual fee for the 2002–03 fiscal year shall be collected at the time the 2003–04 fiscal year assessments are made.

127665. This chapter shall remain in effect until January 1, 2007, and shall be repealed as of that date, unless a later enacted statute that becomes operative on or before January 1, 2007, deletes or extends that date.



Senate Bill No. 1704

CHAPTER 684

An act to amend Sections 127660, 127662, 127664, and 127665 of the Health and Safety Code, relating to public health.

[Approved by Governor September 29, 2006. Filed with
Secretary of State September 29, 2006.]

LEGISLATIVE COUNSEL'S DIGEST

SB 1704, Kuehl. Health care benefits.

Existing law requests the University of California to assess legislation proposing a mandated health benefit or service, as defined, to be provided by health care service plans and health insurers, and to prepare a written analysis in accordance with specified criteria.

This bill would, instead, request the University of California to establish the California Health Benefit Review Program to assess legislation proposing to mandate a benefit or service, as defined, and legislation proposing to repeal a mandated service or benefit, as defined, that, if enacted, would become effective on or after January 1, 2008, and to prepare a written analysis in accordance with specified criteria.

Existing law further requests the University of California to develop and implement conflict-of-interest provisions that would prohibit a person from participating in any analysis in which he or she knows or has reason to know he or she has a material financial interest.

Existing law requests the University of California to submit a report to the Governor and the Legislature no later than January 1, 2006, regarding the implementation of the aforementioned provisions.

This bill would request the University of California to submit another such report to the Governor and the Legislature by January 1, 2010.

Existing law provides funding for the University of California's implementation of these provisions from fees imposed upon health care service plans and health insurers, which would not exceed a total of \$2,000,000, and are to be deposited in the Health Care Benefits Fund.

This bill would extend to January 1, 2011, the repeal date of those provisions, and would authorize the continued imposition of that fee through the 2009–10 fiscal year.

The people of the State of California do enact as follows:

SECTION 1. Section 127660 of the Health and Safety Code is amended to read:

127660. (a) The Legislature hereby requests the University of California to establish the California Health Benefit Review Program to assess legislation proposing to mandate a benefit or service, as defined in subdivision (c), and legislation proposing to repeal a mandated benefit or service, as defined in subdivision (d), and to prepare a written analysis with relevant data on the following:

(1) Public health impacts, including, but not limited to, all of the following:

(A) The impact on the health of the community, including the reduction of communicable disease and the benefits of prevention such as those provided by childhood immunizations and prenatal care.

(B) The impact on the health of the community, including diseases and conditions where gender and racial disparities in outcomes are established in peer-reviewed scientific and medical literature.

(C) The extent to which the benefit or service reduces premature death and the economic loss associated with disease.

(2) Medical impacts, including, but not limited to, all of the following:

(A) The extent to which the benefit or service is generally recognized by the medical community as being effective in the screening, diagnosis, or treatment of a condition or disease, as demonstrated by a review of scientific and peer reviewed medical literature.

(B) The extent to which the benefit or service is generally available and utilized by treating physicians.

(C) The contribution of the benefit or service to the health status of the population, including the results of any research demonstrating the efficacy of the benefit or service compared to alternatives, including not providing the benefit or service.

(D) The extent to which mandating or repealing the benefits or services would not diminish or eliminate access to currently available health care benefits or services.

(3) Financial impacts, including, but not limited to, all of the following:

(A) The extent to which the coverage or repeal of coverage will increase or decrease the benefit or cost of the benefit or service.

(B) The extent to which the coverage or repeal of coverage will increase the utilization of the benefit or service, or will be a substitute for, or affect the cost of, alternative benefits or services.

(C) The extent to which the coverage or repeal of coverage will increase or decrease the administrative expenses of health care service plans and health insurers and the premium and expenses of subscribers, enrollees, and policyholders.

(D) The impact of this coverage or repeal of coverage on the total cost of health care.

(E) The potential cost or savings to the private sector, including the impact on small employers as defined in paragraph (1) of subdivision (l) of Section 1357, the Public Employees' Retirement System, other retirement systems funded by the state or by a local government, individuals purchasing individual health insurance, and publicly funded state health

insurance programs, including the Medi-Cal program and the Healthy Families Program.

(F) The extent to which costs resulting from lack of coverage or repeal of coverage are or would be shifted to other payers, including both public and private entities.

(G) The extent to which mandating or repealing the proposed benefit or service would not diminish or eliminate access to currently available health care benefits or services.

(H) The extent to which the benefit or service is generally utilized by a significant portion of the population.

(I) The extent to which health care coverage for the benefit or service is already generally available.

(J) The level of public demand for health care coverage for the benefit or service, including the level of interest of collective bargaining agents in negotiating privately for inclusion of this coverage in group contracts, and the extent to which the mandated benefit or service is covered by self-funded employer groups.

(K) In assessing and preparing a written analysis of the financial impact of legislation proposing to mandate a benefit or service and legislation proposing to repeal a mandated benefit or service pursuant to this paragraph, the Legislature requests the University of California to use a certified actuary or other person with relevant knowledge and expertise to determine the financial impact.

(b) The Legislature requests that the University of California provide every analysis to the appropriate policy and fiscal committees of the Legislature not later than 60 days after receiving a request made pursuant to Section 127661. In addition, the Legislature requests that the university post every analysis on the Internet and make every analysis available to the public upon request.

(c) As used in this section, “legislation proposing to mandate a benefit or service” means a proposed statute that requires a health care service plan or a health insurer, or both, to do any of the following:

(1) Permit a person insured or covered under the policy or contract 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.

(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.

(d) As used in this section, “legislation proposing to repeal a mandated benefit or service” means a proposed statute that, if enacted, would become operative on or after January 1, 2008, and would repeal an existing requirement that a health care service plan or a health insurer, or both, do any of the following:

(1) Permit a person insured or covered under the policy or contract 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.

(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.

SEC. 2. Section 127662 of the Health and Safety Code is amended to read:

127662. (a) In order to effectively support the University of California and its work in implementing this chapter, there is hereby established in the State Treasury, the Health Care Benefits Fund. The university's work in providing the bill analyses shall be supported from the fund.

(b) For fiscal years 2006–07 to 2009–10, inclusive, each health care service plan, except a specialized health care service plan, and each health insurer, as defined in Section 106 of the Insurance Code, shall be assessed an annual fee in an amount determined through regulation. The amount of the fee shall be determined by the Department of Managed Health Care and the Department of Insurance in consultation with the university and shall be limited to the amount necessary to fund the actual and necessary expenses of the university and its work in implementing this chapter. The total annual assessment on health care service plans and health insurers shall not exceed two million dollars (\$2,000,000).

(c) The Department of Managed Health Care and the Department of Insurance, in coordination with the university, shall assess the health care service plans and health insurers, respectively, for the costs required to fund the university's activities pursuant to subdivision (b).

(1) Health care service plans shall be notified of the assessment on or before June 15 of each year with the annual assessment notice issued pursuant to Section 1356. The assessment pursuant to this section is separate and independent of the assessments in Section 1356.

(2) Health insurers shall be noticed of the assessment in accordance with the notice for the annual assessment or quarterly premium tax revenues.

(3) The assessed fees required pursuant to subdivision (b) shall be paid on an annual basis no later than August 1 of each year. The Department of Managed Health Care and the Department of Insurance shall forward the assessed fees to the Controller for deposit in the Health Care Benefits Fund immediately following their receipt.

(4) "Health insurance," as used in this subdivision, does not include Medicare supplement, vision-only, dental-only, or CHAMPUS supplement insurance, or hospital indemnity, accident-only, or specified disease insurance that does not pay benefits on a fixed benefit, cash payment only basis.

SEC. 3. Section 127664 of the Health and Safety Code is amended to read:

127664. The Legislature requests the University of California to submit a report to the Governor and the Legislature by January 1, 2010, regarding the implementation of this chapter.

SEC. 4. Section 127665 of the Health and Safety Code is amended to read:

127665. This chapter shall remain in effect until January 1, 2011, and shall be repealed as of that date, unless a later enacted statute that becomes operative on or before January 1, 2011, deletes or extends that date.

This bill would change the repeal date to January 1, 2013.

(8) Existing law establishes the Local Education Agency Medi-Cal Recovery Account in the Special Deposit Fund, to be used only to support the department in meeting the requirements of the above provisions, and specifies a formula for funding and staffing activities provided for under these provisions.

Existing law provides that as of January 1, 2010, unless the Legislature enacts a new statute or extends the date beyond January 1, 2010, all funds in the Local Education Agency Medi-Cal Recovery Account shall be returned proportionately to all local education agencies whose federal Medicaid funds were used to create the account.

This bill would rename the account the Local Educational Agency Medi-Cal Recovery Fund.

This bill would also provide that, as of January 1, 2013, unless the Legislature enacts a new statute or extends the repeal date, all funds in the Local Educational Agency Medi-Cal Recovery Fund shall be returned proportionally to all local educational agencies whose federal Medicaid funds were used to create the fund.

(9) Existing law, until January 1, 2011, requests the University of California to establish the California Health Benefit Review Program to assess legislation proposing a mandated health benefit or service, as defined, to be provided by health care service plans and health insurers, and to prepare a written analysis in accordance with specified criteria.

This bill would extend the repeal date of the above provisions to June 30, 2015.

(10) Existing law requests the University of California to submit a report to the Governor and the Legislature no later than January 1, 2010, regarding the implementation of the above provisions.

This bill would, instead, request the University of California to submit a report no later than January 1, 2014.

(11) Existing law, for fiscal years 2006–07 to 2009–10, inclusive, provides funding for the University of California's implementation of the above provisions from a fee imposed upon health care service plans and health insurers, which would not exceed a total of \$2,000,000, and is to be deposited in the Health Care Benefits Fund.

This bill, instead, provides for the imposition of that fee for fiscal years 2010–11 to 2014–15, inclusive.

(12) Existing law requires the State Department of Public Health to maintain a program for the control of tuberculosis. Existing law, until January 1, 2011, requires a local health department that elects to participate in the program to provide for certification for one year, by the local health officer, of tuberculin skin test technicians.

This bill would delete the repeal date of these provisions, thereby extending the operation of these provisions indefinitely.

(13) This bill would incorporate additional changes to Section 6276.24 of the Government Code proposed by SB 359, that would become operative only if SB 359 and this bill are both chaptered and become effective on or

(2) Practical instruction, under the supervision of a licensed physician or registered nurse at the local health department, including the successful placement and correct measurement of 10 tuberculin skin tests, at least five of which are deemed positive by the licensed physician or registered nurse supervising the practical instruction.

(h) The local health officer or the tuberculosis controller may deny or revoke the certification of a tuberculin skin test technician if the local health officer or the tuberculosis controller finds that the technician is not in compliance with this section.

(i) Each county or city participating in the program under this section using tuberculin skin test technicians, that elects to participate on or after January 1, 2005, shall submit to the CTCA a survey and an evaluation of its findings, including a review of the aggregate report, by July 1, 2006, and by July 1 of each year thereafter to, and including, July 1, 2011. The report shall include the following:

(1) The number of persons trained and certified as tuberculin skin test technicians in that city or county.

(2) The estimated number of tuberculin skin tests placed by tuberculin skin test technicians in that city or county.

(j) By July 1, 2008, the CTCA shall submit a summary of barriers to implementing the tuberculosis technician program in the state to the department and to the appropriate policy and fiscal committees of the Legislature.

(k) The local health officer of each participating city or county shall report to the Tuberculosis Control Branch within the department any adverse event that he or she determines has resulted from improper tuberculin skin test technician training or performance.

SEC. 20. Section 127662 of the Health and Safety Code is amended to read:

127662. (a) In order to effectively support the University of California and its work in implementing this chapter, there is hereby established in the State Treasury, the Health Care Benefits Fund. The university's work in providing the bill analyses shall be supported from the fund.

(b) For fiscal years 2010–11 to 2014–15, inclusive, each health care service plan, except a specialized health care service plan, and each health insurer, as defined in Section 106 of the Insurance Code, shall be assessed an annual fee in an amount determined through regulation. The amount of the fee shall be determined by the Department of Managed Health Care and the Department of Insurance in consultation with the university and shall be limited to the amount necessary to fund the actual and necessary expenses of the university and its work in implementing this chapter. The total annual assessment on health care service plans and health insurers shall not exceed two million dollars (\$2,000,000).

(c) The Department of Managed Health Care and the Department of Insurance, in coordination with the university, shall assess the health care service plans and health insurers, respectively, for the costs required to fund the university's activities pursuant to subdivision (b).

(1) Health care service plans shall be notified of the assessment on or before June 15 of each year with the annual assessment notice issued pursuant to Section 1356. The assessment pursuant to this section is separate and independent of the assessments in Section 1356.

(2) Health insurers shall be noticed of the assessment in accordance with the notice for the annual assessment or quarterly premium tax revenues.

(3) The assessed fees required pursuant to subdivision (b) shall be paid on an annual basis no later than August 1 of each year. The Department of Managed Health Care and the Department of Insurance shall forward the assessed fees to the Controller for deposit in the Health Care Benefits Fund immediately following their receipt.

(4) "Health insurance," as used in this subdivision, does not include Medicare supplement, vision-only, dental-only, or CHAMPUS supplement insurance, or hospital indemnity, accident-only, or specified disease insurance that does not pay benefits on a fixed benefit, cash payment only basis.

SEC. 21. Section 127664 of the Health and Safety Code is amended to read:

127664. The Legislature requests the University of California to submit a report to the Governor and the Legislature by January 1, 2014, regarding the implementation of this chapter.

SEC. 22. Section 127665 of the Health and Safety Code is amended to read:

127665. This chapter shall remain in effect until June 30, 2015, and shall be repealed as of that date, unless a later enacted statute that becomes operative on or before June 30, 2015, deletes or extends that date.

SEC. 23. Section 128730 of the Health and Safety Code is amended to read:

128730. (a) Effective January 1, 1986, the office shall be the single state agency designated to collect the following health facility or clinic data for use by all state agencies:

(1) That data required by the office pursuant to Section 127285.

(2) That data required in the Medi-Cal cost reports pursuant to Section 14170 of the Welfare and Institutions Code.

(3) Those data items formerly required by the California Health Facilities Commission that are listed in Sections 128735 and 128740. Information collected pursuant to subdivision (g) of Section 128735 and Sections 128736 and 128737 shall be made available to the State Department of Health Care Services and the State Department of Public Health. The departments shall ensure that the patient's rights to confidentiality shall not be violated in any manner. The departments shall comply with all applicable policies and requirements involving review and oversight by the State Committee for the Protection of Human Subjects.

(b) The office shall consolidate any and all of the reports listed under this section or Sections 128735 and 128740, to the extent feasible, to minimize the reporting burdens on, provided, however, that the office shall neither add nor delete data items from the Hospital Discharge Abstract Data



Appendix 2: CHBRP Staff List

Garen Corbett, MS
Director

Laura Grossmann, MPH
Principal Analyst

Chelsea Kelleher
Graduate Health Policy Intern

John Lewis, MPA
Associate Director

Hanh Kim Quach
Principal Analyst

Nimit Ruparel, MPP
Policy Analyst

Karla Wood
Program Specialist

Mailing Address:

California Health Benefits Review Program
University of California, Office of the President
Office of Health Sciences and Services
1111 Franklin Street, 11th Floor
Oakland, CA 94607-5200
Tel: (510) 287-3876
Fax: (510) 763-4253
Email: chbrpinfo@chbrp.org
www.chbrp.org



Appendix 3: Task Force Membership List

Below is a list of CHBRP's faculty task force (FTF) membership, as of 9/1/2013.

Task Force Members

Ed Yelin, PhD
Vice Chair, Medical Effectiveness
University of California, San Francisco

Joy Melnikow, MD, MPH
Vice Chair, Public Health Impact
University of California, Davis

Ninez Ponce, PhD
Vice Chair, Cost Impact
University of California, Los Angeles

Susan L. Ettner, PhD
University of California, Los Angeles

Theodore Ganiats, MD
University of California, San Diego

Sheldon Greenfield, MD
University of California, Irvine

Sylvia Guendelman, PhD, LCSW
University of California, Berkeley

Task Force Contributors

Wade Aubry, MD
University of California, San Francisco

Janet Coffman, MPP, PhD
University of California, San Francisco

Gina Evans-Young
University of California, San Francisco

Margaret Fix, MPH
University of California, San Francisco

Ronald L. Fong, MD, MPH
University of California, Davis

Brent Fulton, PhD
University of California, Berkeley

Erik Groessl, PhD
University of California, San Diego

Shana Lavarreda, PhD, MPP
University of California, Los Angeles

Stephen McCurdy, MD, MPH
University of California, Davis

Sara McMenamain, PhD
University of California, San Diego

Ying-Yeng Meng, PhD
University of California, Los Angeles

Jack Needleman, PhD
University of California, Los Angeles

Nadereh Pourat, PhD
University of California, Los Angeles

Dominique Ritley, MPH
University of California, Davis

Dylan Roby, PhD
University of California, Los Angeles

Megan Soulsby, MPH
University of California, Davis

Chris Tonner, MPH
University of California, San Francisco

Byung-Kwang (BK) Yoo, MD, MS, PhD
University of California, Davis



Appendix 4: National Advisory Council Membership List

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

Stuart H. Altman, PhD
Professor of National Health Policy
Brandeis University
Waltham, MA

Deborah Chollet, PhD
Senior Fellow
Mathematica Policy Research
Washington, DC

Joseph P. Ditrè, Esq
Executive Director
Consumers for Affordable Health Care
Augusta, ME

Allen D. Feezor
Fmr. Deputy Secretary for Health Services
North Carolina Department of Health &
Human Services
Raleigh, NC

Charles “Chip” Kahn, MPH
President and CEO
Federation of American Hospitals
Washington, DC

Jeffrey Lerner, PhD
President and CEO
ECRI Institute Headquarters
Plymouth Meeting, PA

Trudy Lieberman
Director, Health and Medicine Reporting
Program
Graduate School of Journalism, City
University of New York
New York, NY

Donald E. Metz
Executive Editor
Health Affairs
Bethesda, MD

Marilyn Moon, PhD
Vice President and Director, Health Program
American Institutes for Research
Silver Spring, MD

Carolyn Pare
CEO
Buyers Health Care Action Group
Bloomington, MN

Michael Pollard, JD, MPH
Senior Fellow
Institute for Health Policy Solutions
Washington, DC

Christopher Queram
President and Chief Executive Officer
Wisconsin Collaborative for Healthcare Quality
Madison, WI

Richard Roberts, MD, JD
Professor of Family Medicine
University of Wisconsin-Madison
Madison, WI

Frank Samuel, LLB
Former Science and Technology Advisor
Governor's Office, State of Ohio
Columbus, OH

Patricia Smith
President and CEO
Alliance of Community Health Plans
Washington, DC

Prentiss Taylor, MD
Corporate Medical Director
Advocate Health Centers, Advocate Health Care
Chicago, IL

J. Russell Teagarden
Vice President, Clinical Practices and
Therapeutics
Medco Health Solutions, Inc.
Brookfield, CT

Alan Weil, JD, MPP
Executive Director
National Academy for State Health Policy
Washington, DC



Appendix 5: CHBRP Actuaries

The California Health Benefits Review Program's (CHBRP's) authorizing statute requires the University of California (UC) to use a certified actuary or other person with relevant knowledge and expertise to determine the financial impact of proposed health insurance benefit mandates. Specifically, California Health and Safety Code Section 12766 (a)(3) (K) states, "In assessing and preparing a written analysis of the financial impact of legislation proposing to mandate a benefit or service and legislation proposing to repeal a mandated benefit or service pursuant to this paragraph, the Legislature requests the University of California to use a certified actuary or other person with relevant knowledge and expertise to determine the financial impact."

CHBRP originally retained Milliman, Inc., to serve this function in 2003. In 2007, UC issued a request for proposals and competitively re-bid the contract. This was awarded to Milliman, Inc.

The actuarial firm has made a commitment for a senior actuary to conduct internal peer review and provide analytic services if needed.

Senior consulting actuaries on CHBRP projects are:

Bob Cosway, FSA-MAAA

Milliman, Inc.

9255 Towne Center Drive, Suite 900

San Diego, CA 92121

Susan Pantely, FSA, MAA

Milliman, Inc.

650 California Street, 17th Floor

San Francisco, CA 94108

Information on Milliman is available at:

www.milliman.com



Appendix 6: CHBRP Librarians

Bruce Abbott, MLS
Reference Librarian
Health Sciences Library
University of California, Davis

Stephen Clancy, MLS, AHIP
Health Sciences Librarian
Science Library
University of California, Irvine

Penny Coppernoll-Blach, MLIS
Reference Coordinator
Biomedical Library
University of California, San Diego

Min-Lin Fang, MLIS
Education Information Consultant
Library and Center for Knowledge Management
University of California, San Francisco



Appendix 7: CHBRP Funding Process and Operating Costs

In order to effectively support the California Health Benefits Review Program (CHBRP), Section 127662 of the Health and Safety Code provides that:

- The Health Care Benefits Fund (HCBF) be established in the State Treasury;
- Each health plan and each health insurer be assessed an annual fee for which the total annual assessment not exceed \$2 million;
- The California Department of Managed Health Care (DMHC) assess health plans.
- Health plans be notified of the assessment on or before June 15 of each year;
- The California Department of Insurance (CDI) assess health insurers;
- Health insurers be notified of the assessment in accordance with the notice for the annual assessment or quarterly premium tax revenues;
- Assessed fees be paid on an annual basis no later than August 1 of each year; and
- DMHC and CDI forward the assessed fees to the Controller for deposit in the Health Care Benefits Fund following their receipt.

This appendix details the process by which DMHC and CDI determine the amount to assess health plans and insurers for a given fiscal year. The annual amounts transferred into the HCBF are equal to the total assessments less whatever amount was not collected by DMHC or CDI.

Regulator Assessments and Transfers into the Health Care Benefits Fund

1. During the spring, CHBRP provides the following pieces of information to DMHC:
 - a. Actual expenditures for the previous fiscal year;
 - b. Projected expenditures for the remainder of that fiscal year; and
 - c. Projected budget for the next fiscal year.
2. Based on the information provided in step #1, in the spring, DMHC determines the total amount to be transferred to the HCBF for the next fiscal year.
3. Simultaneously, DMHC calculates the percentage share it and CDI are required to collect and transfer to the HCBF.
 - a. The CDI and DMHC percentage shares are based on the market shares of the privately insured population enrolled in health plans regulated by DMHC versus the privately insured population enrolled in preferred provider organizations or fee-for-services insurance policies regulated by CDI.

- b. The market shares were determined in 2002 and are set at: 87.6% for DMHC and 12.4% for CDI. For example, if the total amount CHBRP may receive by law is \$2 million, the maximum both Departments would be required to assess and transfer into the HCBF would be calculated as follows:

Assessment Shares (Example)

DMHC portion	87.6%	\$1,752,000
CDI portion	12.4%	\$248,000
Total	100%	\$2,000,000

4. DMHC notifies health plans of the amount they will be assess, usually by mid-June.
5. CDI notifies health insurers of the amounts they will be assessed, usually by October.
6. DMHC transfers collected funds to the HCBF, usually by September. CDI transfers collected funds to the HCBF, usually in December and in March.

Summary of CHBRP Expenditures

The following tables provide a summary of the actual funding provided to CHBRP since the program’s last reauthorization, and then provides detail for the 2010–2011 through 2013–2014 fiscal years (FY). Please note the 2013–2014 FY details are projected expenditures. Prior year expenditures may be found in prior implementation reports on CHBRP’s website.

Table 7-1. CHBRP Operating Costs and Assessment Share, Fiscal Years 2011–2014

Fiscal Year	Operating Costs (a)	DMHC Share (b)	CDI Share (b)
2010–2011	\$1,896,851.00	\$1,595,467.31	\$235,945.84
2011–2012	\$1,995,314.00	\$1,616,070.99	\$223,589.70
2012–2013	\$1,999,176.00	\$1,751,278.18	\$247,897.82
2013–2014	\$1,999,736,00	(c)	(c)

Source: California Health Benefits Review Program, 2013.

Notes:

- (a) These amounts reflect the actual amounts transferred into the HCBF, not the actual amounts assessed on plans and insurers by DMHC and CDI. Slight differences in the amount assessed and the amount transferred are due to differences in the amounts assessed and actually collected by DMHC and CDI.
- (b) The CDI and DMHC percentage shares are based on the market shares of the privately insured population enrolled in health plans regulated by DMHC versus the privately insured population enrolled in preferred provider organizations or fee-for-services insurance policies regulated by the CDI. The market shares were determined in 2002 and are set at: 87.6% for DMHC and 12.4% for CDI.
- (c) Transfers for 2013-2014 have not yet taken place

Table 7-2. CHBRP Average Expenditures by Category

Category	FY 2009–2014
Salary, wages, benefits (a)	31%
Actuarial services (b)	15%
Payments to campuses (c)	45%
Other (d)	9%
Total	100%

Source: California Health Benefits Review Program, 2013.

Notes:

- (a) Salaries, wages, and benefits for central offices operations.
- (b) CHBRP's authorizing statute requires use of actuarial services to conduct the cost impact analyses.
- (c) Campus payments are for services provided by the faculty and researchers to conduct the medical effectiveness, cost impact, and public health impact analyses, and for reviews.
- (d) This includes payments for travel, workshops, staff training, advisory council services, content expert services, librarian services, editorial services, website hosting, supplies and equipment, and other vendor payments.



Appendix 8: CHBRP List of Reports, Letters, and Products, 2009–Present

2013

California Health Benefits Review Program (CHBRP). *Analysis of Senate Bill 126: Health Care Coverage: Pervasive Developmental Disorder or Autism*. Report to California State Legislature. Oakland, CA: CHBRP.

California Health Benefits Review Program (CHBRP). *Analysis of Assembly Bill 219: Health Care Coverage: Cancer Treatment*. Report to California State Legislature. Oakland, CA: CHBRP; 2013.

California Health Benefits Review Program (CHBRP). *Analysis of Assembly Bill 460: Health Care Coverage: Infertility*. Report to California State Legislature. Oakland, CA: CHBRP; 2013.

California Health Benefits Review Program (CHBRP). *Analysis of Assembly Bill 889: Health Care Coverage: Prescription Drugs*. Report to California State Legislature. Oakland, CA: CHBRP; 2013.

California Health Benefits Review Program (CHBRP). *Analysis of Assembly Bill 912: Health Care Coverage: Fertility Preservation*. Report to California State Legislature. Oakland, CA: CHBRP; 2013.

California Health Benefits Review Program (CHBRP). *Analysis of Senate Bill 189: Health Care Coverage: Wellness Programs*. Report to California State Legislature. Oakland, CA: CHBRP; 2013.

California Health Benefits Review Program (CHBRP). *Analysis of Senate Bill 320: Acquired Brain Injury*. Report to California State Legislature. Oakland, CA: CHBRP; 2013.

California Health Benefits Review Program (CHBRP). *Analysis of Senate Bill 799: Colorectal Cancer: Genetic Testing and Screening*. Report to California State Legislature. Oakland, CA: CHBRP; 2013.

California Health Benefits Review Program (CHBRP). *Estimates of Sources of Health Insurance in California for 2014*. Oakland, CA: CHBRP; 2013.

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California Health Benefits Review Program (CHBRP). *Analysis of Assembly Bill 2064: Immunizations for Children.* Report to California State Legislature. Oakland, CA: CHBRP; 2012.

California Health Benefits Review Program (CHBRP). *Analysis of Assembly Bill 1800: Health Care Coverage.* Report to California State Legislature. Oakland, CA: CHBRP; 2012.

California Health Benefits Review Program (CHBRP). *Analysis of Assembly Bill 1738: Health Care Coverage: Tobacco Cessation.* Report to California State Legislature. Oakland, CA: CHBRP; 2012.

California Health Benefits Review Program (CHBRP). *Analysis of Assembly Bill 1000: Cancer Treatment.* Letter to California State Legislature. Oakland, CA: CHBRP; 2012.

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California Health Benefits Review Program (CHBRP). *Issue Brief: Interaction between California State Benefit Mandates and the Affordable Care Act’s “Essential Health Benefits.”* Oakland, CA: CHBRP; 2012.

California Health Benefits Review Program (CHBRP). *Issue Brief: Mammography Mandates, Benchmark Plan Choices, and Essential Health Benefits.* Oakland, CA: CHBRP; 2012.

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California Health Benefits Review Program (CHBRP). *Policy Brief: Pediatric Dental and Pediatric Vision Essential Health Benefits*. Report to California State Legislature. Oakland, CA: CHBRP; 2012.

California Health Benefits Review Program (CHBRP). *The Federal Preventive Services Health Insurance Benefit Mandate and California's Health Insurance Benefit Mandates*. Oakland, CA: CHBRP; 2012.

California Health Benefits Review Program (CHBRP). *CHBRP's California Health Benefits Review Program: Overview*. Public Presentation, January, 2012. Sacramento, CA.

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California Health Benefits Review Program (CHBRP). *Approach to Medical Effectiveness Analysis*. Public Presentation, September, 2012. Vancouver, BC, Canada.

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California Health Benefits Review Program (CHBRP). *Analysis of Senate Bill 173: Mammograms*. Report to California State Legislature. Oakland, CA: CHBRP; 2011.

California Health Benefits Review Program (CHBRP). *Analysis of Senate Bill 155: Maternity Services*. Report to California State Legislature. Oakland, CA: CHBRP; 2011.

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California Health Benefits Review Program (CHBRP). *Analysis of Assembly Bill 428: Fertility Preservation*. Report to California State Legislature. Oakland, CA: CHBRP; 2011.

California Health Benefits Review Program (CHBRP). *Analysis of Assembly Bill 369: Health Care Coverage: Prescription Drugs*. Report to California State Legislature. Oakland, CA: CHBRP; 2011.

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California Health Benefits Review Program (CHBRP). *Analysis of Assembly Bill 185: Maternity Services*. Report to California State Legislature. Oakland, CA: CHBRP; 2011.

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California Health Benefits Review Program (CHBRP). *Analysis of Assembly Bill 154: Mental Health Services*. Report to California State Legislature. Oakland, CA: CHBRP; 2011.

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California Health Benefits Review Program (CHBRP). *Analysis of Assembly Bill 72: Health Care Coverage: Acupuncture*. Report to California State Legislature. Oakland, CA: CHBRP; 2011.

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California Health Benefits Review Program (CHBRP). *Analysis of Senate Bill 1104: Diabetes-Related Complications*. Report to California State Legislature. Oakland, CA: CHBRP; 2010.

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California Health Benefits Review Program (CHBRP). *Policy Considerations Relevant to Assembly Bill 2587: Benefit Mandates*. Issue Analysis. Oakland, CA: CHBRP; 2010.

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Appendix 9: Summary of CHBRP Completed Reports on Mandate Bills, 2009–2013

Bill Summary	Medical Effectiveness of a Mandated Service or Treatment	Coverage	Estimated Utilization Impact of Mandate	Estimated Cost Impact in Terms of Total Health Care Expenditures (a)	Estimated Cost Impact in Terms of % Premium Changes by Payer (b)	Burden of Disease	Estimated Public Health Impact
2013							
<p>SB 799, Colorectal Cancer: Genetic Testing and Screening (6/17/13)</p> <p>SB 799 would require coverage of Lynch syndrome (LS) genetic testing for specified groups of enrollees as well as annual colorectal cancer (CRC) screening, including colonoscopy, for some LS+ enrollees.</p>	<p>Evidence indicates that genetic testing can identify LS+ enrollees. There is insufficient evidence to assess effect on CRC outcomes of annual (as opposed to biennial or third year) colonoscopy for LS+ persons.</p>	<p>96% of enrollees have coverage and 57.1% have mandate-compliant coverage for LS genetic testing.</p> <p>100% have coverage and 79.9% have mandate-compliant coverage for CRC screening.</p>	<p>Among enrollees with an LS+ relative with CRC: +6.3% genetic counseling</p> <p>+11.5% LS genetic testing</p> <p>Among LS+ enrollees with an LS+ relative with CRC: +3.7% colonoscopies</p>	<p>\$637,000 (+0.0004%)</p>	<p>PRIVATE</p> <p>Employers (+0.0004%)</p> <p>Enrollees w/group insurance (+0.0005%)</p> <p>Enrollees w/individual insurance (+0.0008%)</p> <p>PUBLIC</p> <p>CalPERS (+0%)</p> <p>Medi-Cal (+0.0017%)</p> <p>HFP (+0.0034%)</p> <p>Enrollee out-of-pocket expenses for copayments, etc. (+\$95,000)</p> <p>Enrollee expenses for noncovered benefits (-\$232,000)</p>	<p>Approximately 3% of CRCs are caused by LS. In 2009, an estimated 183 LS+ Californians were diagnosed with CRC.</p>	<p>No measurable public health impact in the first year after enactment of SB 799, but, over time, health and quality of life improvements would be expected for persons identified as LS+.</p>

Bill Summary	Medical Effectiveness of a Mandated Service or Treatment	Coverage	Estimated Utilization Impact of Mandate	Estimated Cost Impact in Terms of Total Health Care Expenditures (a)	Estimated Cost Impact in Terms of % Premium Changes by Payer (b)	Burden of Disease	Estimated Public Health Impact
<p>SB 320, Beall, Acquired Brain Injury (4/19/13)</p> <p>SB 320 would prohibit DMHC-regulated plans and CDI-regulated policies from denying coverage for medically necessary medical or rehabilitation treatment for ABI at specified facilities.</p>	<p>Preponderance of evidence suggests:</p> <ul style="list-style-type: none"> • Among those with mTBI, only those requiring hospitalization benefit from post-acute multidisciplinary rehab. • Multidisciplinary interventions seem to work compared to minimal or no intervention <p>Studies also suggest:</p> <ul style="list-style-type: none"> • There is insufficient evidence to determine settings in which multidisciplinary rehab interventions occur affects' patients outcomes • Delivery of rehabilitation in specialized vs. unspecialized settings are ambiguous. 	<p>Unknown impact</p>	<p>Unknown impact</p>	<p>Unknown impact</p>	<p>Unknown impact</p>	<p>The California Department of Public Health reported that Californians aged 0 to 64 experienced 19,164 nonfatal TBI hospitalizations in 2011; 15,515 of those patients were treated and released, 1,144 were transferred to an acute care hospital, and 2,044 transferred to a nonacute care hospital (the remainder were classified as unknown). About 350,000 Californians are living with TBI.</p>	<p>Unknown impact</p>

Bill Summary	Medical Effectiveness of a Mandated Service or Treatment	Coverage	Estimated Utilization Impact of Mandate	Estimated Cost Impact in Terms of Total Health Care Expenditures (a)	Estimated Cost Impact in Terms of % Premium Changes by Payer (b)	Burden of Disease	Estimated Public Health Impact
<p>SB 189, Monning, Wellness Programs (4/25/13)</p> <p>SB 189 would place requirements on DMHC-regulated plans and CDI-regulated insurers regarding their offering of and/or interaction with wellness programs established after January 1, 2014. The requirements would not be applicable to wellness programs established prior to January 1, 2014.</p>	<p>Participating in workplace wellness programs that address tobacco and alcohol use are effective at improving health outcomes.</p> <p>The effectiveness of participating in workplace wellness programs that address diet, exercise, obesity, and stress is ambiguous.</p> <p>The evidence suggests that financial incentives other than those linked to premiums or cost-sharing increase participation in workplace wellness programs but there is insufficient evidence to assess the relative effectiveness of different types of financial incentives.</p>	<p>CHBRP is unable to project any impact on benefit coverage for this mandate.</p>	<p>CHBRP is unable to project any impact on benefit coverage, and so cannot project any impact on utilization.</p>	<p>CHBRP is unable to project any impact on benefit coverage, and so cannot project any impact on total health care expenditures.</p>	<p>CHBRP is unable to project any impact on benefit coverage, and so cannot project any impact on expenditures and PMPM amounts by payer category.</p>	<p>Among insured Californians:</p> <ul style="list-style-type: none"> • 11.4% smoke <p>Among Californians:</p> <ul style="list-style-type: none"> • 18.6% binge drink • 22.8% are obese 	<p>SB 189 could impact enrollee coverage or utilization of work-based wellness programs affecting health behaviors and outcomes such as tobacco use, excessive alcohol consumption, poor diet, physical inactivity, and related health outcomes.</p> <p>However, CHBRP is unable to estimate any change in coverage or utilization of work-based wellness programs. Therefore, the public health impact is unknown.</p>

Bill Summary	Medical Effectiveness of a Mandated Service or Treatment	Coverage	Estimated Utilization Impact of Mandate	Estimated Cost Impact in Terms of Total Health Care Expenditures (a)	Estimated Cost Impact in Terms of % Premium Changes by Payer (b)	Burden of Disease	Estimated Public Health Impact
<p>SB 126, Steinberg, Health care coverage: Pervasive Developmental Disorder or Autism (3/24/13)</p> <p>SB 126 would extend the sunset date of an existing state benefit mandate requiring coverage for behavioral health treatment for pervasive developmental disorder or autism (PDD/A). Specifically, the existing state benefit mandate, and thus SB 126, requires coverage for applied behavioral analysis (ABA) and other intensive behavioral intervention therapies for enrollees with PDD/A.</p>	<p>Literature suggests that intensive behavioral intervention therapies are more effective than usual treatment and less intensive intervention therapies in improving adaptive behavior and intelligence quotient. However, the literature is ambiguous as to the effects of intensive behavioral intervention therapy on language and academic placement.</p>	<p>Because SB 126 extends the sunset date of an existing benefit mandate, 100% of enrollees in DMHC-regulated plans and CDI-regulated policies subject to SB 126 currently have coverage for intensive behavioral intervention therapy.</p>	<p>No impact.</p> <p>It is estimated that of the 127,000 enrollees diagnosed with PDD/A in DMHC-regulated plans and CDI-regulated policies subject to SB 126, 12,700 currently use intensive behavioral intervention therapies.</p>	<p>No impact.</p> <p>Current annual expenditures for intensive behavioral intervention therapies among enrollees in DMHC-regulated plans and CDI-regulated policies subject to SB 126 is estimated to be \$686 million.</p>	<p>No impact.</p>	<p>CHBRP estimated the prevalence of PDD/A in California in 2012 is:</p> <ul style="list-style-type: none"> • 240/10,000 children aged 5 to 9; • 180.7/10,000 children aged 10 to 14; and • 133.4/10,000 children aged 15 to 19. <p>The lower prevalence rates in the older population are artifacts of differences in true risk, changes to diagnostic criteria, and other factors.</p> <p>CHBRP estimated there are 127,000 enrollees diagnosed with PDD/A in DMHC-regulated plans and CDI-regulated policies subject to SB 126.</p>	<p>No impact.</p>

Bill Summary	Medical Effectiveness of a Mandated Service or Treatment	Coverage	Estimated Utilization Impact of Mandate	Estimated Cost Impact in Terms of Total Health Care Expenditures (a)	Estimated Cost Impact in Terms of % Premium Changes by Payer (b)	Burden of Disease	Estimated Public Health Impact
<p>AB 912, Quirk-Silva, Health care coverage: Fertility Preservation (4/25/13)</p> <p>AB 912 would require group and individual market DMHC-regulated plans and CDI-regulated policies to provide coverage for “medically necessary expenses for standard fertility preservation services when a necessary medical treatment may directly or indirectly cause iatrogenic infertility to an enrollee.”</p>	<p>There are seven fertility preservation services for females, of which five are standard procedures. Of the five standard fertility preservation services for females, three—embryo cryopreservation, oocyte cryopreservation, and conservative gynecological surgery—have a preponderance of evidence that the method is effective.</p> <p>There are five fertility preservation services for males, of which two are standard procedures. Of the two standard fertility preservation services for males, one—sperm cryopreservation after masturbation—has a preponderance of evidence that the method is effective.</p>	<p>Currently, 1.6 million enrollees (8.3%) of the 19.4 million enrollees in DMHC-regulated plans and CDI-regulated policies subject to AB 912 have benefit coverage for fertility preservation services.</p>	<p>The number of males using sperm cryopreservation was estimated to increase 19%, from 1,051 to 1,249.</p> <p>The number of females using embryo cryopreservation was estimated to increase 175%, from 36 to 99.</p> <p>The number of females using oocyte cryopreservation also was estimated to increase 175%, from 36 to 99.</p>	<p>\$2.1 million (0.0015%)</p>	<p>PRIVATE</p> <p>Employers: 0.0024%</p> <p>Individuals w/group insurance: 0.0024%</p> <p>Individuals w/individual coverage: 0.0028%</p> <p>PUBLIC</p> <p>CalPERS: 0.003%</p> <p>Medi-Cal: N/A</p> <p>Enrollee out-of-pocket expenditures: 0.0024%</p>	<p>Because estimates of the incidence of all-cause iatrogenic infertility do not exist, most literature relies on rates of cancer among men and women of reproductive age as a proxy. In California, approximately 10% of the 145,000 new cancer cases diagnosed annually occur among cancer patients under the age of 45.</p> <p>Using probabilities of developing cancer by age and gender for the top 10 cancers most likely to lead to infertility, CHBRP estimates that 7,650 cancer patients enrolled in health plans subject to AB 912 would be at risk for infertility due to cancer treatments each year.</p>	<p>AB 912 is estimated to reduce the <i>net</i> financial burden by almost \$750,000 across enrollees who would have paid previously for uncovered fertility preservation services to prevent iatrogenic infertility.</p> <p>Annual long-term benefits include an estimates five additional male and four additional female cancer patients having a biologic child each year as a result of AB 912.</p>

Bill Summary	Medical Effectiveness of a Mandated Service or Treatment	Coverage	Estimated Utilization Impact of Mandate	Estimated Cost Impact in Terms of Total Health Care Expenditures (a)	Estimated Cost Impact in Terms of % Premium Changes by Payer (b)	Burden of Disease	Estimated Public Health Impact
<p>AB 889, Frazier, Prescription Drug Benefits (4/25/13)</p> <p>AB 889 prohibits DMHC-regulated health plans and CDI-regulated policies from requiring patients to try and fail more than two medications before allowing patients access to the initially prescribed medication, or a generic version of the same medication.</p>	<ul style="list-style-type: none"> The only study to directly evaluate the impact of fail-first protocols on a health outcome found that step therapy for NSAIDs had no statistically significant effect on quality of life among persons with chronic pain. Although the stated goal of fail-first protocols is not to prevent persons from receiving prescription medications, the preponderance of evidence suggests that this may occur for some persons. The generalizability of findings from these studies to AB 889 is unknown because none of these studies assessed fail-first protocols involving more than two steps and none compared a fail-first protocol with one or two steps to a fail-first protocol with more than two steps. 	<p>18.5% of enrollees subject to AB 889 have outpatient prescription drug coverage that includes medications that are subject to three or more steps in a fail-first protocol. If AB 889 were enacted, this would decline to 0%.</p>	<p>CHBRP estimates that 11.1 filled prescriptions per 1,000 enrollees annually are for drugs that are prescribed after the second step but before the final step in a specific therapeutic class.</p> <p>Postmandate, CHBRP estimates that with implementation of AB 889, the number of prescriptions filled for medications that are subject to three or more steps in a fail-first protocol would increase by 10%</p>	<p>Total net annual health expenditures are projected to increase \$26 million (0.0180%) (see Table 1). This increase in expenditures is due to a \$24.6 million total increase in health insurance premiums and a \$1.4 million increase in enrollee copayments associated with earlier use of final step medications.</p>	<p>PRIVATE</p> <p>Employers (0.0127%)</p> <p>Individuals w/group insurance (0.0119%)</p> <p>Individuals w/individual coverage (0.0000%)</p> <p>PUBLIC</p> <p>CalPERS (0.0000%)</p> <p>Medi-Cal (0.0883%)</p> <p>HFP (0.1597%)</p> <p>Members' out-of-pocket expenditures (c)</p> <p>Copayment (-0.0099%)</p> <p>Direct payment (0%)</p>	<p>There is insufficient data in the literature about the prevalence of more than two steps of fail-first protocols as would be prohibited in AB 889.</p>	<p>Unknown public health impact.</p>

Bill Summary	Medical Effectiveness of a Mandated Service or Treatment	Coverage	Estimated Utilization Impact of Mandate	Estimated Cost Impact in Terms of Total Health Care Expenditures (a)	Estimated Cost Impact in Terms of % Premium Changes by Payer (b)	Burden of Disease	Estimated Public Health Impact
<p>AB 460, Ammiano, Health care coverage: Infertility (4/19/13)</p> <p>AB 460 would modify an existing state benefit mandate that requires group market DMHC-regulated plans and CDI-regulated policies to <i>offer</i> coverage for the treatment of infertility. AB 460 would require that treatment for infertility be “offered and provided without discrimination.”</p>	<p>The medical effectiveness review focused on the impact of health insurance coverage for infertility treatment. There is evidence that infertility treatment benefit mandates are associated with an increase in utilization of infertility treatments. This is strongest for “mandates to cover” compared to “mandates to offer.”</p>	<p>Of the 14.4 million enrollees in DMHC-regulated plans and CDI-regulated policies subject to the existing infertility benefit mandate and thus AB 460, it is estimated that 10.1 million (or 70%) currently have coverage for at least one type of infertility treatment.</p>	<p>How discrimination would be interpreted as it relates to coverage of treatment for infertility is unknown, therefore the impact of AB 460 is unknown at the time of the CHBRP analysis. Therefore the estimated utilization impact of the mandate is unknown.</p>	<p>Unknown impact.</p>	<p>Unknown impact.</p>	<p>Of women aged 15 to 44 in the United States, over 7 million have impaired fecundity (ability to reproduce), over half of whom (4.2 million) are infertile. Of men, 7.3 million men report infertility problems. Over 7 million women have ever received any infertility treatment, with the most common being advice and infertility testing. Although infertility rates are highest among racial/ethnic minorities, the use of infertility treatments is highest among non-Hispanic white women.</p>	<p>Unknown impact.</p>

Bill Summary	Medical Effectiveness of a Mandated Service or Treatment	Coverage	Estimated Utilization Impact of Mandate	Estimated Cost Impact in Terms of Total Health Care Expenditures (a)	Estimated Cost Impact in Terms of % Premium Changes by Payer (b)	Burden of Disease	Estimated Public Health Impact
<p>AB 219, Perea, Oral Anticancer Medications (4/4/13)</p> <p>AB 219 prohibits cost sharing over \$100 per oral chemotherapy prescription.</p>	<p>The number of oral anticancer drugs has grown dramatically over the past decade, with 13 new drugs introduced since 2011. Many do not have IV equivalents.</p>	<p>N/A</p>	<p>No measureable increase</p>	<p>Total expenditures increase by \$454,000 (0.0003%)</p>	<p>PRIVATE Employers (0.0025%) Individuals w/group insurance (0.0024%) Individuals w/individual coverage (0.0037%) PUBLIC CalPERS (0.0000%) Medi-Cal (0.0000%) Enrollees' out-of-pocket expenditures (c) Copayment (-0.0176%) Enrollee expenses for noncovered benefits (-0%)</p>	<p>144,800 cancer cases/55,415 deaths in 2012.</p>	<p>No measurable change in utilization/therefore no expected reduction in premature death or economic loss</p>

Bill Summary	Medical Effectiveness of a Mandated Service or Treatment	Coverage	Estimated Utilization Impact of Mandate	Estimated Cost Impact in Terms of Total Health Care Expenditures (a)	Estimated Cost Impact in Terms of % Premium Changes by Payer (b)	Burden of Disease	Estimated Public Health Impact
2012							
<p>AB 2064, Pérez, Immunizations for Children (4/23/12)</p> <p>For plans and policies that provide coverage for childhood and adolescent immunizations, AB 2064 would prohibit cost sharing for administration of a childhood or adolescent immunization or for procedures related to administration. The mandate would also prohibit dollar-limit provisions for childhood or adolescent immunization-related procedures.</p>	<p>Due to the rigor and thoroughness of the ACIP systematic review on the efficacy and safety of vaccines, for the purposes of this report, CHBRP concludes that any vaccine that has been recommended as part of the routine immunization schedule has <i>clear and convincing evidence</i> that it is effective in preventing disease.</p>	<p>No change in benefit coverage, but an increase in compliant benefit coverage (+1.7%)</p>	<p>+ less than 100 immunizations</p>	<p>\$155,000 (+0.0001%)</p>	<p>PRIVATE</p> <p>Employers (0.0003%)</p> <p>Individuals w/group insurance (0.0004%)</p> <p>Individuals w/individual coverage (0.0052%)</p> <p>PUBLIC</p> <p>CalPERS (0%)</p> <p>Medi-Cal (0%)</p> <p>MRMIB (0.%)</p> <p>Members' out-of-pocket expenditures (c)</p> <p>Copayment (-0.0058%)</p>	<p>N/A</p>	<p>With fewer than 100 additional immunizations administered, no impact on California's rates of immunizations and vaccine-preventable diseases and their related mortality are expected. However, children whose parents abstained from or delayed immunization due to cost-sharing requirements for immunization-related procedures may benefit from AB 2064.</p>

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<p>AB 1800, Ma, Health Care Coverage (4/23/12)</p> <p>AB 1800 would require health care service plans and health insurance policies to provide coverage for at least two courses of treatment within a 12-month period for all tobacco cessation services rated “A” or “B” by the U.S. Preventive Services Task Force (USPSTF).</p> <p>It would also prohibit CDI-regulated policies and DMHC-regulated plans from:</p> <ul style="list-style-type: none"> • Imposing copayments, coinsurance, or deductibles for those services; and • Imposing prior authorization or stepped care⁷ requirements on tobacco cessation treatments. 	<p>The preponderance of evidence suggests that persons who face higher cost sharing use fewer health care services. No studies were found that directly address the sort of annual out-of-pocket maximum requirement proposed in AB 1800. No studies were found that addressed having a single deductible as opposed to separate deductibles for prescription drugs and other covered benefits. However, there is a preponderance of evidence from studies on high-deductible health plans (HDHPs) that enrollment in HDHPs is associated with poorer adherence to drug therapy for certain chronic conditions.</p>	<p>AB 1800 does not require new coverage for any tests, treatments, or services. AB 1800 modifies the terms and conditions of coverage for 21.7 million enrollees with coverage subject to AB 1800.</p> <p>For the annual out-of-pocket maximum requirement of AB 1800, 13.9 million enrollees were estimated to have coverage that was not compliant.</p>	<p>CHBRP estimated that there would not be a change in the number of users of health care services. However, due to a decrease in enrollee out-of-pocket expenses, CHBRP estimated an increase in utilization that would shift costs from enrollees to plans/policies. CHBRP estimated a 1% increase in plans/policies’ total medical costs per user and a 3% decrease in total medical costs per user paid by the user.</p>	<p>\$246.5 million (0.24%)</p>	<p>PRIVATE</p> <p>Employers (0.60%)</p> <p>Individuals w/group insurance (0.60%)</p> <p>Individuals w/individual coverage (0.96%)</p> <p>PUBLIC</p> <p>CalPERS, Medi-Cal, and MRMIB plans (0%)</p> <p>Enrollees’ out-of-pocket expenses for covered benefits: -\$275.5 million (3.23%)</p>	<p>N/A</p>	<p>To the extent that the financial burden from out-of-pocket expenses for covered benefits is reduced under AB 1800, there is a potential for a public health impact. However, due to a lack of data CHBRP was not able to estimate the potential magnitude.</p> <p>The increase in premiums in the CDI-regulated markets were estimated to result in an increase in the uninsured of 5,151.</p>

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<p>AB 1738, Huffman, Tobacco Cessation Services (4/20/12)</p> <p>AB 1738 would require a limit on annual out-of-pocket expenses for all covered benefits, including prescription drugs.</p>	<p>Counseling intervention, brief advice from physicians and clinical staff, and FDA-approved pharmacotherapy are effective treatments for tobacco cessation, as measured by abstinence or quit rates. The preponderance of evidence suggests that full coverage for these three treatments and services is associated with improved abstinence from smoking, relative to no coverage for these treatments.</p>	<p>Full coverage is defined as coverage for all three treatments/services: cessation counseling, FDA-approved prescription and over-the-counter drugs. CHBRP found that 79.4% of enrollees with state-regulated health insurance had benefit coverage for counseling, 21.5% had benefit coverage for OTC drugs, and 23.5% had benefit coverage for prescription drugs.</p>	<p>Utilization would increase by 27.4% or 83,300 individuals using one or more services.</p>	<p>Net increase of \$38.4 million or .04%.</p> <p>Out-of-pocket expenses would be reduced by \$11.1 million. Noncovered expenses reduced by \$16.3 million.</p>	<p>PRIVATE Employers: Group market (0.06%) Individual market (0.18%) PUBLIC CalPERS HMO (0.09%) Medi-Cal HMO (0%) MRMIB(0.03%)</p>	<p>Percentage mortality attributable to smoking (though not limited to these conditions):</p> <ul style="list-style-type: none"> • 19% of heart disease mortality • 6% trachea cancer • 5% bronchus cancer • 5% lung cancer 	<p>Increase successful quitters by 5,287 per year; between 37,009 and 65,559 life years gained.</p>

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2011							
<p>SB TBD 1, Steinberg, Mental Illness: Autism (5/20/11)</p> <p>SB TBD 1 would require coverage of intensive behavioral intervention therapy for PDD/A. The bill defines intensive behavioral intervention therapy as including but not being limited to applied behavioral analysis (ABA). Although current mental health parity law in California requires that coverage be provided for medically necessary treatment of PDD/A, including outpatient services, it does not specify that coverage is required for intensive behavioral intervention therapy. Therefore, SB TBD 1 would alter the current mandate.</p>	<p>For persons with Autistic Disorder or Pervasive Developmental Not Otherwise Specified (PDD-NOS) aged 18 months to 9 years receiving intensive behavioral intervention therapy (IBIT), there is a preponderance of evidence suggesting that IBIT is more effective than other therapies for improving adaptive behavior and intelligence quotient.</p>	<p>14.5 million enrollees would gain coverage for IBIT as a treatment for PDD/A (any of five disorders: Autistic Disorder; PDD-NOS; Childhood Disintegrative Disorder; Retts Disorder; Asperger’s Disorder).</p>	<p>+521% (includes utilization by enrollees with any of the five disorders included in PDD/A)</p>	<p>+\$93 million (+0.1%)</p>	<p>PRIVATE</p> <p>Employers (+0.24%)</p> <p>Individuals w/group insurance (+0.27%)</p> <p>Individuals w/individual coverage (+0.14%)</p> <p>PUBLIC</p> <p>CalPERS HMOs (+0.26%)</p> <p>Medi-Cal Managed Care Plans (+0.00%)</p> <p>MRMIB Plans (+3.54%)</p> <p>ENROLLEE</p> <p>Enrollee out-of-pocket expenses for covered benefits (c) (+0.23%)</p> <p>Enrollee expenses for noncovered benefits (-44.67%)</p>	<p>Approximately 77,000 enrollees have PDD/A.</p>	<p>For some enrollees with PDD/A, particularly those between the ages of 18 months and 9 years and those diagnosed with Autistic Disorder or PDD-NOS, SB TBD 1 would result in improved adaptive behaviors and IQ.</p> <p>For some enrollees, SB TBD 1 would result in a decreased financial burden.</p>

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<p>AB 1000, Perea, Cancer Treatment (4/21/11)</p> <p>AB 1000 would mandate that plans and policies which provide coverage for cancer chemotherapy treatment be required to review the percentage cost share for oral nongeneric anticancer medications and injected/intravenous nongeneric anticancer medications and apply the lower of the two as the cost-sharing provision for oral nongeneric anticancer medications. It would also require plans to provide coverage for a prescribed, orally administered, nongeneric cancer medication used to kill or slow the growth of cancerous cells, and not provide for an increase in enrollee cost sharing for nongeneric cancer medications.</p>	<p>AB 1000 would apply to such a large number of oral anticancer medications for such a wide range of cancers that a systematic review of the literature on the effectiveness of all of them was not feasible</p> <p>When compared to intravenous and injectable anticancer medications, oral anticancer medications have both advantages and disadvantages. Advantages are that oral anticancer medications may allow administration of the medication on a daily basis, may be more convenient for patients, and may reduce the risk of infection or other infiltration complications. Disadvantages include less certainty in patient adherence to treatment regimens and a reduction in interaction between patients and their health care providers to manage complications of treatment.</p>	<p>Although AB 1000 is not expected to expand benefit coverage, CHBRP estimates that almost all enrollees with health insurance subject to the mandate have at least some coverage for anticancer medications.</p>	<p>CHBRP estimates that 0.3% of enrollees with health insurance subject to the mandate will use nongeneric oral anticancer medications during the year following implementation.</p> <p>CHBRP does not estimate a measurable increase in the number of oral anticancer medications users nor a measurable increase in the number of prescriptions per user</p>	<p>AB 1000 would shift some nongeneric oral anticancer medication costs from users to health plans and insurers through reduced cost sharing. In total, users would see a reduction in out-of-pocket costs of an estimated \$2,650,000 due to lesser cost-sharing requirements.</p> <p>On average, the amount of the shift is estimated to be \$100.28 per user per year.</p> <p>Postmandate amounts shifted from users to plan/insurer would range from \$0 to \$18,262 per user per year.</p> <p>Total net annual expenditures are estimated to increase by \$487,000, or 0.0005%, mainly due to the administrative costs associated with the implementation of AB 1000.</p>	<p>The mandate is estimated to increase premiums by about \$3,137,000 (0.0036%). The distribution of the impact on premiums is as follows:</p> <p>Private employers (0.0039%)</p> <p>Group insurance (0.0036%)</p> <p>Individually purchased insurance (0.0084%)</p> <p>Increases vary by privately purchased market segment, ranging from approximately 0.0030% (DMHC-regulated large-group plans) to 0.0139% (CDI-regulated individual policies).</p> <p>Increases as measured by per member per month (PMPM) payments are estimated to range from approximately \$0.0120 (DMHC-regulated large-group plans) to \$0.0383 (CDI-regulated small-group policies).</p>	<p>Breast cancer is the most prevalent cancer in California, almost exclusively affecting women. Approximately 70% of the prescriptions and 31% of the total cost for nongeneric oral anticancer medications are for drugs used to treat breast cancer.</p>	<p>CHBRP does not project a measurable increase in utilization of oral anticancer medications as a result of AB 1000. Therefore, the only potential public health impact as a result of AB 1000 is a reduction in out-of-pocket costs for oral anticancer medications.</p>

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<p>AB 652, Mitchell, Child Health Assessments (4/18/11)</p> <p>AB 652 includes two benefit mandates that fall under CHBRP’s purview for analysis. The first would require health plans and insurers to provide an initial health assessment for children who have “out-of-home” placements.</p> <p>The second benefit mandated by AB 652 pertains to coverage of forensic medical evaluations.</p>	<p>There is a preponderance of evidence that the following preventive services for children and adolescents are effective: immunizations recommended by the CDC, screening children younger than 5 years for visual impairment, screening of children age 6 and older for obesity, screening of adolescents for major depressive disorder, screening newborns for hearing loss, providing Pap smears to sexually active adolescent females, screening sexually active females for chlamydial infections, counseling to prevent sexually transmitted infections among adolescents</p> <p>There is <i>insufficient evidence</i> to recommend the following preventive services: screening asymptomatic children for iron deficiency anemia, screening for elevated blood lead levels among those at increased risk for it , counseling children/adolescents regarding nutrition, interventions to prevent and treat tobacco use, counseling adolescents regarding alcohol use</p>	<p>Of the population subject to the mandate, 13.5% of enrollees have coverage for forensic medical evaluations (Table 1). If AB 652 were enacted, 100% of this population would have full coverage for forensic medical evaluations paid for by their health insurance.</p> <p>CHBRP estimates no measurable impact of the mandate on the number of uninsured due to premium increases.</p>	<p>CHBRP estimated that 9.1% of physical and sexual abuse allegations receive a forensic medical evaluation each year. According to the Center for Social Services Research Child Welfare Dynamic Report System, in 2009 there were 133,169 child abuse allegations (for physical and sexual abuse) in California.</p> <p>Therefore, among individuals in health plans and policies affected by the mandate, CHBRP estimates that there are approximately 9,000 forensic medical evaluations performed yearly and of those, about 1,000 enrollees receiving an evaluation currently have coverage.</p>	<p>CHBRP estimated the average per-unit cost of forensic medical evaluations to be \$735.</p> <p>Total health expenditures are projected to increase by approximately \$911,000 (0.0010%) for the year following implementation of the mandate</p>	<p>The mandate is estimated to increase premiums by about \$6.86 million. The distribution of the impact on premiums is as follows:</p> <p>Private employers for group insurance: 0.0047%</p> <p>Individually purchased insurance: 0.0069%</p> <p>CalPERS HMOs: 0.0051%.</p> <p>Group insurance, CalPERS HMOs, Healthy Families Program, AIM or MRMIP: 0.0054%.</p> <p>Medi-Cal Managed Care Plans: 0.0250%.</p> <p>MRMIB Plans: 0.0701%.</p> <p>Increases as measured by PMPM premiums are estimated to range from an average of \$0.01 to \$0.08.</p>	<p>N/A</p>	<p>The standard public health outcomes for evaluating health benefit coverage are not applicable in the case of forensic medical evaluations.</p> <p>CHBRP found no evidence in the literature related to forensic exams and health outcomes. Therefore, the public health impact is unknown.</p> <p>Although AB 652 could impact utilization of forensic medical evaluations, CHBRP is unable to estimate any change in utilization. Therefore, the public health impact is unknown.</p>

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<p>AB 428, Portantino, Fertility Preservation (4/15/11)</p> <p>AB 428 would require health plans and policies to cover “medically necessary expenses for standard fertility preservation services when a necessary medical treatment may directly or indirectly cause iatrogenic infertility to an enrollee.”</p>	<p>Medical effectiveness of fertility preservation varies depending on the type of procedure:</p> <ul style="list-style-type: none"> • There is a preponderance of evidence that sperm cryopreservation with sperm collected through ejaculate, embryo cryopreservation, and conservative gynecologic surgery are effective methods of fertility preservation. • There is insufficient evidence to conclude that ovarian transposition and testicular/ovarian shielding during radiation are effective methods of fertility preservation. 	<p>AB 428 would apply to the 21.9 million enrollees in all DMHC-regulated, privately funded plans and DMHC-regulated, publicly funded plans, as well as all CDI-regulated policies. Standard medical services for fertility preservation include procurement and storage of sperm and embryos.</p> <p>Approximately 5.4% of the 21.9 million enrollees currently have coverage for fertility preservation services. If enacted, AB 428 would increase this to 100% of enrollees.</p> <p>No publicly funded DMHC-regulated plans currently include coverage for fertility preservation services.</p>	<p>CHBRP estimates that currently, 1,057 male enrollees use sperm cryopreservation and 222 female enrollees use embryo cryopreservation.</p> <p>If AB 428 is enacted, CHBRP estimates total postmandate utilization to equal 1,263 male enrollees and 578 female enrollees. This is primarily due to the reduction in costs associated for benefits that were previously not covered. This represents a 19% increase among male enrollees and a 161% increase among female enrollees.</p> <p>In total, postmandate, CHBRP estimates a 44% increase in the use of fertility preservation services, as measured by the number of new users.</p>	<p>Total net health expenditures are projected to increase by \$6.5 million (0.0068%) (Table 1). This is due to an \$8.5 million increase in premiums partially offset by a net reduction in enrollee out-of-pocket expenditures of \$2 million, comprised of a reduction in enrollee expenses for noncovered benefits (\$3.2 million) and an increase in enrollee out-of-pocket expenses for the newly covered benefits (\$1.2 million).</p>	<p>Increases in per member per month (PMPM) premiums for the newly mandated benefit coverage vary slightly by market segment. Increases as measured by percentage changes in PMPM premiums are estimated to range from an average of 0.00% (for DMHC-regulated Medi-Cal Managed Care plans for ages 65+) to an average of 0.0173% (for CDI-regulated individual policies) in the affected market segments.</p> <p>Among publicly funded DMHC-regulated plans, CHBRP estimates that premiums will increase for Medi-Cal Managed Care Plans, Managed Risk Medical Insurance Board (MRMIB) Plans, and CalPERS HMOs. The increase would range from an average of 0.00% to 0.0125%.</p>	<p>Loss of fertility can negatively impact the quality of life for cancer survivors of reproductive age. As a result of AB 428, it is expected that the quality of life could improve for some of the 6,346 cancer patients at risk for iatrogenic infertility each year who would gain coverage for fertility preservation services.</p>	<p>Although CHBRP is unable to quantify the effects, there would likely be a benefit to patients of reproductive age being treated for autoimmune disorders such as Crohn’s disease, where loss of fertility may result from treatment of their disease.</p> <p>AB 428 would decrease expenses paid directly by enrollees who use fertility preservation services by almost \$2 million. Therefore, AB 428 is estimated to reduce financial hardship for enrollees who face the risk of iatrogenic infertility.</p> <p>No evidence was found on potential disparities in the use of fertility preservation treatments by race/ethnicity. Therefore, the extent to which AB 428 would have an impact on disparities is unknown.</p>

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<p>AB 369, Huffman, Pain Prescriptions (4/14/11)</p> <p>AB 369 would allow DMHC-regulated plans and CDI-regulated policies to use fail-first protocols as methods of utilization management for pain medications.</p>	<p>CHBRP finds insufficient evidence to characterize the medical effectiveness of fail-first protocols (including those protocols that would exceed two trials of alternatives, as addressed by AB 369) for pain medications. Therefore, CHBRP concludes that the impact of AB 369 on the medical effectiveness of pain treatment is unknown. The <i>lack of evidence</i> for the effectiveness of fail-first protocols does not prove that use of such protocols leads to either positive or negative health outcomes.</p>	<p>Of the 21.9 million Californians enrolled in DMHC-regulated plans and CDI-regulated policies, approximately 20.9 million have outpatient prescription drug benefit coverage.</p> <p>Approximately 45.5% of enrollees with an outpatient pharmacy benefit have coverage for at least one pain medication which is subject to a fail-first protocol.</p>	<p>Because fail-first protocols can vary by plan contract or policy, as well as by health plan or insurer, and because the clinical considerations that would cause a patient to fail trials of more than two alternate medications are so complex, CHBRP lacks sufficient information to estimate the change in utilization or cost for enrollees whose prescribed medications may be subject to a fail-first protocol not compliant with AB 369. In addition, as mentioned most fail-first protocols appear to already comply with AB 369 in that they do not have requirements to try and fail more than twice.</p>	<p>AB 369 would not be expected to impact total health care costs for enrollees in DMHC-regulated health plans and CDI-regulated health policies.</p>	<p>CHBRP assumes that the administrative cost proportion of premiums would be unchanged because there is no increase in coverage, utilization, or costs.</p> <p>However, this analysis has not addressed the possible impacts that could result from AB 369's requirements beyond the prohibition of fail-first protocols that include trial of more than two alternate medications.</p> <p>The stipulations AB 369 includes regarding provider determination of the length of a trial for an alternate medication and the requirement that provider chart notes and/or a provider's note on a prescription suffice as proof of completion of a fail-first protocol may have administrative and costs impacts on health plans and insurers.</p>	<p>Pain is a prevalent condition in the U.S. population, with approximately 26% of adults experiencing chronic pain (i.e., pain lasting 6 months or longer). Pain varies widely in its presentation and duration and is caused by a wide array of known and unknown origins.</p>	<p>Although there is some evidence that fail-first protocols studied for conditions other than pain can lead to lower levels of patient satisfaction, delays in receiving medications, and higher rates of unfulfilled prescriptions, this research is not generalizable to populations outside of those studied. Therefore, the impact of AB 369 on patient satisfaction, delays in receiving medication, or higher rates of unfilled prescriptions is unknown.</p> <p>CHBRP did not identify any literature that examined the relationship between fail-first protocols and gender or race/ethnicity. Therefore, the impact of AB 369 on gender and racial/ethnic disparities and the differential impacts by subpopulation on pain management is unknown.</p>

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<p>AB 310, Ma, Prescription Drugs (4/14/11)</p> <p>AB 310 would:</p> <ul style="list-style-type: none"> Prohibit coinsurance as the basis for cost sharing for outpatient prescription drug benefits Limit copayments for outpatient prescription drugs to \$150 per one-month supply or its equivalent for prescriptions for longer periods If a plan or policy has an annual out-of-pocket maximum, require outpatient prescription drug benefit cost sharing to be included under that annual out-of-pocket maximum. 	<p>Prescription drugs can be divided into two major categories: traditional agents and specialty drugs. The medical effectiveness analysis for AB 310 focused on the impact of cost sharing (i.e., the portion of expenditures paid by enrollees) on use of prescription drugs.</p> <p><u>Specialty drugs</u></p> <p>The <i>preponderance of evidence</i> from these studies suggests that demand for specialty drugs is sensitive to price but that the size of the effect is small. Estimates of the price elasticity of demand⁶ for specialty drugs suggest that each 10% increase in cost sharing for specialty drugs would reduce spending for these drugs by 0.1% to 2.1% depending on the disease a specialty drug is used to treat.</p> <p><u>Traditional drugs</u></p> <p>The <i>preponderance of evidence</i> from these studies suggests that demand for traditional agents is more sensitive to price than demand for specialty drugs.</p>	<p>AB 310 applies to all plans and policies that have an outpatient prescription drug benefit (96% of the plans and policies that may be subject to state level mandates).</p> <p>Therefore, the mandate would directly affect the health insurance of 20.9 million people (56% of Californians).</p>	<p>Premandate, CHBRP estimates that 0.018% of enrollees with outpatient prescription drug benefit have filled prescriptions where the cost share exceeded \$150 for a one-month supply. The utilization rate among such persons was approximately 8.8 prescriptions per 1,000 enrollees. These enrollees' out-of-pocket costs were on average \$271 per prescription.</p> <p>Postmandate, overall utilization rates are expected to change. Prescriptions for which coinsurance cost sharing would have exceeded \$150 per one-month supply would be limited to that amount. The average cost share for those prescriptions would therefore fall from \$271 premandate to \$150 per one-month supply postmandate. As a result, CHBRP estimates an 4% increase in utilization for these prescriptions.</p>	<p>Total net health expenditures are projected to increase by \$31.7 million (0.033%) (Table 1). This is due to a \$220.3 million increase in health insurance premiums partially offset by reductions in enrollee cost sharing (\$188.6 million).</p> <p>There are likely to be long-term cost impacts but the magnitude is unknown at this time. Advances in drug development are likely to yield new, higher-cost drugs. CHBRP recognizes that a decrease in out-of-pocket expenditures may interact with these trends and thereby further increase the demands for these medications as a result of AB 310.</p>	<p>Premium expenditures by private employers for group insurance: 0.2907%</p> <p>Premium expenditures for individually purchased insurance: 0.1741%</p> <p>Premium expenditures by persons with group insurance, CalPERS HMOs, Healthy Families Program, AIM or MRMIP: 0.2927%</p> <p>CalPERS HMO employer expenditures: 0.3167%</p> <p>Medi-Cal Managed Care Plan expenditures: 0.0000%</p> <p>MRMIB Plan expenditures: 0.0000%</p>	<p>Prescription drugs can be divided into two major categories: traditional agents and specialty drugs.</p> <p>Specialty drugs are new, high-cost drugs, primarily biologics that are primarily used to treat complex chronic conditions, such as anemia, cancer, growth hormone deficiency, hemophilia, hepatitis, multiple sclerosis, and rheumatoid arthritis.</p> <p>Traditional agents consist of generic and brand-name drugs that are produced using traditional pharmaceutical manufacturing processes. They are used to treat a wide range of chronic and acute conditions. They play major roles in the prevention and treatment of common conditions such as heart disease, diabetes, asthma, and depression.</p>	<p>CHBRP estimates no public health impact of the provision capping copayments at \$150 per prescription per one-month supply since CHBRP estimates that no enrollees are currently in plans and policies with outpatient prescription drug copayments exceeding \$150.</p> <p>AB 310's provision requiring those plans or policies that have an annual OOP maximum to include out-of-pocket cost for the prescription drug benefit may have a public health impact; however, given lack of evidence and data, the potential public health impact is unknown.</p>

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<p>SB 255, Pavley, Breast Cancer (4/14/11)</p> <p>SB 255 would amend existing California law by clarifying the definition of mastectomy to specify that partial removal of the breast includes, but is not limited to, lumpectomy. Lumpectomy includes surgical removal of the tumor with clear margins. The bill would require coverage of postsurgery consultation regarding the length of any hospital stay.</p>	<p>Breast cancer is typically treated through a combination of surgery and/or radiation, chemotherapy, and hormone therapy. Women with early stage breast cancer are often given two options for initial treatment: mastectomy or lumpectomy plus radiation.</p> <p>There is clear and convincing evidence from multiple randomized controlled trials (RCTs) that rates of overall survival and local/regional recurrence of breast cancer are equivalent for women with stage I or II breast cancer who are treated with mastectomy or lumpectomy plus radiation.</p> <p>There is clear and convincing evidence from multiple RCTs that women with stage I or II breast cancer who receive lumpectomy with radiation have a lower rate of in-breast recurrence of breast cancer than women with stage I or II cancer who receive lumpectomy alone. There is also a preponderance of evidence that they also have a lower rate of death from all causes.</p>	<p>DHMC-regulated plans and CDI-regulated policies are estimated to be currently compliant with the provision in SB 255 of medically necessary lumpectomy upon provider referral. Therefore, no measurable change in coverage for these services is expected.</p>	<p>As no measurable change in benefit coverage is expected (100% of female enrollees in DMHC-regulated plans and CDI-regulated policies are estimated to be in compliant plans), no measurable change in utilization is projected.</p>	<p>As no measurable change in benefit coverage is expected, no measurable changes in total premiums and total health care expenditures are expected.</p>	<p>SB 255 would not be expected to increase total expenditures and PMPM premiums in the large-group, small-group, or individual markets for DMHC-regulated plans or CDI-regulated policies. Total expenditures and PMPM premiums in CalPERS HMOs, Medi-Cal Managed Care, and MRMIB plans are not expected to increase.</p>	<p>Breast cancer is the most commonly diagnosed cancer in California. In 2008, there were nearly 30,000 new cases of breast cancer diagnosed. This translates to an annual age-adjusted incidence rate of 153.1 cases of breast cancer per 100,000 women in California. An average woman's lifetime risk of being diagnosed with breast cancer in California is one in eight. There are nearly 300,000 women currently living with breast cancer in California.</p>	<p>Although lumpectomy procedures are medically effective treatments for DCIS, stage I, and some stage II cancers, CHBRP finds that no change in enrollee coverage or utilization of this treatment would occur through SB 255. Therefore, CHBRP anticipates no public health impact on short- and long-term health outcomes, possible disparities, premature death, or economic loss related to breast cancer or its treatment through lumpectomy procedures.</p>

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<p>SB 173, Simitian, Mammograms (4/7/11)</p> <p>SB 173 contains two separate mandates:</p> <p>SB 173 would require DMHC-regulated plans and CDI-regulated policies to cover “comprehensive breast cancer screening” for enrollees whose mammograms indicate they have dense or heterogeneous breast tissue and for enrollees “believed to be” at increased risk for breast cancer.</p> <p>SB 173 would also require that mammography reports issued by DMHC-regulated plans or CDI-regulated policies contain information about breast density and, when applicable, a recommendation to persons with dense breasts to pursue supplementary screening tests.</p>	<p>There is clear and convincing evidence that mammography is an effective breast cancer screening method. There is insufficient evidence to state whether breast magnetic resonance imaging BMRI or ultrasound is effective.</p>	<p>No measurable impact.</p>	<p>No measurable impact.</p>	<p>No measurable impact.</p>	<p>No measurable impact.</p>	<p>In California, breast cancer is one of the most commonly diagnosed cancers but survival rates are high when it is diagnosed at an early stage.</p>	<p>No measurable impact.</p>

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<p>SB 136, Yee, Tobacco Cessation (4/7/11)</p> <p>SB 136 would require health care service plans and health insurance policies to include coverage for smoking cessation services, including:</p> <p>Telephone, group, or individual counseling.</p> <p>All prescription and over-the-counter (OTC) medications approved by the Food and Drug Administration (FDA) to help smokers quit, including drugs for nicotine replacement therapy (NRT) and prescription drug therapies in, but not limited to, the form of gum, dermal patch, inhaler, nasal spray, and lozenge, varenicline, and bupropion SR6 or similar drugs that counter the urge to smoke or the addictive qualities of nicotine.</p>	<p>The literature on the efficacy of behavioral interventions (e.g., counseling, brief advice) and pharmaceuticals for smoking cessation is large and includes numerous meta-analyses of randomized controlled trials (RCTs), the strongest form of evidence for CHBRP analyses. These meta-analyses provide clear and convincing evidence that behavioral and pharmacological treatments and combinations of the two improve quit rates and increase the likelihood of sustained abstinence from smoking. These conclusions about the efficacy of smoking cessation interventions are not likely to be diminished or altered with the publication of new studies, because of the large quantity of literature summarized in the meta-analyses.</p>	<p>Of the population subject to the mandate, 82.5% of enrollees have mandate-compliant coverage for smoking cessation-related counseling and 98.8% have mandate-compliant coverage for prescription smoking cessation treatment, but a lower percentage (62.0%) have mandate-compliant coverage for over-the-counter (OTC) smoking cessation treatment. If SB 136 were enacted, 100% of this population would have mandate-compliant coverage for smoking cessation treatments.</p>	<p>Premandate, of the 1.93 million adult smokers enrolled in DMHC- or CDI-regulated plans or policies, 308,604 used one or more smoking cessation treatments, with 252,226 using treatments covered through their existing insurance and 56,378 enrollees using treatments for which they were not covered.</p> <p>Postmandate, of the 1.93 million insured adult smokers, CHBRP estimates that the utilization of counseling services would increase by 9.2%, OTC treatments by 19.8%, and prescription treatments by 0.6%.</p> <p>In total, the utilization of one or more smoking cessation treatments would increase by 11.2%, representing an additional 34,660 insured adult smokers receiving treatment postmandate.</p>	<p>Total net health expenditures are projected to increase by \$16.4 million (0.017%). This is due to a \$32.9 million increase in health insurance premiums and enrollee expenses for newly covered benefits, partially offset by a reduction in enrollee out-of-pocket expenditures for previously noncovered benefits (\$16.5 million).</p>	<p>Increases in per member per month (PMPM) premiums for the newly mandated benefit coverage vary by market segment. Increases as measured by percentage changes in PMPM premiums are estimated to range from an average increase of 0.00% (for DMHC-regulated Medi-Cal Managed Care Plans) to an average increase of 0.17% (for CDI-regulated individual policies) in the affected market segments.</p> <p>Among publicly funded DMHC-regulated health plans, CHBRP estimates that premium increases for Medi-Cal Managed Care Plans, MRMIB plans and CalPERS HMOs would range from average increases of 0.00% to 0.05%.</p>	<p>Tobacco use is the leading preventable cause of death in the United States and California. An estimated 443,000 deaths per year are attributable to tobacco use, or one in five deaths annually. Smoking leads to lung cancer, coronary heart disease, chronic lung disease, stroke, and other cancers. Smoking cessation—that is, quitting completely—is the only safe alternative. Smoking cessation, however, is a complex process: there are typically multiple quit attempts, degrees of “quitting” (i.e., cutting down consumption), high rates of relapse, and more choices of cessation treatments. Common forms of smoking cessation treatment include counseling, nicotine replacement therapy, and antidepressant and prescription cessation medications.</p>	<p>CHBRP estimates that due to clear and convincing evidence of effectiveness of smoking cessation treatments and increased enrollee coverage, SB 136 would produce a positive public health impact by increasing the number of successful quitters by 2,364 enrollees annually.</p> <p>CHBRP finds clear and convincing evidence that smoking cessation is a cost-effective preventive treatment that results in improvements in long-term in multiple health outcomes and reduces both direct medical costs and indirect costs associated with smoking. CHBRP estimates between 16,548 to 29,314 life years would be gained annually under the new mandate.</p>

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<p>SB 155, Evans, Maternity Services (4/1/11)</p> <p>SB 155 would require health insurance policies regulated by the CDI to cover maternity services, therefore affecting the health insurance of approximately 2.86 million Californians (13% under state-regulated health insurance).</p>	<p>Studies of prenatal care can be divided into two major groups:</p> <ul style="list-style-type: none"> • Studies of the impact of variation in the number of prenatal care visits that pregnant women receive, and • Studies of the effectiveness of specific medical services provided to pregnant women (e.g., laboratory tests and medications). <p>Randomized controlled trials (RCTs) have consistently found no statistically significant association between the number of prenatal visits pregnant women receive and birth outcomes for either infants or for mothers. However, there is clear and convincing evidence from multiple RCTs that several prenatal care services are effective in producing better birth outcomes for mothers and infants.</p>	<p>SB 155 would apply only to CDI-regulated health insurance policies subject to the California Insurance Code. It would require all CDI-regulated policies to cover maternity services. About 2,858,000 Californians, or 13% of enrollees in health insurance plans and policies subject to state regulation, are in the CDI-regulated market.</p> <p>SB 155 would expand maternity services coverage to approximately 1,184,000 enrollees with CDI-regulated individual policies, including about 268,181 women aged 19 to 44 years.</p>	<p>CHBRP estimates that approximately 8,574 pregnancies would be newly covered under CDI-regulated insurance policies postmandate.</p> <p>CHBRP is unable to estimate the precise impact SB 155 would have on the utilization of prenatal care.</p>	<p>Among all enrollees in state-regulated policies (both CDI-regulated and DMHC-regulated), total annual health expenditures are estimated to increase by \$22.2 million, or 0.02%, as a result of this mandate.</p>	<p>Mandating maternity coverage is expected to increase per member per month (PMPM) premiums for CDI-regulated individual policies by \$6.92, or 3.5%, on average.</p> <p>Premium impacts are summarized as follows:</p> <p>CHBRP estimates that for the majority (88%) of enrollees in the CDI-regulated individual market who do not currently have maternity benefits, SB 155 would <i>increase</i> average premiums by 2% to 28% among those aged 19 to 44 years, depending on the age of the enrollee.</p> <p>Among the minority (12%) of enrollees in the CDI-regulated individual market who currently have maternity benefits, SB 155 is expected to <i>decrease</i> average premiums by 0.5% to 23%, depending on the age of the enrollee among those aged 19 to 44 years.</p>	<p>SB 155 mandates coverage for maternity services. Maternity services generally include prenatal care, such as office visits and screening tests; labor and delivery services, including hospitalization; care resulting from complications related to a pregnancy; and postnatal care. In 2009, there were more than 526,000 births in California, of which 3.1% were to women either not receiving prenatal care or receiving prenatal care starting in the third trimester.</p>	<p>To the extent that SB 155 increases utilization of effective prenatal care services, there is a potential that this mandate could lead to a reduction in infant and maternal mortality and improve health outcomes, such as the rates of low birth weight or preterm births, infectious disease transmissions, and respiratory distress syndrome.</p>

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<p>AB 185, Hernández, Maternity Services (03/27/11)</p> <p>AB 185 would require health insurance policies regulated by the CDI to cover maternity services.</p>	<p>Evidence shows that there is no difference in birth outcomes for infants or mothers in association with the number of prenatal visits.</p> <p>However, there is clear and convincing evidence from multiple RCTs that a number of prenatal care services that are provided during those prenatal care visits are effective in providing better birth outcomes (i.e., counseling; screening tests; diagnostic and preventive services; supplements).</p>	<p># of individuals in CDI-regulated policies with maternity coverage, in:</p> <p><i>Large- and small-group policies,</i> Before: 1,515,000 (100%)</p> <p><i>Individual plans,</i> Before: 159,000 After: 1,343,000 Change: 963,000 (745% increase)</p> <p><i>All CDI-regulated policies (total),</i> Before: 1,475,000 After: 2,438,000 Change: 1,184,000 (71% increase)</p>	<p>+\$40.0 million (+0.1%) for the entire DMHC and CDI-regulated marketplace.</p>	<p>PRIVATE</p> <p>Employers (0%)</p> <p>Individuals w/group insurance (0%)</p> <p>Individuals w/individual coverage (+2%)</p> <p>PUBLIC</p> <p>CalPERS (0%)</p> <p>Medi-Cal (0%)</p> <p>HFP (0%)</p> <p>Members' out-of-pocket expenditures (c)</p> <p>Copayment (+0.4%)</p> <p>Direct payment (-100%)</p>	<p>An upper bound estimate would assume that all 8,574 newly covered pregnancies would have financial barriers to prenatal care removed and thus an increase in the utilization of effective prenatal care services, and corresponding health outcomes would be expected. A lower bound estimate would assume that there will be no increase in the utilization of effective prenatal care services because these pregnant women will likely still face high out-of-pocket costs.</p> <p>To the extent that AB 185 increases the utilization of effective prenatal care, there is a potential to reduce economic loss associated with preterm births and related mortality.</p>	<p>AB 185 (De La Torre) Maternity Services AB 185 would require health insurance policies regulated by the California Department of Insurance (CDI) to cover maternity services.</p> <p>AB 185 defines maternity services to include prenatal care, ambulatory care maternity services, involuntary complications of pregnancy, neonatal care, and inpatient hospital maternity care including labor and delivery and postpartum care.</p>	<p>Evidence shows that there is no difference in birth outcomes for infants or mothers in association with the number of prenatal visits.</p> <p>Evidence suggests that a number of prenatal care services that are provided during those prenatal care visits are effective in providing better birth outcomes (i.e., counseling; screening tests; diagnostic and preventive services; supplements).</p>

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<p>AB 171, Beall, Autism (3/26/11)</p> <p>AB 171 would require coverage for “screening” and “diagnosis” relevant to pervasive developmental disorders or autism (PDD/A).</p> <p>It would require that benefit coverage be provided under terms and conditions no less favorable than the terms and conditions for benefit coverage provided by the plan or policy for “physical illness.” It would require that benefit coverage be extended to “all medically necessary services.”</p>	<p>Evidence from a small number of studies suggests that there are effective tests for screening children for PDD/A and diagnosing children suspected of having PDD/A.</p> <p>For persons with Autistic Disorder or Pervasive Developmental Not Otherwise Specified (PDD-NOS) aged 18 months to 9 years receiving intensive behavioral intervention therapy (IBIT), there is a preponderance of evidence suggesting that IBIT is more effective than other therapies for improving adaptive behavior and intelligence quotient.</p> <p>A preponderance of evidence suggests that a number of medication are effective in treating behaviors associated with PDD/A.</p>	<p>18.4 million enrollees would gain coverage for IBIT as a treatment for PDD/A (any of five disorders: Autistic Disorder; PDD-NOS; Childhood Disintegrative Disorder; Retts Disorder; Asperger’s Disorder).</p> <p>267,000 enrollees would gain coverage for medication for PDD/A.</p> <p>1.3 million enrollees would gain coverage for durable medical equipment (DME) for PDD/A</p>	<p>The following figures include utilization by enrollees with any of the five disorders included in PDD/A)</p> <p>IBIT (+764%)</p> <p>Prescription Drugs (+1.15%)</p> <p>DME (+0.00%)</p>	<p>+\$138 million (+0.14%)</p>	<p>PRIVATE</p> <p>Employers (+0.24%)</p> <p>Individuals w/group insurance (+0.27%)</p> <p>Individuals w/individual coverage (+0.15%)</p> <p>PUBLIC</p> <p>CalPERS HMOs (+0.26%)</p> <p>Medi-Cal Managed Care Plans (+1.32%)</p> <p>MRMIB Plans (+3.54%)</p> <p>ENROLLEE</p> <p>Enrollee out-of-pocket expenses for covered benefits (c) (+0.23%)</p> <p>Enrollee expenses for noncovered benefits (-44.17%)</p>	<p>Approximately 77,000 enrollees have PDD/A.</p>	<p>For some enrollees with PDD/A, particularly those between the ages of 18 months and 9 years and those diagnosed with Autistic Disorder or PDD-NOS, use of IBIT as a benefit mandated by SB TBD 1 would result in improved adaptive behaviors and IQ.</p> <p>For some enrollees with PDD/A, use of outpatient medication as a benefit mandated by SB TBD 1 could reduce symptoms (stereotypic or aggressive behavior)</p> <p>For some enrollees, SB TBD 1 would result in a decreased financial burden.</p>

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<p>AB 154, Beall, Mental Health Services (3/20/11)</p> <p>Health plans regulated by the DMHC and health policies regulated by the CDI would be subject to AB 154. Medi-Cal Managed Care plans and California Public Employees' Retirement System (CalPERS) plans would not be subject. Therefore, the mandate would affect the health insurance of approximately 17.2 million Californians (46%). Under the proposed mandate, health plans and insurers would be required to cover all mental health benefits at parity for persons with disorders defined in the <i>Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition</i> (DSM-IV) excluding "V codes," as specified in the bill, as well as nicotine dependence, subject to regulatory revision.</p>	<p>The impact of mental health or substance abuse (MH/SA) parity legislation on the health status of persons with MH/SA conditions depends on a hypothetical chain of events. Parity reduces consumers' out-of-pocket costs for MH/SA services. Lower cost sharing may lead to greater utilization of these services. If consumers obtain more MH/SA services, and if these services are appropriate and effective, their mental health may improve or they may recover from substance use disorders. Improvement in mental health and recovery from substance use disorders may lead to greater productivity, better quality of life, and reduction in illegal activity.</p>	<p>In California, 74.1% of enrollees in plans and policies subject to AB 154 presently have coverage for non severe mental health services and 63.5% have coverage for SA treatment that is at parity with their coverage for medical services, even with the federal Mental Health Parity and Addiction Equity Act (MHPAEA) regulations in effect. Under AB 154, coverage levels among enrollees would increase to 100% for both, providing new covered benefits for non-SMI MH services for 4.5 million enrollees and SA treatment for 6.3 million enrollees.</p>	<p>CHBRP estimates that among enrollees with either DMHC-regulated health plan contracts or CDI-regulated policies subject to AB 154, utilization would increase by 7.41 outpatient mental health visits (2.62%) and 2.32 outpatient substance use visits (15.81%) per 1,000 members. Annual inpatient days per 1,000 members would decrease by 0.02 (0.56%) for mental health and increase by 0.72 (11.76%) for substance use disorders.</p>	<p>Total net annual expenditures among enrollees subject to state regulation are estimated to increase by about \$41.4 million, or 0.04%.</p>	<p>The total premium contributions from private employers who purchase group insurance are estimated to increase by \$28.4 million per year, or 0.05%.</p> <p>Premiums for MRMIB plans are estimated to increase by \$134,000, or 0.01%.</p> <p>Enrollee contributions toward premiums for those in privately funded group insurance and publicly funded group coverage subject to the bill are estimated to increase by \$7.3 million per year, or 0.05%.</p> <p>The total premiums for enrollees who purchase their own DMHC-regulated plan contracts or CDI-regulated policies (individually purchased) would increase by about \$31.5 million, or 0.47%.</p>	<p>Mental illness and substance use disorders are among the leading causes of death and disability in the United States and California. Psychotherapy and prescription drugs are effective treatments for many of the MH/SA conditions to which AB 154 applies.</p>	<p>It is not possible to quantify the anticipated impact of the mandate on the public health of Californians because (1) the numerous approaches for treating MH/SA disorders and the large number of disorders covered by AB 154 render a medical effectiveness analysis of mental health care treatment outside the scope of this analysis; and (2) there are insufficient data in the scientific literature to evaluate whether introduction of parity laws similar to AB 154 has an impact on MH/SA health and social outcomes.</p>

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<p>AB 137, Portantino, Mammography Services (3/18/11)</p> <p>AB 137 contains two separate mandates, one involving mammography coverage and the other related to notification regarding timelines for breast cancer screening.</p> <p>AB 137 would require CDI-regulated policies to cover medically necessary mammography upon a provider’s referral.</p>	<p>A preponderance of evidence indicates that, for women 40 to 74 years mammography reduces breast cancer mortality.</p> <p>No studies were identified that assessed the effectiveness of providing subscribers/policyholder (regardless of age or gender) with recommended timelines for breast cancer screening.</p>	<p>Mandated mammography coverage for enrollees in CDI regulated policies would become “at provider referral,” rather than being mandated at specific frequencies for specific age ranges.</p>	<p>No measurable impact estimated.</p>	<p>No measurable impact estimated.</p>	<p>No measurable impact estimated.</p>	<p>Breast cancer is a disease that affects primarily women. It is one of the most commonly diagnosed cancers in California, but survival rates are high when it is diagnosed at an early stage.</p>	<p>No measurable impact estimated.</p>

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<p>AB 72, Eng, Health Care Coverage: Acupuncture (3/18/11)</p> <p>AB 72 is a mandate to reimburse for acupuncture care—that is, it requires coverage for treatments delivered by a particular profession, in this case, acupuncturists. It applies to every health care service plan that provides coverage for hospital, medical, or surgical expenses and to every issuer of health insurance.</p>	<p>Needle acupuncture versus no treatment</p> <p>The preponderance of evidence suggests that needle acupuncture is more effective than no treatment in reducing pain and improving the functioning of persons with back pain, peripheral joint osteoarthritis, migraine headache, and tension-type headache. It also suggests that needle acupuncture may increase abstinence from smoking relative to no treatment.</p> <p>Needle acupuncture versus other treatments</p> <p>The preponderance of evidence suggests that acupuncture is more effective than other treatments for back pain (immediately post-treatment only), peripheral joint osteoarthritis pain (when compared to osteoarthritis education), and for migraine headaches (reduction in frequency but not in intensity). That same evidence suggests that needle acupuncture is as effective as other treatments for postoperative nausea and vomiting.</p>	<p>According to CHBRP’s estimates, there are 21.9 million insured Californians currently enrolled in health plans subject to the California Health and Safety Code or insured by health insurance policies subject to the California Insurance Code and, therefore, subject to AB 72.</p> <p>Currently, 87.2% of insured Californians subject to the mandate have coverage for acupuncture. This mandate impacts those who currently do not have coverage (12.8%).</p>	<p>It is estimated that there would be a negligible change in utilization due to the mandate as both the 2002 and 2007 California Health Interview Survey (CHIS) showed only small differences in utilization of alternative medical systems between the privately insured and the uninsured (2002: 3.0% and 3.1% respectively, 2007: 3.9% and 4.0% respectively).</p> <p>Cultural acceptance of acupuncture may be a more important factor in utilization than financial barriers.</p>	<p>Total net annual expenditures are estimated to increase by \$7.45 million or 0.0078%.</p>	<p>There is an estimated increase in premiums of \$54.9 million. Total premiums for private employers purchasing group health insurance are estimated to increase by \$31.7 million, or 0.0601%, and enrollee contributions toward premiums for group insurance are estimated to increase by \$11.5 million, or 0.0757%.</p> <p>Total employer premium expenditures for CalPERS HMOs are estimated to increase by \$11.7 million, or 0.3380%.</p> <p>No change is estimated for MRMIB Plan premiums⁸ and Medi-Cal Managed Care Plan premiums as this mandate would not apply to these programs.</p>	<p>N/A</p>	<p>The primary health outcomes associated with acupuncture treatment for musculoskeletal and neurological disorders are reduced pain and improved functionality.</p> <p>Although acupuncture needling has been found to be effective for some conditions, AB 72 is not expected to result in an overall increase in utilization in the short term, and thus is not expected to have measurable impact on the public’s health in the 1-year time frame used in this analysis. It is possible that in the longer term, passage of AB 72, along with a potential increase in cultural acceptance of acupuncture as a treatment option, would contribute to an increase in utilization of acupuncture, and therefore, improved health outcomes for persons who do not respond to other treatments.</p>

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2010							
<p>SB 1104, Cedillo, Diabetes-Related Complications (4/17/10)</p> <p>SB 1104 would mandate that plans and policies provide coverage for the diagnosis and treatment of diabetes-related complications. SB 1104 would also require that copayments and deductibles for these benefits not exceed those established for similar benefits within the given plan or policy. SB 1104 does not specify what are to be considered diabetes-related complications and does not specify the scope of the coverage. CHBRP assumes that SB 1104 would require coverage of all services, devices, and medications medically necessary for the diagnosis and treatment of all diabetes-related complications.</p>	<p>Diabetes-related complications (DRCs) can lead to kidney failure, blindness, and/or amputation. DRCs include but are not limited to nephropathy, neuropathy, retinopathy, and foot ulcers. There is clear and convincing evidence that treatments for these DRCs can improve health outcomes. Treatments for which there is evidence of effectiveness include outpatient prescription medications, services delivered in hospitals or physician/provider offices, devices, and wound care supplies.</p>	<p>1.55 million enrollees (9%) would gain coverage for medical treatments relevant to diabetes-related complications.</p> <p>1.02 million enrollees (6%) would gain coverage for outpatient medications relevant to diabetes-related complications.</p>	<p>Per diabetic enrollee per year, for previously noncovered benefits</p> <p>+0.05 units of medical treatment (DME, prosthesis, wound dressing)</p> <p>+2.17 outpatient prescriptions</p>	<p>\$49.6 million (+0.07%)</p>	<p>PRIVATE</p> <p>Employers (0.11%)</p> <p>Individuals w/group insurance (0.11%)</p> <p>Individuals w/individual coverage (1.40%)</p> <p>PUBLIC</p> <p>CalPERS (0.10%)</p> <p>Medi-Cal (0%)</p> <p>HFP (0%)</p> <p>Members' out-of-pocket expenses (c) (0.36)</p> <p>Member expenses for noncovered benefits (-100.00%)</p>	<p>Diabetes affects 2.2 million Californians (8.3%). 60% to 70% of diabetics have mild mild-to-severe forms of neuropathy. 60% of nontraumatic lower limb amputations stem from diabetes-related complications. Diabetes is a leading cause of kidney failure. Diabetes is a leading cause of blindness among adults aged 20 to 74 years.</p>	<p>The mandate would expand medical treatment coverage for 88,000 diabetic enrollees and would expand outpatient medication coverage for 58,000 diabetic enrollees. The expanded benefit coverage is expected to prompt increased/earlier treatment which can lead to improved health status and decreased loss of productivity among the diabetic enrollees with newly expanded benefit coverage.</p> <p>The increase in premiums resulting from the mandate in the individual market is expected to increase the number of uninsured persons by 3,000.</p>

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<p>SB 961, Wright, Cancer Treatment (4/17/10)</p> <p>SB 961 would require that plans and policies that provide “coverage for orally administered cancer medications used to kill or slow the growth of cancerous cells...not charge a co-payment for these drugs in excess of 200% of the lowest co-payment required by the plan/policy for brand name medications in the plans/policies formulary.”</p> <p>Therefore, the bill would (on a policy-by-policy and plan contract-by-plan contract basis) limit flat dollar copays for oral anticancer medications.</p>	<p>All oral anticancer medications must be approved by the FDA, which requires that the drug be safe and at least as effective as any other medication approved for treatment of the disease or condition for which the manufacturer seeks to market the medication.</p> <p>To date, the FDA has approved 40 oral anticancer medications that may be used in the treatment of multiple different types of cancer. Currently, 11 have an IV/injectable substitute. As many as 100 additional oral anticancer medications are in various stages of development.</p> <p>Some oral anticancer medications are used alone. Some are used either alone or in combination with other anticancer medications (oral, intravenous, or injectable) depending on the type and stage of cancer being treated.</p>	<p># of enrollees with coverage of outpatient pharmacy benefits for oral anticancer medications subject to flat dollar copays:</p> <p>15,331,000 (82.1%) (No coverage impact)</p>	<p>Oral anticancer medication</p> <p>+0%</p>	<p>+\$3,000 (0.0000%)</p>	<p>PRIVATE</p> <p>Employers (0.0001%)</p> <p>Individuals w/group insurance (0%)</p> <p>Individuals w/individual coverage (0%)</p> <p>PUBLIC</p> <p>CalPERS (0%)</p> <p>Medi-Cal (0%)</p> <p>HFP (0%)</p> <p>Members’ out-of-pocket expenditures (c) (-0.0005%)</p>	<p>134,000 new cancer cases projected in California for 2010, 45% of those in the non-elderly population</p>	<p>No changes in utilization are expected, so no impact on health outcomes is projected. A decrease for some enrollees of an average of \$0.20 per brand name prescription (for enrollees with outpatient pharmacy benefits subject to flat dollar copays) represents a small part of the financial burden that may be associated with cancer.</p>

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<p>SB 890, Alquist, Basic Health Care Services (4/17/10)</p> <p>SB 890 would make four changes to the CDI-regulated health insurance market:</p> <ul style="list-style-type: none"> • Create a benefits floor 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). • Prohibit such policies from having an annual limit or lifetime limit on BHCS. • Establish that BHCS must be covered per medical necessity. • Provide the commissioner the authority to approve copayments, deductibles, or limitations. 	<p><u>Clear & convincing evidence for effectiveness of:</u> physical exams (partial), immunizations, health education-prevention, HE-chronic disease management, home health care (elderly/disabled), maternity (partial)</p> <p><u>Preponderance for:</u> hearing screening (ages <18, 55 to 74), maternity (partial)</p> <p><u>Ambiguous for:</u> PT/OT/ST (varies by condition), hospice care</p> <p><u>Insufficient for:</u> physical exams (health outcomes, children), vision screening, home health care (children)</p> <p><u>Evidence that <i>not</i> effective:</u> None</p>	N/A	+1.8% to +2.4%, depending on the service	+\$49.0 million (+0.06%)	<p>PRIVATE</p> <p>Employers (+0.01%)</p> <p>Individuals w/group insurance (+0.01%)</p> <p>Individuals w/individual insurance (+2.14%)</p> <p>PUBLIC</p> <p>CaPERS HMO (0%)</p> <p>Medi-Cal Managed Care (0%)</p> <p>HFP (0%)</p> <p>Members’ out-of-pocket expenditures (c)</p> <p>Copayment (+0.54%)</p> <p>Direct payment (-100%)</p>	N/A	<p>Public health benefits are expected from the 1.8% to 2.4% increased utilization of: preventive care, PT/OT/ST, maternity services, and home health care</p> <p>Impact by gender/race is unknown due to insufficient literature on differential impacts of coverage</p> <p>SB 890 could contribute to reduction in premature death</p>

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<p>SB 220, Yee, Tobacco Cessation Services (6/11/10)</p> <p>SB 220 requires coverage for the following smoking cessation services, to be selected by the enrollee and the provider: telephone, group, or individual counseling, and all prescription and over-the-counter (OTC) medications approved by the Food and Drug Administration (FDA) to help smokers quit, including drugs for nicotine replacement therapy (NRT) and prescription drug therapies.</p>	<p><i>Counseling:</i> Evidence suggests that counseling by physicians and other health professionals increase abstinence from smoking.</p> <p><i>Pharmacotherapy:</i> Among first-line pharmacological agents, nicotine replacement therapy and bupropion are effective treatments.</p> <p>Among second-line agents, Varenicline, other forms of cytisine, clonidine, and nortriptyline increase smoking cessation.</p> <p><i>Coverage for tobacco cessation services:</i> Full coverage for tobacco cessation counseling and pharmacotherapy is associated with improved abstinence from smoking relative to no coverage. The evidence of the effect of more generous coverage for tobacco cessation counseling and pharmacotherapy relative to partial coverage on abstinence from smoking is ambiguous.</p>	<p># of enrollees with coverage for:</p> <p>Counseling</p> <p><i>Before:</i> 15,426,000</p> <p><i>After:</i> 18,892,655</p> <p><i>Change:</i> 3,466,161</p> <p>OTC treatments</p> <p><i>Before:</i> 10,835,982</p> <p><i>After:</i> 18,892,655</p> <p><i>Change:</i> 8,056,673 (74.35% increase)</p> <p>RX treatments</p> <p><i>Before:</i> 14,689,182</p> <p><i>After:</i> 18,892,655</p> <p><i>Change:</i> 4,203,474 (28.62% increase)</p>	<p>Change in number of enrollees who smoke and use:</p> <p><i>Counseling</i></p> <p>42,107 (34.30% increase)</p> <p><i>OTC treatments</i></p> <p>104,232 (54.20% increase)</p> <p><i>RX treatments</i></p> <p>23,565 (37.16% increase)</p> <p><i>At least one treatment</i></p> <p>118,482 (44.15% increase)</p>	<p>+\$52.7 million (+0.07%)</p>	<p>PRIVATE</p> <p>Employers (+0.12%)</p> <p>Individuals w/group insurance (+0.12%)</p> <p>Individuals w/individual coverage (+0.25%)</p> <p>PUBLIC</p> <p>CalPERS (+0.07%)</p> <p>Medi-Cal (0%)</p> <p>HFP (+0.01%)</p> <p>Members' out-of-pocket expenditures (c)</p> <p>Copayment (-0.18%)</p> <p>Direct payment (-100%)</p>	<p>California's average annual smoking-attributable deaths: 34,492</p> <p>Smoking prevalence among currently insured California adults: 14.2%</p>	<p>Approximately 8,081 additional smokers will successfully quit due to SB 220 each year. During the first year after implementation, this mandate is estimated to result in <10 fewer cases of AMI or stroke and <10 fewer low birth-weight deliveries each year.</p> <p>Racial and ethnic disparities in smoking prevalence are also apparent in California. The extent to which SB 220 will modify these disparities is unknown.</p> <p>For each quitter, between 7.0 and 12.4 years of life is gained due to prevention of premature death from smoking-related illnesses. This adds up to a total of 56,567 to 100,204 years of potential life gained across the state each year.</p>

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<p>AB 2587, Berryhill, Benefit Mandates (4/16/10)</p> <p>AB 2587 would allow health plans and insurers to be <i>out of</i> compliance with current or future benefit mandates when the Labor Market Information Division of the Employment Development Department (EDD-LMI) declares that the unemployment rate has been greater than 5.5% for four consecutive quarters.</p>	<p>The amount and strength of the evidence regarding the medical effectiveness of the services for which coverage may be excluded under AB 2587 varies. The outcomes that are most important for assessing effectiveness also differ. Nevertheless, many of the mandates and mandated offerings require health insurance products to provide coverage for health care services for which there is strong evidence of effectiveness.</p>	<p>AB 2587 would allow out-of-state carriers to market health insurance products that are not subject to California benefit mandates. As a result, CHBRP estimates that 12,000 to 28,000 persons could become newly insured. 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. The newly insured therefore could face beneficial health outcomes as they use effective health care services.</p>	<p>The impact on utilization of AB 2587 is unclear.</p>	<p>CHBRP did not model the cost impacts of AB 2587 to determine an estimate of total health care expenditures for this analysis.</p>	<p>Individual benefit mandates typically raise premiums by less than 1%; the cumulative annual cost of the state's mandated benefits is between 5% and 19% of the total premium for the health insurance product. Studies of the <i>marginal</i> 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 5% of premiums.</p>	<p>N/A</p>	<p>CHBRP was unable to model the public health impacts of AB 2587.</p>

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<p>AB 1904, Villines, Out-of-State Carriers (4/16/10)</p> <p>Would allow a carrier domiciled in another state to offer, sell, or renew a health plan or insurance policy in California without holding a license issued by the California Department of Managed Health Care (DMHC) or without a certificate of authority issued by the Insurance Commissioner. The bill would exempt the carrier's plan contract or policy from requirements otherwise applicable to plans and insurers providing health care coverage in this state, 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.</p>	<p>AB 1904 could represent a <i>de facto</i> repeal of all health insurance requirements in California including 44 benefit mandate laws.</p> <p>There is evidence that many benefits mandates in California law require health plans to cover services for which there is evidence of medical effectiveness.</p>	<p>The estimated impact of AB 1904 on the number of uninsured differs between three scenarios.</p> <p>According to Scenario 1, an estimated 87,000 Californians would become insured as a result of the reduced premiums in this scenario, representing a 1.31% decrease in the number of uninsured. Scenario 1 is unlikely.</p> <p>According to Scenario 2, an estimated 12,000 Californians would become insured as a result of the reduced premiums in this scenario, representing a 0.18% decrease in the number of uninsured.</p> <p>According to Scenario 3, an estimated 28,000 Californians would become insured as a result of the reduced premiums in this scenario, representing a 0.42% decrease in the number of uninsured.</p>	<p>Scenario 1: The combined effect on overall health expenditures would be a net savings of about \$1.8 billion, or 2.01%.</p> <p>Scenario 2: The combined effect would be a net savings of about \$19.4 million, or 0.02%.</p> <p>Scenario 3: The combined effect on overall health expenditures of this scenario would be a net increase of about \$24.2 million, or 0.03%.</p>	<p>Total health care expenditures would be expected to decline by as much as 2.01%</p> <p>Scenario 1: Expenditure reductions of \$1.79 billion, or 2.01%.</p> <p>Scenario 2: Expenditures reductions of \$19.421 million, or 0.02%.</p> <p>Scenario 3: Expenditures increase of \$24.213 million, or 0.03%.</p>	<p>Scenario 1: -4.92% in premiums by private employers for group insurance, -5% for individual premiums, and -4.83% for individuals with group insurance, CalPERS, Healthy Families, AIM, and MRMIP.</p> <p>Scenario 2. No change in state expenditures for currently insured CalPERS, Healthy Families, AIM, or MRMIP premiums. No change for premium expenditures for private employers for group or individual insurance.</p> <p>Scenario 3: -0.03% premium reduction by private employers for group insurance. -0.40% reduction for individuals purchasing individual insurance, and a -0.40% reduction for individuals with group CalPERS, Healthy Families, AIM, and MRMIP. CalPERS, Medi-Cal, and Healthy Families state expenditures do not change.</p>	<p>N/A</p>	<p>Using the projections from the hypothetical scenarios, the primary health benefit of AB 1904 could be an expansion of the insured population to an estimated 12,000 to 28,000 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 poorer self-reported health. In addition to the issues of health and health care access, lack 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 estimated 12,000 to 28,000 persons who are expected to no longer be uninsured due to AB 1904 would likely realize improved health outcomes and reduced financial burden for medical expenses.</p>

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<p>AB 1826, Huffman, Pain Prescriptions (4/16/10)</p> <p>AB 1826 would mandate that plans and policies providing outpatient pharmacy benefits provide coverage for medication prescribed by a participating licensed health care professional for the treatment of pain “without first requiring the subscriber or enrollee to use an alternative prescription or over-the-counter product.”</p>	<p>Fail-first protocols (step therapy, step edit, some prior authorization, some generic substitution, etc.) are applicable to pain medication outpatient pharmacy benefit coverage for a portion of enrollees.</p> <p>When fail-first protocols are used, a great deal of variation is present as to which and how many pain medications are listed. CHBRP found insufficient evidence to characterize the medical effectiveness of fail-first protocols.</p>	<p>No estimated change in benefit coverage.</p>	<p>No measurable change estimated in the number of prescriptions for pain medications. Brand name medications as a proportion of all prescribed pain medications are expected to increase.</p>	<p>\$27.7 million (+0.04%)</p>	<p>PRIVATE</p> <p>Employers (0.21%)</p> <p>Individuals w/group insurance (0.02%)</p> <p>Individuals w/individual coverage (0.03%)</p> <p>PUBLIC</p> <p>CalPERS* (0%)</p> <p>Medi-Cal (0.20%)</p> <p>HFP (0.23%)</p> <p>Members’ out-of-pocket expenditures (c)</p> <p>Copayment (0.05%)</p> <p>*CalPERS is exempt from the mandate</p>	<p>As estimated 26% of adults in the U.S. experience chronic pain (lasting 6 months or longer).</p> <p>Pain varies in presentation and duration and is caused by a wide array of known and unknown origins.</p>	<p>The public health impact of AB 1826 is unknown.</p>

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<p>AB 1825, De La Torre, Maternity Services (4/16/10)</p> <p>Would require health insurance policies regulated by the California Department of Insurance (CDI) to cover maternity services.</p> <p>AB 1825 defines maternity services to include prenatal care, ambulatory care maternity services, involuntary complications of pregnancy, neonatal care, and inpatient hospital maternity care including labor and delivery and postpartum care.</p>	<p>Evidence shows that there is no difference in birth outcomes for infants or mothers in association with the number of prenatal visits.</p> <p>Evidence suggests that a number of prenatal care services that are provided during those prenatal care visits are effective in providing better birth outcomes (i.e., counseling; screening tests; diagnostic and preventive services; supplements).</p>		<p># of individuals in CDI-regulated policies with maternity coverage, in:</p> <p><i>Large- and small-group policies,</i> <i>Before:</i> 1,259,000 (100%)</p> <p><i>Individual plans,</i> <i>Before:</i> 216,000 <i>After:</i> 1,179,000 <i>Change:</i> 963,000 (446% increase)</p> <p><i>All CDI-regulated policies (total),</i> <i>Before:</i> 1,475,000 <i>After:</i> 2,438,000 <i>Change:</i> 963,000 (65% increase)</p>	<p>+\$40.0 million (+0.1%) for the entire DMHC and CDI-regulated marketplace.</p>	<p>PRIVATE</p> <p>Employers (0%)</p> <p>Individuals w/group insurance (0%)</p> <p>Individuals w/individual coverage (+2%)</p> <p>PUBLIC</p> <p>CalPERS (0%)</p> <p>Medi-Cal (0%)</p> <p>HFP (0%)</p> <p>Members' out-of-pocket expenditures (c)</p> <p>Copayment (+0.5%)</p> <p>Direct payment (-100%)</p>		<p>An upper bound estimate would assume that all 8,298 newly covered pregnancies would have financial barriers to prenatal care removed and thus an increase in the utilization of effective prenatal care services, and corresponding health outcomes would be expected. A lower bound estimate would assume that there will be no increase in the utilization of effective prenatal care services because these pregnant women will likely still face high out-of-pocket costs.</p> <p>To the extent that AB 1825 increases the utilization of effective prenatal care, there is a potential to reduce economic loss associated with preterm births and related mortality.</p>

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<p>AB 1600, Beall, Mental Health Services (3/19/10)</p> <p>AB 1600 would expand the mandated coverage for mental health benefits from the limited conditions currently covered—severe mental illness for individuals of all ages and serious emotional disturbances in children—to a broader range of conditions. The bill would also extend the “parity” requirement for mental health benefits from the limited conditions covered in current law to a broader range of conditions.</p>	<p>The impact of mental health and substance abuse (MH/SA) parity legislation on the health status of persons with MH/SA conditions depends on a hypothetical chain of events. Parity reduces consumers’ out-of-pocket costs for MH/SA services. Lower cost sharing may lead to greater utilization of these services. If consumers obtain more MH/SA services, and if these services are appropriate and effective, their mental health may improve or they may recover from substance use disorders. Improvement in mental health and recovery from substance use disorders may lead to greater productivity and quality of life and reduction in illegal activity.</p>	<p>In California, 66.2% of enrollees in plans and policies subject to AB 1600 presently have coverage for non-SMI MH services and 55.3% have coverage for SA treatment that is at parity with their coverage for medical services, even with the federal MHPAEA regulations in effect. Under AB 1600, coverage levels among enrollees would increase to 100% for both, providing new covered benefits for non-SMI MH services for 5.4 million enrollees and SA treatment for 7.1 million enrollees.</p>	<p>The relative impact of the legislation will be greater for SA than mental health services. CHBRP estimates that among enrollees with either DMHC-regulated health plan contracts or CDI-regulated policies subject to AB 1600, utilization would increase by 10.46 outpatient mental health visits (4.75%) and 3.13 outpatient substance use visits (16.15%) per 1,000 members as a result of the mandate. Annual inpatient days per 1,000 members would increase by 0.02 (0.58%) for mental health and by 0.69 (10.10%) for substance use disorders.</p>	<p>Overall, annual costs for these additional services are projected to be 0.06% of total annual expenditures within California, or \$44.9 million.</p>	<p>AB 1600 is estimated to increase premiums by about \$63 million. The distribution of the impact on premiums is as follows:</p> <p>The total premium contributions from private employers who purchase group insurance are estimated to increase by \$25.4 million per year, or 0.06%.</p> <p>Enrollee contributions toward premiums for either privately funded group coverage or for publicly funded group coverage (including Healthy Families, AIM or MRMIP) are estimated to increase by \$8.3 million per year, or 0.06%.</p> <p>The total premiums for enrollees who purchase their own DMHC-regulated plan contracts or CDI-regulated policies would increase by about \$28.8 million, or 0.48%.</p>	<p>Mental illness and substance use disorders are among the leading causes of death and disability in the United States and California.</p>	<p>It is not possible to quantify the anticipated impact of the mandate on the public health of Californians because (1) the numerous approaches for treating MH/SA disorders and the multiple disorders (that would be covered under AB 1600) on which these approaches may be applied renders a medical effectiveness analysis of mental health care treatment outside of the scope of this analysis; and (2) the literature review found an insufficient number of studies in the peer-reviewed scientific literature that specifically address physical, mental health, and social outcomes related to the implementation of mental health parity laws.</p>

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<p>AB 754, Chesbro, Durable Medical Equipment (6/24/10)</p> <p>AB 754 would require that enrollees with health insurance regulated by the DMHC or CDI have DME coverage and have coverage at the same level or “at parity” with other health care benefits.</p>	<p>There is insufficient evidence to assess the impact of health insurance coverage for DME on use of DME and health outcomes for persons who use DME.</p> <ul style="list-style-type: none"> The few studies that have been conducted suggest that need is the primary factor associated with use of DME. No studies were found that specifically address the effects of increasing annual or lifetime limits for DME coverage on DME usage or the impact of reducing deductibles, coinsurance, or copayments for DME on such usage. No studies were found that address the impact of coverage for DME on health outcomes. 	<p>Prior to the mandate, approximately 93.32% of enrollees with health insurance subject to the mandate have at least some coverage for DME.</p> <p>Post-mandate, the 1,301,462 (6.68%) of enrollees previously without DME coverage would gain DME benefits compliant with AB 754.</p>	<p>Post-mandate, CHBRP estimates that there would be a \$52.01 (6.99%) per DME user per year increase in DME utilization and related expenses.</p>	<p>Total net annual expenditures are estimated to increase by \$135,933,000 annually, or 0.18%.</p>	<p>The mandate is estimated to increase premiums by \$276,306,000. The distribution of the impact on premiums is as follows:</p> <p>Total premiums for private employers are estimated to increase by \$161,681,000, or 0.37%.</p> <p>Enrollee contributions toward premiums for group insurance are estimated to increase by \$50,314,000, or 0.39%.</p> <p>Total premiums for those with individually purchased insurance are estimated to increase by \$64,311,000, or 1.07%.</p> <p>Total premium expenditures for CalPERS HMOs would not increase because the DME coverage is already compliant with the mandate.</p>	<p>N/A</p>	<p>The health outcomes associated with the use of DME vary according to the type of DME that is being used. Some health outcomes include increased independence, mobility, functionality, survival, and decreased morbidity.</p> <p>AB 754 is not expected to affect the number of DME users, but is expected to increase the amount of DME used by each current DME user. The impact on health outcomes of this increase is unknown.</p>

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2009							
<p>AB 513, de Leon, Breast-Feeding (4/17/2009)</p> <p>AB 513 mandates coverage of lactation consultation by International Board Certified Lactation Consultants and coverage of breast pump rental.</p>	<p>Multiple guidelines recommend lactation consultation and use of breast pumps as means of supporting breast-feeding— which is recommended as a means of reducing morbidity and improving health outcomes.</p> <p>Breast pumps are effective.</p> <p>Lactation consultation is effective.</p>	<p>If the mandate is enacted, CHBRP makes the following estimates for changes in coverage:</p> <ul style="list-style-type: none"> • 8.5 million enrollees would gain coverage for outpatient lactation consultation. • 2.8 million enrollees would gain coverage for breast pump rental. 	<p>Lactation Consultation +0%</p> <p>Breast Pumps +50%</p>	<p>+\$2.4 million (+0.0028%)</p>	<p>PRIVATE</p> <p>Employers (+0.0064%)</p> <p>Individuals w/group insurance (+0.0065%)</p> <p>Individuals w/individual coverage (+0.0061%)</p> <p>PUBLIC</p> <p>CalPERS (0.0066%)</p> <p>Medi-Cal (0.1879%)</p> <p>HFP (0.0000%)</p> <p>Members' out-of-pocket expenditures (c)</p> <p>Copayment (-0.0419%)</p> <p>Direct payment (-94.3529%)</p>	<p>N/A</p>	<p>Increased use of breast pumps is expected to promote duration of breast-feeding and/or exclusivity of breast-feeding, which may result in health benefits.</p>

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<p>AB 259, Skinner, Certified Nurse Midwives: Direct Access (4/17/2009)</p> <p>AB 259 would require every health care service plan regulated by the Department of Managed Health Care (DMHC) and every health insurance policy regulated by the California Department of Insurance (CDI) to allow a member the option to seek obstetrical and gynecological (OB/GYN) services directly from a certified nurse-midwife (CNM) provided that the services fall within the scope of practice of the CNM.</p>	<p>Evidence from one RCT and two nonrandomized studies conducted in both the United States and a meta-analysis of RCTs conducted in other developed countries indicates that there are no differences in Apgar scores (a measure of newborn health administered immediately after delivery) and in the risks of low birthweight, preterm birth, and admission to a neonatal intensive care unit between infants whose mothers received maternity services from CNMs or licensed midwives, and those cared for by physicians. Another study conducted in other developed countries found no differences in rates of prenatal hemorrhage, postpartum hemorrhage, and postpartum depression between mothers who received maternity services from licensed midwives and those cared for by physicians.</p>	<p>Approximately 98.0% of insured Californians have coverage for services provided by a CNM. Of those with coverage, an estimated 67.0% have coverage for direct access to a CNM</p>	<p>The extent to which AB 259 would impact the use of CNMs would depend on whether prior authorization and referral requirements are currently a barrier to ultimately obtaining CNMs services for those members who demand those services. There is inadequate evidence to determine the number of members who may be demanding OB/GYN services from CNMs but are ultimately not able to obtain them due to preauthorization or referral requirements.</p>	<p>If AB 259 would result in more women choosing to seek OB/GYN services from CNMs, the potential shift toward greater use of CNMs would have no measurable change in total expenditures, because CNMs are generally paid the same rates for their services as physicians.</p>	<p>AB 259 would have no measurable change in total premiums, because CNMs are generally paid the same rates for their services as physicians.</p>	<p>N/A</p>	<p>CHBRP is unable to estimate a public health impact for this bill.</p>

Bill Summary	Medical Effectiveness of a Mandated Service or Treatment	Coverage	Estimated Utilization Impact of Mandate	Estimated Cost Impact in Terms of Total Health Care Expenditures (a)	Estimated Cost Impact in Terms of % Premium Changes by Payer (b)	Burden of Disease	Estimated Public Health Impact
<p>AB 244, Beall, Mental Health Services (4/17/2009)</p> <p>AB 244 would expand the mandated coverage for mental health benefits from the limited conditions currently covered to a broader range of conditions. The bill would also extend the “parity” requirement for mental health benefits from the limited conditions covered in current law to a broader range of conditions. The parity requirement mandates that coverage for mental health benefits be no more limited than coverage for other medical conditions.</p>	<p>Coverage for mental health and substance use disorders at parity with other physical illnesses is associated with the following outcomes: (1) consumers’ out-of-pocket costs for MH/SA services decrease; (2) persons with mental health needs are more likely to perceive that their health insurance and access to care have improved; (3) utilization of MH/SA services increases slightly among persons with substance use disorders, persons with moderate symptoms of mood and anxiety disorders, and low-income persons employed by small firms. Very little research has been conducted on the effects of MH/SA parity on the provision of recommended treatment regimens or on mental health status and recovery from chemical dependency.</p>	<p>Pre-mandate, about 64% of individuals in policies subject to AB 244 would have parity coverage for non-SMI disorders, 35% would have less than full parity coverage and 1% would have no coverage. About 64% would have parity coverage for substance use disorders, 30% would have less than full parity coverage and 6% would have no coverage. Post-mandate, 100% of these individuals would have coverage for both non-SMI and substance use disorders.</p>	<p>Outpatient days per 1,000 members would increase by 4.1% mental health visits and 8.7% for substance abuse.. Inpatient days per 1,000 members would increase by 0.06% for mental health and 4.97% for substance abuse.</p>	<p>\$34.6 million (0.04%) including \$2 million in total savings for AIM and MRMIP.</p>	<p>PRIVATE Employers (0.03%) Individuals w/group insurance (0.02%) Individuals w/individual coverage (0.3%) PUBLIC CalPERS HMOs (0%) Medi-Cal Managed Care (-0.03%) for AIM and MRMIP HFP (0.02%) Members’ out-of-pocket expenditures (c) Copayment (-0.01%) Direct payment N/A</p>	<p>Mental illness and substance abuse are among the leading causes of death and disability in the United States and California.</p>	<p>The scope of potential outcomes includes reduced suicides, reduced symptomatic distress, improved quality of life, reduced pregnancy-related complications, reduced injuries, improved medical outcomes, reduced employment absenteeism, reduced cessation of employment, and improved social outcomes, such as a decrease in criminal activity.</p> <p>The bill would alleviate a financial burden for some users.</p> <p>The increased use of tobacco cessation pharmaceuticals is expected to result in 649 persons quitting tobacco use, which is estimated to yield approximately 4,400 years of life gained per year.</p>

Bill Summary	Medical Effectiveness of a Mandated Service or Treatment	Coverage	Estimated Utilization Impact of Mandate	Estimated Cost Impact in Terms of Total Health Care Expenditures (a)	Estimated Cost Impact in Terms of % Premium Changes by Payer (b)	Burden of Disease	Estimated Public Health Impact
<p>SB 161, Wright, Chemotherapy Treatment (4/17/2009)</p> <p>For both plans and policies that provide coverage for chemotherapy treatments, SB 161 would mandate that coverage for orally administered anticancer medications be provided on a basis no less favorable than coverage provided for injected or intravenously administered anticancer medications.</p>	<p>CHBRP did not conduct a standard medical effectiveness review for this bill due to the large number of drugs and cancers addressed.</p> <p>At the point the analysis was completed, 38 oral anticancer medications approved by the FDA were used to treat 52 different types of cancer. Specific uses vary across medications and types of cancer.</p> <p>Some oral anticancer medications are used alone. Some are used either alone or in combination with other anticancer medications (oral, intravenous, or injectable) depending on the type and stage of cancer being treated.</p> <p>There are no intravenous or injected substitutes for many oral anticancer medications.</p>	<p>Enrollees with coverage for oral anticancer medications,</p> <p><i>Before:</i> 20,868,000</p> <p><i>After:</i> 21,340,000</p> <p><i>Change:</i> 472,000 (2% increase)</p>	<p>Oral anticancer medication</p> <p>+0%</p>	<p>+\$5 million (+0.01%)</p>	<p>PRIVATE</p> <p>Employers (+0.01%)</p> <p>Individuals w/group insurance (+0.01%)</p> <p>Individuals w/individual coverage (+0.18%)</p> <p>PUBLIC</p> <p>CalPERS (0.01%)</p> <p>Medi-Cal (0.00%)</p> <p>HFP (0.00%)</p> <p>Members' out-of-pocket expenditures (c)</p> <p>Copayment (-0.10%)</p> <p>Direct payment (-100.00%)</p>	<p>An estimated 140,000 cases of cancer each year; one in two Californians born today will develop cancer at some point in their lifetime</p>	<p>The reduction in out-of-pocket costs for oral anticancer medications could reduce the financial burden and related health consequences faced by cancer patients.</p> <p>Breast cancer is the most prevalent cancer in California, almost exclusively affecting women. 65% of the prescriptions and 33% of the total cost for oral anticancer medications are for drugs used to treat breast cancer. There is a potential to reduce the financial burden faced by women undergoing treatment for breast cancer.</p>

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<p>SB 158, Wiggins, Human Papillomavirus Vaccination (4/14/2009)</p> <p>SB 158 would amend current law to require health plans and insurance policies that include coverage for treatment of or surgery for cervical cancer to provide coverage for a human papillomavirus (HPV) vaccination upon referral.</p>	<p>Among females who complete all three doses of the quadrivalent HPV vaccine (Gardasil) and who were not previously exposed to HPV 16 or 18, the vaccine provides for a 98% reduction in pre-cancerous cervical lesions caused by HPV types 16 and 18. The vaccine is less effective among females who have not completed all three doses of the vaccine and/or were exposed to HPV prior to vaccination.</p> <p>Evidence suggests the vaccine does not have a statistically significant effect on the occurrence of the cervical intraepithelial neoplasia 3 and adenocarcinoma in situ associated with types of HPV other than the four toward which the vaccine is targeted.</p> <p>The quadrivalent vaccine appears safe at 5 years postvaccination. Duration of protection is unknown beyond 5 years.</p>	<p># of females aged 11 to 26 in plans subject to mandate with coverage for the benefit,</p> <p><i>Before:</i> 3,331,000</p> <p><i>After:</i> 3,348,000</p> <p><i>Change:</i> 17,000 (0.5% increase)</p>	<p>Change in # of females aged 11 to 26 vaccinated annually</p> <p>+1.4% (2,500)</p>	<p>+\$1.6 million (+0.0019%)</p>	<p>PRIVATE</p> <p>Employers (+0.0002%)</p> <p>Individuals w/group insurance (+0.0002%)</p> <p>Individuals w/individual coverage (+0.0228%)</p> <p>PUBLIC</p> <p>CalPERS (0%)</p> <p>Medi-Cal (0%) HFP (0%)</p> <p>Enrollees' out-of-pocket expenditures (c)</p> <p>Copayment (+0.0054%)</p> <p>Direct payment (-100%)</p>	<p>27% of females aged 14 to 59 are infected with HPV</p>	<p>Assuming 2,500 additional females get vaccinated in the first year after passage, 8 to 13 cases of cervical cancer could be prevented. After catch-up vaccinations are complete, the number of additional females receiving vaccinations due to the mandate falls to ~350, preventing 1 to 2 cases of cervical cancer over the lifetime of these females.</p> <p>Additional possible reductions in cases of anal, vulvar, vaginal, penile, or oral cavity and phalanx cancer due to increased HPV vaccination.</p>

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<p>SB 92, Aanestad, Health Care Reform (4/13/2013)</p> <p>SB 92 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.</p>	<p>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 require health insurance products to provide coverage for health care services for which there is strong evidence of effectiveness.</p>	<p>CHBRP analyzed two different scenarios to assess the coverage impacts of SB 92.</p> <p>Under Scenario 1:</p> <p>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.</p> <p>Under Scenario 2:</p> <p>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.</p>	<p>The impact on utilization of SB 92 is unclear.</p>	<p>Under Scenario 1:</p> <p>The combined effect on overall health expenditures of this scenario would be a net savings of \$1.985 billion, or 2.12%.</p> <p>Under Scenario 2:</p> <p>The combined effect on overall health expenditures of this scenario would be a net savings of \$71.582 million, or 0.08%.</p>	<p>Individual benefit mandates typically raise premiums by less than 1%; the cumulative annual cost of the state's mandated benefits is between 5% and 19% of the total premium for the health insurance product. Studies of the <i>marginal</i> 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 5% of premiums.</p>	<p>N/A</p>	<p>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.</p>

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<p>AB 214, Chesbro, Durable Medical Equipment (4/9/2009)</p> <p>AB 214 would require health plans and insurers to provide coverage for durable medical equipment (DME) and do so at the same levels of coverage as other health care benefits.</p>	<p>Persons with a wide range of diseases and conditions use durable medical equipment (DME) to improve health, functioning, quality of life, and productivity.</p> <p>There is little evidence of the effectiveness of having private health insurance coverage for DME on use of DME.</p> <p>Some evidence shows that utilization management reduces use of some types of DME.</p>	<p># of insured individuals with coverage for DME compliant with AB 214,</p> <p><i>Before:</i> 8,248,000</p> <p><i>After:</i> 21,340,000</p> <p><i>Change:</i> 13,092,000 (159% increase)</p>	<p>No impact on the number of DME users; +4.03% per user/per year increase in average DME costs</p>	<p>\$72.9 million including (+0.09%)</p>	<p>PRIVATE</p> <p>Employers (+0.29%)</p> <p>Individuals w/group insurance (+0.28%)</p> <p>Individuals w/individual coverage (+0.59%)</p> <p>PUBLIC</p> <p>CalPERS (0.00%)</p> <p>Medi-Cal (0.00%)</p> <p>HFP (0.00%)</p> <p>Members' out-of-pocket expenditures (c)</p> <p>Copayment (-2.28%)</p> <p>Direct payment (-100%)</p>	<p>2.4% privately insured Californians aged 18 to 64 reported having a health problem that required the use of special equipment</p>	<p>Among the current users of DME, AB 214 is expected to result in an increased utilization because increased annual limits and coinsurance are expected to lead to some persons receiving more DME, more expensive DME items, and more-frequent replacement of existing DME items. The health benefits associated with this increased utilization are unknown.</p> <p>There is no evidence that AB 214 would impact racial and ethnic health disparities.</p> <p>AB 214 will have no impact on premature death</p> <p>The impact that AB 214 would have on economic loss associated with the conditions related to the use of DME is unknown.</p>

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<p>AB 163, Emmerson, Amino Acid-Based Elemental Formula (3/30/2009)</p> <p>AB 163 would mandate coverage of amino acid-based elemental formulas, regardless of the delivery method, for the diagnosis and treatment of eosinophilic gastrointestinal disorders when the prescribing physician has issued a written order stating that the amino acid-based formula is medically necessary.</p>	<p>Literature on the effectiveness of amino acid-based elemental formula was found for only two eosinophilic gastrointestinal disorders (EGID)—eosinophilic esophagitis and eosinophilic gastroenteritis</p> <p>Evidence from studies suggests that amino acid-based elemental formula and elimination diets are both effective strategies to treat eosinophilic esophagitis. The evidence does not indicate which regimen is more effective.</p> <p>A single case report suggests that elemental formula is effective in improving symptoms associated with eosinophilic gastroenteritis (EG).</p>	<p># of individuals with coverage for formula used:</p> <p><i>With a feeding tube,</i></p> <p><i>Before:</i> 21,161,800</p> <p><i>After:</i> 21,340,000</p> <p><i>Change:</i> 178,200 (0.8% increase)</p> <p><i>Without a feeding tube,</i></p> <p><i>Before:</i> 7,553,800</p> <p><i>After:</i> 21,340,000</p> <p><i>Change:</i> 13,786,200 (183% increase)</p>	<p>Of the insured population who would be affected by the bill, approximately 4 per 10,000 individuals—for a total of 8,500—are estimated to have EGID. Of these 8,500 people, approximately 615 would access coverage for formula taken orally or with a feeding tube. CHBRP estimates no change in the utilization rates post-mandate.</p>	<p>\$1.3 million (less than 0.01%) annually, solely due to the additional administrative costs associated with providing coverage for persons who do not currently have this benefit.</p>	<p>PRIVATE</p> <p>Employers (+0.01%)</p> <p>Employees covered by group insurance (+0.01%).</p> <p>Individually purchased insurance (+4.75%).</p> <p>PUBLIC</p> <p>CalPERS (0.01%)</p> <p>Medi-Cal (0.00%)</p> <p>HFP (0.00%)</p> <p>Members out-of-pocket expenses:</p> <p>Copayment (1.28%)</p> <p>Direct payment (–100%)</p>	<p>EE occurs in approximately 4.3/10,000 children and 2.3/10,000 adults.</p>	<p>AB 163 would not increase utilization of amino acid-based elemental formula, therefore no impact on health outcomes are expected.</p> <p>Insurance coverage for this benefit will increase for and out-of-pocket costs will decrease for approximately 615 individuals and therefore will likely reduce the administrative burden and financial hardship associated with these disorders for those families.</p> <p>AB 163 is not expected to have an impact on gender, racial, or ethnic disparities in health outcomes.</p> <p>AB 163 is not expected to have an impact on premature death.</p> <p>AB 163 is not expected to reduce economic loss associated with EGID.</p>

Bill Summary	Medical Effectiveness of a Mandated Service or Treatment	Coverage	Estimated Utilization Impact of Mandate	Estimated Cost Impact in Terms of Total Health Care Expenditures (a)	Estimated Cost Impact in Terms of % Premium Changes by Payer (b)	Burden of Disease	Estimated Public Health Impact
<p>AB 98, De La Torre, Maternity Services (3/16/2009)</p> <p>AB 98 would require health insurance products regulated under the California Department of Insurance (CDI) to cover maternity services.</p>	<p>Evidence shows that there is no difference in birth outcomes for infants or mothers in association with numbers of prenatal visits.</p> <p>Evidence suggests that some prenatal care services are effective (i.e., counseling; screening tests; diagnostic and preventive services; supplements).</p>	<p># of individuals in CDI-regulated plans with maternity coverage, in:</p> <p><i>Large- and small-group plans,</i></p> <p><i>Before:</i> 1,132,000 (100%)</p> <p><i>Individual plans,</i></p> <p><i>Before:</i> 233,000</p> <p><i>After:</i> 1,038,000</p> <p><i>Change:</i> 805,000 (345% increase)</p> <p><i>All CDI-regulated plans (total),</i></p> <p><i>Before:</i> 1,565,000</p> <p><i>After:</i></p> <p>2,370,000</p> <p><i>Change:</i></p> <p>805,000 (51% increase)</p>	<p>No increase in utilization of maternity services including prenatal care services</p>	<p>\$29 million (0.04%)</p>	<p>PRIVATE</p> <p>Employers (0.0%)</p> <p>Employees covered by group insurance (0.0%).</p> <p>Individually purchased insurance (+1.50%).</p> <p>PUBLIC</p> <p>CalPERS (N/A)</p> <p>Medi-Cal (N/A)</p> <p>HFP (N/A)</p> <p>Members out-of-pocket expenses:</p> <p>Copayment (0.34%)</p> <p>Direct payment (-100%)</p>	<p>Approximately 550,000 births occur annually in California.</p>	<p>CHBRP is unable to estimate what the impact of AB 98 will be on the utilization of prenatal care. To the extent that AB 98 increases the utilization of effective prenatal care that can reduce outcomes such as preterm births and related infant mortality, there is a potential to reduce morbidity and mortality and the associated societal costs.</p> <p>To the extent that AB 98 increases the utilization of effective prenatal care, there is a potential to reduce preterm births and infant mortality. To the extent that AB 98 increases the utilization of effective prenatal care, there is a potential to reduce economic loss associated with preterm births and related mortality.</p>

Bill Summary	Medical Effectiveness of a Mandated Service or Treatment	Coverage	Estimated Utilization Impact of Mandate	Estimated Cost Impact in Terms of Total Health Care Expenditures (a)	Estimated Cost Impact in Terms of % Premium Changes by Payer (b)	Burden of Disease	Estimated Public Health Impact
<p>AB 56, Portantino, Mammography (3/16/2009)</p> <p>AB 56 requires health insurance policies regulated by the California Department of Insurance (CDI) to provide coverage for mammography upon provider referral.</p>	<p>Evidence shows that among women aged 40 years and older, mammography screening reduces breast cancer mortality by: (1) 15% to 26% after 7 to 9 years of follow-up for women aged 50 years and older; and (2) 15% to 17% after 10 to 14 years of follow-up for women aged 40 to 49 years.</p> <p>Harms associated with mammography screening are primarily false positive findings that result in additional outpatient visits, additional diagnostic imaging, and biopsies.</p> <p>Evidence shows that notifying women through written notice about routine mammography screening can increase the overall mammography screening rate by one third.</p>	<p># of individuals with mandated coverage for mammograms (similar to mandated level, women in CDI regulated plans), 1,185,000 (100%)</p> <p># turning 40 who receive mandated written notification by CDI- and DMHC regulated plans,</p> <p><i>Before:</i> 35,000</p> <p><i>After:</i> 160,000</p> <p><i>Change:</i> 125,000 (357% increase))</p>	<p>Due to increased notification an increase of approximately 20,000 (0.38%) in total # of mammograms among women with coverage after AB 56 implementation.</p>	<p>+\$3.8 million</p>	<p>PRIVATE</p> <p>Employers (+0.01%)</p> <p>Individuals w/individual coverage (+0.01%)</p> <p>PUBLIC</p> <p>CalPERS (+0.01%)</p> <p>Medi-Cal (+0.01%)</p> <p>HFP (+0%)</p> <p>Members' out-of-pocket expenditures</p> <p>Copayment (+0.01%)</p> <p>Direct payment (+0%)</p>	<p>One in nine women in California will be diagnosed with breast cancer in her lifetime.</p>	<p>Due to increased notification, this mandate is expected to increase the number of women who receive mammograms each year by 20,000. A reduction in mortality is expected with the prevention of approximately 16 deaths from breast cancer per year, beginning approximately 14 years after implementation of AB 56.</p> <p>To the extent that notification increases mammography screening among non-white women, there is the potential for AB 56 to reduce the racial/ethnic disparities in screening rates and health outcomes associated with breast cancer.</p> <p>AB 56 is expected to save 366 life-years and \$5.2 million in productivity.</p>

Notes: (a) Total expenditures include total premiums and out-of-pocket spending for copayments and noncovered benefits.

(b) Percentages differ from those in published reports due to rounding to the second decimal place.

(c) Members' out-of-pocket expenditures refer to privately insured members' out-of-pocket expenditures, copayments, and direct payments for services not covered under the benefit.



Appendix 10: Medical Effectiveness Analysis Research Approach¹

Background

California Health Benefits Review Program (CHBRP) reports present three types of information about proposed health insurance benefit mandates or repeals: (1) the medical effectiveness of screening, diagnostic, treatment, and other health services addressed in the legislation; (2) the financial impacts of the legislation; and (3) the impact on public health. This document describes the seven steps in the process used to analyze medical effectiveness:

- I. Preparing to conduct the literature search
- II. Conducting the literature search
- III. Deciding whether to retrieve articles
- IV. Selecting articles for inclusion in the review
- V. Reviewing the literature
- VI. Making a qualitative “call” on evidence of effectiveness in the literature
- VII. Summarizing the quantifiable evidence for specific outcome

Preparing to Conduct the Literature Search

- A. CHBRP staff at the University of California Office of the President (UCOP) receive a request from the California State Legislature to analyze a bill that would establish or repeal a health insurance mandate. An electronic copy of the bill is made available to all CHBRP faculty and staff.
- B. CHBRP staff at UCOP work with CHBRP faculty and staff at UC campuses to determine who will work on the medical effectiveness, cost, and public health analyses.
- C. CHBRP staff at UCOP complete a telephone call with the bill author’s staff (and sometimes the bill sponsor) to clarify the bill author’s intent. The items discussed in the telephone call are derived from a bill author questionnaire that contains standard questions as well as questions specific to the bill that have been posed by CHBRP faculty and staff. The medical effectiveness team reviews the responses to the bill author questionnaire and uses them to refine the specifications for the literature search.
- D. The medical effectiveness team, in consultation with other CHBRP faculty and staff, identifies a content expert for the bill. This person is an expert in a relevant clinical specialty

¹ Prepared by Janet M. Coffman, MPP, PhD; Mi-Kyung Hong, MPH; Wade M. Aubry, MD; Chris Tonner, MPH; Patricia E. Franks; and Ed H. Yelin, PhD.

who is knowledgeable about current clinical practice, as well as clinical controversies associated with the proposed mandate or repeal. The content expert is also usually familiar with clinical epidemiology, health services research, or evidence-based medicine. For some bills, two content experts may be retained to ensure that the team obtains expertise in several areas relevant to the bill. Examples include bills that would have required coverage for oral chemotherapy drugs (SB 161 and SB 961) and for diabetes-related complications (SB 1104). For both of these bills a physician and a pharmacist were retained to provide expertise on pertinent diseases and the medications used to treat them.

- E. The content expert reviews the bill and assists the medical effectiveness team in clarifying the meaning of the clinical terms used in the proposed mandate or repeal. For example, in reviewing the literature pertaining to the analysis of Assembly Bill 1549 (2003), which addressed management of childhood asthma, the content expert explained what physicians mean by “treatment action plans” and the differences between types of action plans (i.e., peak flow-based vs. symptom-based).
- F. The medical effectiveness team, in consultation with the content expert and the medical librarian, defines the scope of the literature search and develops a plan for analyzing the literature. A literature search specifications memo is prepared and submitted to the librarian to guide the search.
 - 1. The team identifies the type of intervention(s) the bill addresses (e.g., is the intervention a screening, diagnostic, or monitoring test, a procedure, or a treatment?) and the literature needed to analyze the impact of the bill on patient outcomes and utilization of health care services.
 - 2. The team identifies the types of studies that contain information pertinent to the intervention(s). For example, if the mandate or repeal were about osteoporosis treatment, studies about the effectiveness of osteoporosis treatments would be included, but studies of the effects of primary prevention of osteoporosis would be excluded.
 - 3. The team, in consultation with the content expert, identifies the outcomes that the literature review will assess. If the language of a bill references specific outcomes, these outcomes will be included in the review. If the bill does not mention specific outcomes, the team and the content expert will identify outcomes most relevant to the proposed mandate or repeal. There is a preference for outcomes that are meaningful to consumers, including patient-reported outcomes, over physiological outcomes. Outcomes of particular interest to CHBRP include mortality, morbidity, quality of life, ability to perform everyday activities, and absences from school and work due to illness.
 - 4. The medical effectiveness team, in consultation with the medical librarian and content expert, uses the following general inclusion/exclusion criteria:
 - a. Include only studies for which an abstract has been published. The tight time frame for production of CHBRP reports (60 days from legislative request to completed report) compels the team to rely on abstracts as a screen to determine whether articles should be included in a literature review. Although some articles that do not have

- abstracts present research findings, most are commentaries, editorials, and letters to the editor that do not present the results of medical effectiveness studies and, thus, are not included in CHBRP’s literature reviews.
- b. Include only abstracts in English. The time frame for CHBRP reviews is too short to obtain translations of medical literature published in other languages.
 - c. Limit the search to the population affected by the proposed mandate or repeal. For example, for the analysis of AB 1549 (2005), which concerned management of childhood asthma, “children” were defined as persons aged 0 to 18 years and studies in which a large proportion of the subjects were older than 18 years were excluded.
 - d. Limit the search to the past 20 years. The team may shorten the time period, if there is a large body of literature on the topic and/or if the content expert has indicated that treatment has changed considerably over the past 20 years. The team may lengthen the time period if there are few published studies.
 - e. In cases in which CHBRP is asked to analyze a bill that is similar to a bill on which the program has previously issued a report, the search is limited to literature published since the previous report was issued.²
5. The team, in consultation with the medical librarian and the content expert, determines the databases to be searched.

Peer-reviewed literature

The following databases that index peer-reviewed literature are typically searched: The Cochrane Library, MEDLINE (PubMed), and Web of Science. EMBASE, a database that primarily contains international studies, is searched if searches of the aforementioned databases retrieve little literature. Other specialized databases of peer-reviewed literature such as CINAHL, International Pharmaceutical Abstracts, and PsycINFO are searched if they are likely to contain articles relevant to the proposed mandate or repeal.³

Cochrane reviews are authoritative, peer-reviewed systematic reviews that can be treated as a “gold standard” with regard to the rigor of the methods used to review the medical literature.

² For example, in 2009 CHBRP was asked to analyze a bill (SB 158) that would mandate coverage for the human papillomavirus (HPV) vaccine. This bill was identical to a bill (AB 1429) CHBRP had analyzed in 2007. Because CHBRP had conducted a comprehensive search of literature published through 2006 for AB 1429, the search for SB 158 was limited to literature published from January 2007 through March 2009.

³ Some material published in peer-reviewed journals has not been peer reviewed. In particular, journals may publish guidelines issued by organizations whose work is of interest to their readers without peer review. For example, *Obstetrics & Gynecology* publishes guidelines issued by the American College of Obstetrics and Gynecology, and *CA: A Cancer Journal for Clinicians* publishes American Cancer Society guidelines. Some of these guidelines are based on opinion and may provide weaker evidence than peer-reviewed journal articles and some documents in the grey literature. As discussed in Section IV. C., the medical effectiveness team applies the same hierarchy of evidence to all literature regardless of whether it appears in peer-reviewed journals or the grey literature. In addition, the medical effectiveness team and the content expert apply their knowledge of pertinent guidelines, journals, etc., when selecting literature for inclusion in the literature reviews.

Cochrane reviews are often narrow in focus and, thus, most helpful for analyses of bills that address a limited set of services. For more general bills, Cochrane reviews are used to supplement systematic reviews that address broader ranges of services, such as those conducted by the National Institute for Health and Clinical Excellence (NICE)⁴ and the Agency for Healthcare Research and Quality's Evidence-based Practice Centers (AHRQ EPCs).

Grey literature

CHBRP also searches the grey literature, which consists of material that is not published commercially or indexed systematically in bibliographic databases. The grey literature is primarily composed of technical reports, working papers, dissertations, theses, business documents, and conference proceedings. The CHBRP medical effectiveness team draws upon grey literature from government agencies, scientific research groups, and professional societies for its reviews. Systematic reviews are among the types of grey literature most frequently analyzed for CHBRP reviews.

The medical effectiveness team has grouped the sources of grey literature into two hierarchical tiers based on the strength of the evidence.

First tier of the grey literature: The first tier of the grey literature includes systematic reviews and meta-analyses issued by authoritative organizations whose primary mission is to conduct objective analyses of the effectiveness of medical interventions that are used to develop evidence-based clinical practice guidelines. NICE and the US Preventive Services Task Force (USPSTF) are two of the most useful sources in this category, because these organizations commission systematic reviews that explicitly state their research questions, use standardized methods to assess the strength of evidence, and distill detailed findings into a small number of major conclusions. Other sources in this category include: the AHRQ EPCs, the Centers for Disease Control and Prevention Advisory Committee on Immunization Practices (CDC ACIP), the International Network of Agencies for Health Technology Assessment (INAHTA), the National Institutes of Health (NIH), the Scottish Intercollegiate Guidelines Network (SIGN), and the World Health Organization (WHO). These sources are always searched if they address the diseases or conditions covered by a bill (e.g., always search the USPSTF website when analyzing bills on screening tests). Systematic reviews and meta-analyses issued by these organizations will be incorporated into CHBRP's literature review as described in Section IV. C. below. CHBRP will rely most heavily on literature syntheses that present major findings from rigorous analyses of the evidence in a clear and concise manner.

Second tier of the grey literature: The second tier of grey literature consists of clinical practice guidelines issued by medical and scientific societies. They are often based on expert opinion, although some are evidence-based. The merit of these guidelines stems from the authoritative reputation of the societies. Such guidelines include those issued by AACE (American Association of Clinical Endocrinologists), AAP (American Academy of Pediatrics), AAPD (American Academy of Pediatric Dentistry), ACOG (American College of Obstetricians and Gynecologists), ADA (American Diabetes Association), APA (American Psychiatric Association), and NCCN (National Comprehensive Cancer Network). Decisions about searches

⁴ NICE commissions other organizations, such as the National Collaborating Centre for Women's and Children's Health, to produce evidence-based guidelines on some topics.

of professional society Web sites for guidelines will be made on a case-by-case basis. Decisions will be based on the following criteria: knowledge of the medical effectiveness team and content expert regarding guidelines issued by pertinent professional societies, the strength of evidence available from other sources, and whether the bill explicitly references guidelines or is derived from a guideline.

Clinical practice guidelines

CHBRP has developed the following criteria to determine whether and how clinical practice guidelines should be incorporated into its medical effectiveness reviews.

Bills that reference clinical or national practice guidelines

In the cases where a bill may mandate coverage for an intervention that is:

- “consistent with national guidelines,” or
- a guideline is an obvious source of bill language, or
- a guideline is specified in the bill,

the medical effectiveness team will select studies for inclusion per CHBRP’s hierarchy of evidence (discussed in Section IV.A., below) and also will assess relevant guidelines.

Bills that DO NOT reference clinical practice guidelines

The medical effectiveness team will follow CHBRP’s hierarchy of evidence, which ranks clinical practice guidelines below other sources of evidence regarding medical effectiveness. Systematic reviews and meta-analyses that are part of a guideline may be reviewed separately per the hierarchy of evidence. If a guideline appears to be evidence-based and relevant to the issue, the medical effectiveness team may reference it in the text. In a case where little or conflicting information about the issue is available, the medical effectiveness team may cite guidelines with appropriate caveats noted (i.e., strength of evidence, guideline author, etc).

For bills for which the medical effectiveness team determines that clinical practice guidelines should be reviewed, the National Guideline Clearinghouse (NGC) is always searched to identify pertinent guidelines. The medical effectiveness team uses NGC’s summaries to screen guidelines and retrieves the full text of guidelines it selects for inclusion in the literature review.

Web sites maintained by organizations that issue clinical practice guidelines are also searched, because NGC has several important limitations. NGC relies on voluntary submissions and, as a consequence, does not index all guidelines. Some of the most authoritative guidelines are not indexed by NGC. In addition, the quality of the evidence presented in guidelines indexed by NGC varies. Some guidelines are based on systematic reviews of peer-reviewed literature, whereas others are based on expert opinion. In addition, NGC’s summaries of guidelines are not as authoritative or as exhaustive as the full guidelines.

- G. The medical effectiveness team, content expert, and medical librarian take into account both the literal meaning and intent of the proposed mandate or repeal when developing the strategy for the literature search.
1. Some mandates and repeals address coverage for multiple types of services (e.g., medical treatment, medical supplies, physical therapy, and counseling). In such cases, the literature search will be designed to retrieve literature on all types of services to which a mandate or repeal would apply.
 2. For some bills, the medical literature may be assessed in segments because it addresses a wide range of diseases and conditions. For example, if a proposed mandate or repeal addressed cancer screening, the team would need to obtain and separately analyze literature on screening of multiple types of cancer (e.g., breast, colorectal, lung, and prostate).
 3. Screening, diagnostic, monitoring, and treatment interventions require different analytic approaches. For example, a treatment is typically designed to cure a disease or improve function, and designing trials to assess how well the treatment works may be relatively straightforward. On the other hand, a screening test might indicate an increased risk of a disease. This may lead to recommendations for one or more types of preventive interventions. The interventions may vary in their effectiveness, and the disease, which may or may not occur even if the result of the screening test is positive, may be treated in various ways.⁵ Thus, an effectiveness assessment of an intervention will have to be built upon information available from various parts of the “evidence chain.” To assess each of these links, information needs to be collected over a long period of time. Testing and treatment options continually change over time, and studies that directly address all effectiveness questions pertinent to a bill may not exist.
 4. Some bills may concern the terms of coverage for different types of services rather than coverage for individual health care services per se. Examples include SB 572 (2005), which addressed parity in coverage of physical and mental health services, and SB 1198 (2008), which concerned parity in coverage for durable medical equipment. For parity bills, the medical effectiveness analysis focuses on evidence of the effects of parity, such as the effects of reduction in cost sharing for the services addressed by a mandate or repeal on utilization of those services and health status, to the extent literature is available on these topics. Other bills that have addressed the terms of coverage include AB 1826 (2010), which would have prohibited “fail-first protocols” for pain medication. For this bill, the medical effectiveness team reviewed the literature on the impact of “fail-first protocols.”
 5. Some bills address more treatments or conditions than the medical effectiveness team can analyze within 60 days. For example, SB 961 (2010), a bill regarding coverage for oral anti-cancer medications, would have affected coverage for 40 medications that are used

⁵ For example, a screening test may indicate that a person has high cholesterol. Based on this result, his or her physician may recommend exercise, dietary changes, and/or medication. These preventive interventions may or may not lower the person’s cholesterol or prevent him or her from developing heart disease. If he or she develops heart disease, his or her physician may recommend one of several treatments which may or may not be successful.

to treat 54 cancers. In such cases, the medical effectiveness team assigned to a bill will work with other members of the analysis team to develop a feasible research approach. For example, for SB 961, the medical effectiveness team provided readers with general descriptive information regarding oral anti-cancer medications but did not analyze the literature on the effectiveness of any of these medications.

Conducting the Literature Search

- A. The medical librarian conducts the search and contacts the medical effectiveness team and the content expert regarding questions as they arise.
- B. The medical librarian provides the initial search results to the team in EndNote to the maximum extent feasible. All citations to peer-reviewed literature should be included in the EndNote file. Ideally, citations to the grey literature should be included as well, but this may not be feasible in cases in which the number of citations to the grey literature is large
- C. The medical librarian records all search terms, including Medical Subject Headings (MeSH) terms and key words.
- D. The team assesses the extent to which the results of the literature search address the questions and issues underlying the proposed mandate or repeal, consulting the content expert as needed. If the initial literature search returns few results, the search criteria will be reexamined, and the medical librarian will run additional or modified searches, or the lead analyst on the medical effectiveness team will search articles from the reference lists of articles that have already been retrieved to determine if they contain any additional articles pertinent to the bill.

Deciding Whether to Retrieve Articles

- A. At least two medical effectiveness team members review all abstracts returned by the search to identify articles for which the full text will be retrieved.⁶ Criteria for excluding articles may include (1) duplicate studies, (2) study subjects who are not representative of Californians who would be affected by the mandate or repeal, and (3) articles that describe interventions but do not assess their effectiveness.
- B. For utilization outcomes, only studies conducted in the United States are selected. When an outcome is likely to depend on specific aspects of the US health care system, such as the effect of pediatric asthma education on emergency department visits, the results may be affected by policies and norms of “usual care” that differ in other countries. However, if the outcome of interest concerns health status, international studies are included.

⁶ This approach risks excluding useful articles based on their abstracts. This risk is necessary, given the short time frame for CHBRP reports. However, abstracts often overstate, rather than understate, authors’ findings.

- C. Once a full-text article is retrieved,⁷ the team reapplies the initial inclusion/exclusion criteria to ensure the study is relevant to the proposed mandate or repeal.
- D. There may be instances in which the full text of an article cannot be retrieved quickly enough to meet the timeline for a CHBRP review. In these instances, the team relies on the published abstract. Reliance on an abstract may omit information relevant to a CHBRP review, including some of the study's results and information about the characteristics of the study population. The team keeps a log of articles that appear relevant, but for which full text was not available in time for inclusion in the draft report circulated for review. If articles arrive after the due date for the draft report, they will be examined to determine whether they would substantively alter the team's conclusions. If the conclusions would change, the report is revised accordingly.

Selecting Studies for Inclusion in the Literature Review

A. Hierarchy of Evidence

In general, the medical effectiveness team faculty and staff adhere to the following hierarchy of evidence when determining which articles to include in a review.

1. High-quality meta-analyses⁸—particularly those included in the Cochrane Library
2. Systematic reviews—particularly those performed by authoritative organizations, such as the AHRQ, NICE, USPSTF, and other government agencies (e.g., NIH, CDC, and the Centers for Medicare & Medicaid Services)
3. Well-designed randomized controlled trials (RCTs) and cluster RCTs⁹

⁷ The team retrieves full-text articles available on the Internet through the University of California libraries. If an article is not available online, but is available in hard copy at the UCSF library (or the UCSD library in cases in which a medical effectiveness analysis is completed by the UCSD team), a team member retrieves the article from the library. If an article is not available at UCSF or UCSD, the team requests the article through interlibrary loan, from the journal's website, or a commercial document delivery service.

⁸ "High-quality" meta-analyses are meta-analyses that have clear objectives and hypotheses, apply appropriate inclusion/exclusion criteria, assess meaningful outcomes, and use sound methods to find, select, and evaluate studies and to generate pooled estimates of an intervention's effects. In general, results of meta-analyses of randomized controlled trials (RCTs) are likely to produce more valid estimates than meta-analyses of observational studies, because randomization of subjects reduces the risk of selection bias. In addition, meta-analyses with large numbers of observations (i.e., where the sum of observations from all studies included in a review is large) are likely to yield more valid estimates than meta-analyses with small numbers of observations because they have greater power to detect effects. *Cochrane Handbook for Systematic Reviews of Interventions* 4.2.5, Chichester, UK: John Wiley & Sons, 2005, p. 97–99; Egger M, Schneider M, Smith GD. Meta-analysis: Spurious precision? Meta-analysis of observational studies. *British Medical Journal* 1998;316:140-144. Egger M, Smith GD, Phillips AN. Meta-analysis: Principles and procedures. *British Medical Journal* 1997;315:1533-1537; Flather MD, Farkouh ME, Pogue JM, Yusuf S. Strengths and limitations of meta-analysis: Larger studies may be more reliable. *Controlled Clinical Trials*. 1997;18:568-579.

⁹ "Cluster RCTs" are studies in which subjects are randomized in groups rather than as individuals. This research design is typically used in situations in which the intervention is administered to groups of subjects or in which

4. RCTs and cluster RCTs with major weaknesses
5. Nonrandomized studies with comparison groups and time series analyses
6. Case series and case reports
7. Clinical practice guidelines and narrative reviews (i.e., “grey beard reviews”)¹⁰

B. Implementing the Hierarchy of Evidence

1. If published meta-analyses and/or systematic reviews are available, the team generally uses them as the principal source of information for the review. The remainder of the review is then limited to individual studies published after the articles included in the meta-analyses and/or systematic reviews. For example, if a meta-analysis was published in June 2001 and included studies published up to December 1, 2000, the team would focus on individual studies published on or after December 1, 2000.
2. The team reviews published meta-analyses and/or systematic reviews for consistency. If there are several meta-analyses and/or systematic reviews that reach different conclusions, the team will consult with the content expert to identify possible explanations (e.g., the inclusion/exclusion criteria of the meta-analyses and/or systematic reviews vary, one or more meta-analyses and/or systematic reviews do not use rigorous methods). In some cases, the results of one or more meta-analyses and/or systematic reviews may be discounted. The rationale for discounting is discussed in the report.
3. If no applicable meta-analyses and/or systematic reviews are available, the medical effectiveness team proceeds down the hierarchy of evidence.
4. Where meta-analyses and/or systematic reviews are available, narrative (unsystematic) reviews are excluded from CHBRP’s medical effectiveness reviews. However, when literature regarding a disease and intervention is sparse, the medical effectiveness team includes narrative reviews (e.g., AB 163 [2009] on amino-acid based elemental formula; AB 30 [2007] on inborn errors of metabolism).
5. Strict adherence to the hierarchy of evidence may not be possible or advisable in all cases. For example, if a mandate or repeal addresses coverage for a new screening test and there are meta-analyses of the sensitivity and specificity of the test, but only

randomization at the individual level may lead to contamination of the control group (i.e., inadvertent exposure to the intervention).

¹⁰ Clinical practice guidelines are ranked below other sources of evidence because strength of the evidence on which they are based varies widely. Some guidelines contain recommendations based on meta-analyses, systematic reviews, or multiple RCTs, whereas others are based solely on expert opinion. This wide variation exists across organizations that issue guidelines and among guidelines issued by individual organizations. For example, a recent study of guidelines issued by the American College of Cardiology and the American Heart Association found that most recommendations contained in these guidelines were based on expert opinion and only that 11% were based on evidence from meta-analyses or multiple RCTs. Tricoci P, Allen JM, Kramer JM, Califf RM, Smith SC. Scientific evidence underlying the ACC/AHA clinical practice guidelines. *Journal of the American Medical Association*. 2009; 301:831-841.

nonrandomized studies of the test's effects on utilization and clinical outcomes, the meta-analyses cannot fully substitute for the nonrandomized studies. The rigor of the former studies must be balanced against the relevance of the latter.¹¹

C. Use of Grey Literature

1. The hierarchy of evidence is applied in a consistent fashion to both the peer-reviewed literature and the grey literature. Systematic reviews and clinical practice guidelines are the most frequently cited types of grey literature.
2. The medical librarians conduct literature searches jointly for grey literature and peer-reviewed literature, and are instructed to search for those sources of grey literature most likely to publish high-quality literature syntheses. For further discussion of literature search methods, see Section II: *Conducting the Literature Search* (pgs. 4–6).
3. Grey literature and peer-reviewed literature about the medical effectiveness of an intervention may contain varying levels of detail. For example, some organizations that develop clinical practice guidelines, such as the USPSTF, publish summaries in peer-reviewed journals and the full guidelines and associated systematic reviews as grey literature. In such cases, the grey literature version of the guideline is reviewed to obtain additional detail not found in the peer-reviewed version.

Reviewing the Literature

- A. The medical effectiveness team will generally not have time to undertake as detailed a review of the methods and quality of individual studies as the authors of a meta-analysis can.
- B. Once articles have been selected for inclusion in the review, the team prepares a table that records information from each article regarding the study's research design, the population studied, the location in which the study was conducted, and the intervention and comparison groups. This table appears in an appendix to the report. Table 10-1 presents an example of the information recorded for studies of pediatric asthma self-management.
- C. Some of the full-text articles retrieved may ultimately be excluded from the review if the medical effectiveness team, in consultation with the content expert, determines that the study is not relevant to the proposed mandate or repeal, is not generalizable to the population addressed by the mandate or repeal, or has major methodological problems that affect the validity of its findings.

¹¹ CHBRP's analysis of AB 259, a bill that would allow women to obtain services from a certified nurse midwife (CNM) directly without a physician's referral, illustrates the trade-off between rigor and relevance. Most RCTs on the effectiveness of midwives that have been conducted in developed countries were carried out in Australia, Canada, New Zealand, and the United Kingdom. Midwives in these countries work within health care systems that are quite different from that of the United States. The level and type of education mandated for midwifery practice in these countries also differs from that required of CNMs in the United States. The medical effectiveness team decided that its literature review for this bill should go beyond RCTs to also include observational studies with comparison groups that were conducted in the United States (CHBRP 2009e). Although the observational studies are weaker methodologically (in particular, they may be subject to selection bias), their findings are more generalizable to the providers to which the bill would apply (i.e., CNMs) than non-U.S. studies.

Table 10-1. Summary of Published Studies on the Effectiveness of Pediatric Asthma Self-Management and Training Interventions

Citation	Type of Trial*	Intervention vs. Comparison Group	Population Studied	Location
Huss et al., 2003	Level III	Education and computer-based instructional asthma game vs. education alone	Inner-city children	Baltimore, MD
Krishna et al., 2003	Level II	Internet-enabled, interactive multi-media asthma education, conventional education, and asthma action plans vs. conventional education and asthma action plans	Children who visited a pediatric pulmonary clinic	St. Louis, MO
LeBaron et al., 1985	Level II	Education vs. usual care	Children treated at private pediatric allergy practices whose families had a wide range of incomes	San Antonio, TX

* Level I=Well-implemented RCTs and cluster RCTs, Level II=RCTs and cluster RCTs with major weaknesses, Level III=Nonrandomized studies that include an intervention group and one or more comparison group, time series analyses, and cross-sectional surveys, Level IV=Case series and case reports, Level V=Clinical/practice guidelines based on consensus or opinion.

D. As indicated in Section I.F., above, in the cases where (1) a bill may mandate coverage for an intervention that is “consistent with national guidelines”, (2) a guideline is an obvious source of bill language, or (3) a guideline is specified in the bill, the medical effectiveness team will select studies for inclusion per CHBRP’s hierarchy of evidence and also will assess relevant guidelines. The medical effectiveness team will also construct a table that summarizes and rates pertinent guidelines according to CHBRP criteria.

The rating system is under development and will be tested during the 2011 analytic season. CHBRP will review the Institute of Medicine’s Committee on Standards for Developing Trustworthy Clinical Practice Guidelines report (expected release first quarter of 2011) and incorporate relevant recommendations into the finalized approach to using clinical practice guidelines. Based on the rating system, the medical effectiveness team may include a discussion of the consistency of the medical effectiveness review’s conclusions with guidelines.

Making a Qualitative “Call” on Evidence of Effectiveness in the Literature

- A. In a conference call or group meeting, the medical effectiveness team and the content expert review the results of relevant studies for each outcome and decide collectively, based on the weight of the evidence available, on the effectiveness of the intervention across five dimensions.
- B. In making a “call” for each outcome measure, the team and the content expert consider the number of studies as well the strength of the evidence. To grade the evidence for each outcome measured, the team uses a grading system that has the following categories:

Research design
Statistical significance
Direction of effect
Size of effect/Clinical significance
Generalizability of findings

Each of these categories is described below along with the criteria that are used to classify studies within each category. Once studies have been classified within categories, a conclusion about the medical effectiveness of an intervention can be made. The language that is used to describe the medical effectiveness team’s overall conclusion regarding the medical effectiveness of the intervention is also discussed.

1. Research Design

This category contains information about the strength of the research designs of individual studies that evaluate an intervention’s effect on an outcome of interest. Studies are assigned to one of five levels adapted from ranking systems developed by the American College of Chest Physicians and the North American Spine Society.¹² ***The levels refer to the strength of the research designs of individual studies. They do not refer to the overall strength of the evidence regarding an intervention’s effect on an outcome.*** Level I studies have the strongest research designs and Level V studies have the weakest research designs. The five levels are as follows:

Level I: Well-implemented RCTs and cluster RCTs (Strong RCTs)

Level II: RCTs and cluster RCTs with major weaknesses (Weak RCTs)

Level III: Nonrandomized studies that include an intervention group and one or more comparison groups and time series analyses

Level IV: Case series and case reports

Level V: Clinical practice guidelines and narrative reviews

¹² Cook DJ, Guyatt GH, Laupacis A, Sackett DL. Rules of Evidence and Clinical Recommendations on Use of Antithrombotic Agents (Third ACCP Consensus Conference on Antithrombotic Therapy). *Chest*. 1992;102(4):305S-311S. North American Spine Society. Levels of evidence for primary research question. www.spine.org/forms/LevelsofEvidenceFinal.pdf. Accessed on October 4, 2006.

Level I groups RCTs and cluster RCTs because either research design may be more or less appropriate than the other depending on the intervention studied. The RCT design is more appropriate than the cluster RCT design when an intervention is delivered to individuals and is provided in such a manner that the control or comparison group is unlikely to be inadvertently exposed to the intervention. Conversely, the cluster RCT design is more appropriate when an intervention is delivered to groups of individuals or in situations in which the control or comparison group could be contaminated.¹³

“Well-implemented RCTs and cluster RCTs” are defined as studies that have (1) sample sizes that are sufficiently large to detect statistically significant differences between the intervention and control groups (100 or more subjects), (2) low attrition rates (less than 20%), (3) use intent-to-treat methods,¹⁴ and (4) intervention and control groups that are statistically equivalent prior to the intervention, with respect to baseline measures of the outcome and important factors associated with the outcome. To be considered well-implemented, a cluster RCT must also use appropriate statistical methods to determine whether observations are clustered at the level at which randomization occurs and, if so, to adjust for clustering. Such adjustment is necessary to ensure that the statistical significance of findings is not overstated.

Level II includes RCTs and cluster RCTs that have major weaknesses, such as small sample sizes, high attrition rates without use of intent-to-treat methods, or intervention and control groups that are not statistically equivalent at baseline and, in the case of cluster RCTs, do not test for clustering of observations and adjust for clustering if it is present.

Levels III through V are used to classify studies in which subjects are not randomly assigned to either an intervention or a comparison group. Studies that do not randomize subjects are not as well designed as RCTs for assessing the efficacy of an intervention (i.e., detecting causal inference), because they do not control for selection bias.¹⁵

¹³ For example, the RCT design can be easily used for studies of pharmaceuticals because drugs are dispensed to individuals and because drugs and placebos can be made to appear identical. However, the RCT design is problematic for health education classes taught to children in schools, because children who receive the intervention and their teachers may interact with children in the control group and their teachers. Such interaction could involve sharing of knowledge about asthma self-management that might lead to changes in self-care behavior among children in the control group, which would limit the study’s ability to discern differences between the intervention and control groups. In such cases, a cluster RCT design under which schools rather than children are randomized would be more appropriate than an RCT design.

¹⁴ Intent-to-treat analysis addresses the problem of attrition bias by preserving randomization. If a study has a high rate of attrition, the persons in the intervention group who receive the full treatment may be systematically different from persons who drop out of the study. For example, persons who believe the treatment is not helpful may be more likely to drop out. In such cases, analyzing data only for those persons who completed the study could lead researchers to overestimate the effectiveness of the treatment. Intent-to-treat analysis eliminates this bias because all subjects are included in the groups to which they were randomized regardless of whether they received the full treatment. Some experts in intent-to-treat analysis believe it is sufficient to analyze data only for those subjects for whom complete data are available, whereas others believe that data should be imputed for subjects for whom data are missing (Cochrane Collaboration. *Cochrane Handbook for Systematic Reviews of Interventions Version 4.2.5*. Oxford, UK: The Cochrane Collaboration, 2005).

¹⁵ Selection bias is a formal term used to characterize situations in which the intervention and control groups are not equivalent except for exposure to the intervention, due to some consistent factor that is not measured.

Level III encompasses time series analyses and nonrandomized studies that have intervention and comparison groups. Time series studies analyze multiple observations on subjects before and after exposure to an intervention, which enables researchers to separate the effects of interventions from other factors that influence trends in outcomes over time. Nonrandomized studies with comparison groups include quasi-experimental studies, cohort studies, and case-control studies. In cases in which most studies of an outcome are nonrandomized studies with comparison groups, the effectiveness team will parse these studies to distinguish studies with stronger and weaker research designs.

Level IV studies are those without comparison groups. This level encompasses studies that assess a single group of subjects before and after exposure to an intervention, cross-sectional studies of a single group of subjects exposed to an intervention, and case reports on individual subjects exposed to an intervention.

Level V consists of clinical practice guidelines and narrative reviews.

Meta-analyses and systematic reviews are assigned to the research design level to which most of the studies reviewed correspond. For example, the meta-analyses included in the effectiveness review on Alzheimer's drugs for SB 415 (2004) would be classified as Level I, because most of the studies synthesized in these meta-analyses were well-implemented RCTs. In contrast, a systematic review of multiple types of prosthetic ankle-foot mechanisms that was examined for the report on AB 2012 (2006) would be classified as Level IV, because most studies included in that review were cross-over studies that compared the effects of two or more prosthetic ankle-foot mechanisms on a single group of subjects.

A research design level is assigned to each article included in a medical effectiveness review for a CHBRP report. The articles are aggregated by level for each outcome assessed and the aggregate results are reported in a summary table that appears in the effectiveness section of the text of the report.

The numbers of studies at each level reflect the studies included in a medical effectiveness review and not necessarily the totality of studies on the topic. For some bills, CHBRP relies primarily on meta-analyses, systematic reviews, RCTs, or cluster RCTs, and does not consider studies lower in the hierarchy.

2. Statistical Significance

Statistical significance is another important consideration in assessing the effectiveness of an intervention. If a finding is statistically significant, one has greater confidence that it did not occur by chance. CHBRP considers a finding to be statistically significant if there is a 95% or greater probability that a difference in outcomes between the intervention and control or comparison groups did not occur by chance (i.e., if the p value is 0.05 or less). The 95% confidence interval is a conventional threshold for determining statistical significance. Most studies report the results of formal tests of statistical significance, although some case reports and studies with very small samples do not.

Each study that assesses an outcome will be assigned to one of three categories:

Finding was statistically significant

Finding was not statistically significant

Results of a test of statistical significance were not reported

The studies are then grouped by the three categories and the numbers of studies in each category are reported in the summary table that appears in the effectiveness section of the text of the report.

In cases in which most studies of an outcome report have strong research designs and report the 95% confidence intervals around point estimates of effects, the medical effectiveness team also examines the 95% confidence intervals to determine how similar the results are across studies.

3. Direction of Effect

The direction of the relationship between an outcome and an intervention indicates whether the intervention has a favorable effect on the outcome. A favorable effect may be an increase or a decrease in an outcome depending on the nature of the outcome and the intended effect of the intervention. For example, one would expect a drug for Alzheimer's disease to improve cognitive outcomes, whereas one would expect a biological medication for rheumatic disease to reduce joint pain and swelling. In some cases, there may be no relationship between an outcome and an intervention.

For each outcome, studies that address the outcome are categorized into three groups based on the direction of the effect.

Intervention associated with better outcomes for the intervention group

Intervention had no effect or negligible effect

Intervention associated with poorer outcomes for the intervention group

The "no effect or negligible effect" category includes studies in which the intervention had no effect on the outcome and studies in which the effect was very small, regardless of whether it was statistically significant. Examples of negligible effects found in studies previously reviewed by CHBRP include a 1% difference in severity of asthma symptoms, a 2% difference in scores on an instrument measuring cognitive functioning of persons with Alzheimer's disease, and a 0.7% difference in the performance of hearing aids.

Once individual studies have been coded they are grouped by the three categories. The numbers of studies in each category (i.e., better outcomes, no or negligible effect, and poorer outcomes) are reported in the summary table that appears in the effectiveness section of the report.

4. Size of Effect/Clinical Significance

Policymakers need to know whether an intervention's effect on an outcome is large enough to be meaningful to patients and/or their caregivers.¹⁶ The minimum clinically meaningful effect depends on the disease or condition addressed in a bill, the outcome of interest, and the manner in which the outcome is measured. In general, the minimum clinically meaningful effect is greater for diseases and conditions for which effective treatments are widely available than for terminal or severely debilitating illnesses for which no other treatments exist. With respect to measurement, a difference of two points may be very meaningful for an outcome measured by a single question on a five-point Likert scale, but probably is not meaningful for an outcome measured by an instrument that has multiple items and a maximum score of 100 points. For all outcomes assessed, the medical effectiveness team consults the content expert to determine whether minimum clinically meaningful effects have been established through research or expert opinion.¹⁷

The measures used to assess clinical significance vary across outcomes depending on the availability of research on minimum meaningful differences and the measures used in studies of the intervention in question.

CHBRP cites the effects reported in studies included in its reviews. Some studies report continuous outcomes (e.g., differences in means or medians), whereas others report binary outcomes (e.g., percent changes, relative risks, odds ratios). Statistically significant point estimates are cited in the text. Both point estimates and confidence intervals are reported in the tables. Where minimum clinically meaningful effects have been established, the team will note in the text whether the effects reported by the studies included in the review meet or exceed minimum clinically meaningful effects.

The medical effectiveness team's conclusions regarding the statistical significance, direction, and size of effects are based on findings reported in studies published in peer-reviewed publications. These conclusions may be overstated in cases in which there is bias in the reporting of research findings. Forms of bias include publication bias, multiple publication bias, citation bias, and language bias. Studies have found that some journal editors are more likely to accept studies with statistically significant and favorable findings, and that some researchers are more likely to submit statistically significant findings for publication. Multiple publication bias arises when researchers publish findings for a group of patients multiple times, as was the case in the

¹⁶ Statistical significance and the size of an effect are related, but not synonymous. For example, the apparent effect in a diet study may be large, e.g., a 20-pound weight reduction, but measured with such imprecision due to small sample size that it could also be a weight increase. Perhaps more importantly, a very large study might show statistically significant effects that are not meaningful. For example, with a sufficient number of cases, a new diet might show convincingly that it achieves an average weight reduction of one pound—perhaps statistically significant, but not a meaningful effect.

¹⁷ An example of a research-based approach to determining minimum meaningful effects is the American College of Rheumatology (ACR) Response Rate clinical scoring system that was used in many of the studies synthesized in CHBRP's report on SB 913, which would have mandated coverage for biological medications for rheumatic disease. Under the ACR-20 instrument used in many of these studies, a medication was determined to have a meaningful effect if patients experienced a 20% reduction in the number of tender joints, the number of swollen joints, laboratory test results, and patient and physician assessment of severity of disease.

literature CHBRP analyzed on transplantation services for persons with human immunodeficiency virus. Citation bias occurs when studies with statistically significant findings are cited more frequently than studies with nonsignificant findings and, thus, more easily retrieved when searching for studies. Language bias is an especially important challenge for CHBRP, because CHBRP reviews are limited to studies published in English. Studies conducted in countries in which English is not the primary language are more likely to be published in English-language journals if their findings are statistically significant.¹⁸

The extent and nature of bias probably vary across topics. The problem is probably greatest where most studies are funded by industry and where most studies have weak research designs. However, except for the few topics on which empirical studies have been published, the magnitude and consequences of bias are unknown. The 60-day time frame for CHBRP reports precludes the team from undertaking its own research to determine whether unpublished studies (i.e., studies not published by commercial publishers or issued by government agencies, professional associations, or other organizations) exist and assess their impact on the team's conclusions.

The team inserts a brief paragraph in every CHBRP report that states that our conclusions are based on the best available evidence from peer-reviewed and grey literature. The paragraph also indicates that unpublished studies are not reviewed because the results of such studies, if they exist, cannot be obtained within the 60-day timeframe for CHBRP reports.

5. Generalizability

Generalizability refers to the extent to which a study's findings can be generalized to a population of interest. For CHBRP, the population of interest is the segment of California's diverse population to which a proposed mandate or repeal would apply. Although some studies enroll persons who are very similar to the population addressed by a proposed mandate or repeal, others enroll different populations (e.g., adults vs. children) or populations with different health care needs than many persons to whom an intervention is typically provided (e.g., persons who are less severely ill or do not have co-morbidities). Findings from studies that enroll persons who are different from the population to which a mandate or repeal would apply are less useful in determining whether a mandate or repeal would benefit Californians, even if the studies are well-designed and report statistically and clinically significant findings that favor the intervention. However, concerns about generalizability must be balanced against the need to provide information about medical effectiveness to the Legislature. It is unrealistic to restrict literature reviews only to studies that enroll Californians similar to persons to whom the mandate or repeal would apply because doing so could lead to an undersampling of studies of a treatment or technology.

¹⁸ The information presented in this paragraph was derived from the following sources: Cochrane Collaboration. *Cochrane Handbook for Systematic Reviews of Interventions Version 4.2.5*. Oxford, UK: The Cochrane Collaboration, 2005; Lee KP, Boyd EA, Holroyd-Leduc JM, Bacchetti P, Bero LA. Predictors of publication: characteristics of submitted manuscripts associated with acceptance at major biomedical journals. *Medical Journal of Australia*. 2006; 184:621-626; Sutton AJ, Abrams KR, Jones DR, Sheldon TA, Song F. *Methods for Meta-Analysis in Medical Research*. Chichester, UK: John Wiley & Sons, LTD, 2000; Sutton AJ, Duval SJ, Tweedie RL, Abrams KR, Jones DR. Empirical assessment of effect on publication bias on meta-analyses. *British Medical Journal*. 2000; 320:1574-1577.

The medical effectiveness team addresses generalizability in two ways. First, the team selects studies for inclusion in reviews that are most likely to be generalizable to the population to which a mandate or repeal would apply. To the extent possible, the parameters for the literature search are set to retrieve studies that enroll persons similar to those to which a proposed mandate or repeal would apply. For example, the search for AB 264 (2006), a bill on pediatric asthma education, was limited to studies that enrolled children. Once the literature search is completed, the team takes generalizability into account when selecting studies for inclusion in the review. For AB 264, the team included only studies conducted in the US, because several of the most important outcomes concerned use of health care services. For AB 259 (2009), the medical effectiveness team decided that its literature review for this bill should go beyond RCTs conducted in other developed countries to also include observational studies with comparison groups that were conducted in the United States because the findings from the US studies were more likely to be generalizable to California.

Once studies are selected for inclusion in a review, the team screens them to assess the degree of generalizability to the population to whom a mandate or repeal would apply. Findings regarding the generalizability of studies will be summarized in the text of the report. It is unlikely that a review would include studies that are not at all generalizable to the population that would be affected by a mandate or repeal, because such studies should have been excluded from the review.

6. Conclusion

The last step in evaluating the evidence of medical effectiveness involves making an overall conclusion regarding the strength and consistency of the evidence based on the five above dimensions (research design, statistical significance, direction of effect, size of effect, and generalizability). The following terms are used to characterize the body of evidence regarding the medical effectiveness of the intervention on the outcome.

Clear and convincing evidence
Favorable effect
No effect
Unfavorable effect
Preponderance of evidence
Favorable effect
No effect
Unfavorable effect
Ambiguous/conflicting evidence
Insufficient evidence

The conclusion states that there is “clear and convincing” evidence that an intervention has a favorable effect on an outcome, if most of the studies included in a review have strong research designs and report statistically significant and clinically meaningful findings that favor the intervention. In rare cases, there may be clear and convincing evidence that an intervention has no effect on an outcome or an unfavorable effect.

The conclusion characterizes the evidence as “preponderance of evidence” that an intervention has a favorable effect if the majority of studies meet the five criteria. For example, for some interventions a majority of studies report statistically significant findings favoring an intervention that are large enough to be clinically meaningful, but some studies find no difference. In such cases, the medical effectiveness team would conclude that there is a “preponderance of evidence” favoring the intervention, unless the studies with favorable effects were so much more rigorous than the studies that found no difference that the results of the latter should be discounted. In some case the preponderance of evidence may indicate that an intervention has no effect or an unfavorable effect.

The evidence is presented as “ambiguous/conflicting” if the findings of studies included in the review vary widely with regard to the direction, statistical significance, and clinical significance/size of the effect.

The category “insufficient evidence” of an intervention’s effect is used where there is little if any evidence of an intervention’s effect. In some cases, the only studies published regarding the effectiveness of an intervention have small sample sizes and weak research designs (e.g., case studies and case series). In other cases, clinical practice guidelines based on expert opinion are the only source of information regarding effectiveness. These sources of evidence are not sufficiently rigorous for the medical effectiveness team to make a determination as to whether an intervention is effective. Note that “insufficient evidence” is not the same as evidence of no effect.

One way to understand these groupings is to imagine that after the assessment was completed a new well-designed RCT was published with findings contrary to those of the report. Such a single contradictory study would do little to change the overall assessment of findings labeled as “clear and convincing,” but might call into question findings previously labeled as “preponderance,” and might become the basis for reevaluating findings previously labeled “ambiguous/conflicting.”

Table 10-2 provides an example of a table that appears at the end of the medical effectiveness section of the report that presents findings regarding the five dimensions assessed and the medical effectiveness team’s conclusions regarding an intervention’s effects on pertinent outcomes.

Table 10-2. Studies That Examined the Effectiveness of Different Numbers of Prenatal Visits

Outcome	Citation(s)	Research Design	Statistical Significance	Direction of Effect	Size of Effect	Conclusion
Low birthweight	Fiscella, 1995; Villar et al., 2001	1 meta-analysis and 1 systematic review of Level II studies	• No statistically significant difference	• No effect	• No effect	• The preponderance of evidence suggests that changing the number of prenatal visits does not affect the odds of having a low-birth weight infant
Preterm birth	Fiscella, 1995; Villar et al., 2001	1 meta-analysis and 1 systematic review of Level II studies	• No statistically significant difference	• No effect	• No effect	• The preponderance of evidence suggests that changing the number of prenatal visits does not affect the odds of giving birth preterm
Admission to neonatal intensive care unit	Fiscella, 1995; Villar et al., 2001	1 meta-analysis and 1 systematic review of Level II studies	• No statistically significant difference	• No effect	• No effect	• The preponderance of evidence suggests that changing the number of prenatal visits does not affect the odds that a newborn will be admitted to a neonatal intensive care unit

Summarizing the Quantifiable Evidence for Specific Outcomes

A. The medical effectiveness team also reports pooled estimates of the effects of the intervention on select medical effectiveness outcomes. These estimates may be used by the cost and public health teams to assess a proposed mandate or repeal’s impact on utilization of health care services and its effect on public health.

- B. In some cases, the medical effectiveness team reports quantitative estimates from meta-analyses or individual studies.
1. Quantitative estimates from recent high-quality meta-analyses are used whenever possible, because the authors of meta-analyses may have greater expertise and more time to thoroughly review the pertinent literature than the team, and may use more sophisticated statistical methods to generate quantitative estimates of effects.¹⁹ In cases in which a meta-analysis has been published, the team asks the content expert to assess whether the meta-analysis adequately addresses current practice in the prevention, diagnosis, or treatment of the disease(s) or condition(s) to which the bill would apply.
 - a. Many meta-analyses (particularly those included in the Cochrane Library) report their results as standardized mean differences (SMDs), which is a unitless measure. To obtain values in meaningful units consistent with those assessed in individual studies, such as the number of physician visits, the team extracts data from the individual studies included in a meta-analysis.
 2. In some cases, a single study may be much more rigorous²⁰ than other studies that analyze an outcome.²¹ The point estimate from such a study is likely to be more accurate than a point estimate derived from pooling this study with less rigorous studies. When deciding whether to use the point estimate from a single study, the medical effectiveness team also considers whether the study enrolled persons who are representative of the population to which the proposed mandate or repeal would apply.
- C. The medical effectiveness team generates its own new quantitative estimate of an intervention's effect on an outcome if the following conditions are met:
1. **The outcome is relevant to consumers and policymakers.** For all proposed mandates or repeals, the team determines which outcomes will be assessed in consultation with the

¹⁹ Findings from systematic reviews would not be used because, unlike meta-analyses, systematic reviews do not typically report quantitative estimates of an intervention's effects.

²⁰ "Rigorous" can encompass a variety of characteristics of a study such as selecting a sample that is sufficiently large to provide adequate power to detect differences between the intervention and control or comparison groups, designing the sampling procedure to maximize the likelihood that the intervention and control or comparison groups are equivalent at baseline, using appropriate statistical methods to adjust for lack of equivalence, implementing procedures to prevent contamination of the intervention and control groups, and concealing allocation to the intervention and control groups to the maximum extent feasible. The assessment of "rigor" in this case is considered within the context of studies that address the questions needed for the review. Thus, a methodologically rigorous study that focused only on a narrow subset of the population to whom the mandate or repeal would be applied would not necessarily "trump" other studies.

²¹ For example, CHBRP relied on a single study in its analysis of the literature on the effect of high-deductible health plans on use of preventive services. The medical effectiveness team found that the literature consisted of one large, rigorous RCT, the RAND Health Insurance Experiment (HIE); a few small RCTs; and a number of retrospective observational studies. The RAND HIE was a highly generalizable study that enrolled children and non-elderly adults with low or moderate household incomes from six urban and rural communities across the United States into various types of health plans, including a high-deductible plan.

members of the analytic team for the bill, the content expert, and State Legislature staff responsible for a bill.

2. There are no recent high-quality meta-analyses on the topic or the findings of the most recent studies differ significantly from findings of studies synthesized in meta-analyses.
3. There is not a single large, well-executed RCT that is much more rigorous than other studies that assess an outcome and that analyzes subjects who are representative of the population to which the proposed mandate or repeal would apply.
4. **The studies that measure the outcome are methodologically rigorous.** RCTs generally provide the best estimates of a proposed mandate or repeal's effect on an outcome, because they provide the greatest assurance that a change in the outcome is due to the intervention and not some other factor. If the majority of studies of an outcome are RCTs or cluster RCTs, the team pools only estimates from RCTs. If a majority of the relevant studies are observational studies, a biostatistician is consulted to assess the appropriateness of pooling the observational studies with one another and with RCTs that assess the outcome. Quantitative estimates are not generated if the only pertinent studies do not randomize subjects, have very small samples, and/or do not include control groups.

D. If the criteria for a quantitative estimate are met, the medical effectiveness team uses the following procedure to calculate these estimates.

1. In general, pool results only from studies in which similar comparisons are made. There are two major types of medical effectiveness studies: (1) studies that compare a group of subjects who receive an intervention to a group that receives either no intervention or a placebo, and (2) studies that compare groups of subjects who receive different interventions (e.g., two different drugs used to treat persons with Alzheimer's disease, chiropractic services vs. surgery for low back pain) or receive the same intervention at different intensities (e.g., different dosage, different number of visits). Estimates from studies that make these two different types of comparisons should not be combined, because combining them is likely to generate pooled results that reflect neither an intervention's effectiveness relative to no intervention nor its effectiveness relative to a different intervention. The team consults with the content expert if its members have difficulty making such distinctions. The team always calculates pooled estimates for studies that compare an intervention group to a group that receives a placebo or no intervention. Studies that compare two different interventions may be pooled, if there are multiple studies that compare the same two interventions.
2. For all studies, review pre-intervention data on the outcome of interest to ascertain whether the intervention and control or comparison groups are equivalent at baseline. Estimates should be pooled only if both pre- and post-intervention data are reported and appropriate multivariate methods are used to adjust for significant baseline differences between the intervention and control groups.²² If the intervention and control or

²² Use of multivariate methods mitigates selection bias only if the additional variables added to an analysis are the only factors other than the intervention that are likely to affect the outcome of interest. This method does not

comparison groups are not equivalent, differences in outcomes may be due to differences between the two groups prior to exposure to the intervention rather than to the intervention. Randomization does not necessarily produce equivalent intervention and control groups, particularly when the sample size is small.²³ Observational studies are even more vulnerable to selection bias, especially if researchers do not use multivariate analytic methods to adjust for baseline differences between the intervention and comparison groups.

3. If a study reports an overall “adjusted” effect of an intervention that takes into account important differences that may exist between the intervention and comparison groups, that estimate is used to calculate the pooled estimate of effects across studies.
4. If a study does not report an overall “adjusted” measure of the effect, the medical effectiveness team calculates the proportionate effect attributable to the intervention and then applies it to the overall study population (intervention plus comparison group).
 - a. Raw data from the study are inserted into a spreadsheet. A sample calculation for Krishna and colleagues’ study (referenced in Table 10-2) appears in Table 10-3 below. This study assessed the effects of an asthma education intervention on a variety of outcomes, including the number of days children with asthma were absent from school.
 - b. Baseline data, if available, and post-intervention data for the study appear in Table 10-3. In this instance, the intervention group had a somewhat higher rate of school absences (7.90) at baseline than the control group (6.40). The difference for the intervention group (-6.50) equals the post-intervention rate (1.40) minus the baseline rate (7.90).
 - c. Baseline data for the intervention and comparison groups (7.15) are averaged. (Implicitly, averaging assumes that the two groups are the same, as they would be if randomization were successful, and that any observed differences are due to chance variation.) If the study reports the numbers of cases in each group, they are used as weights. If not, the two groups are assumed to be of equal size.

eliminate the possibility that there may be unmeasured variables that are associated with the outcome but not correlated with any of the other variables included in the analysis. However, studies that make an effort to adjust for baseline differences are preferable to studies that ignore them.

²³ Randomization of subjects only produces equivalent groups if the trial is repeated many times or if the sample is very large. Well-executed RCTs with small samples may have non-equivalent intervention and control groups just by chance.

Table 10-3. Calculating the Overall Effectiveness of an Intervention: Proportionate Reduction in School Absences

Trial		Intervention Group	Control Group	Average
Krishna et al., 2003	Baseline	7.90	6.40	7.15
	Post-intervention	1.40	5.40	
	Difference	-6.50	-1.00	
	% difference	-82.3%	-15.6%	
	Expected difference	-5.88	-1.12	
	Expected reduction in days absent			-4.77
	Expected days absent in the control group			6.03
	Proportionate reduction in days absent in intervention group			-79.0%

The % difference (-82.3%) = difference (-6.50)/baseline (7.90). This is the observed percentage reduction in the intervention group.

Expected difference (-5.88) = % reduction in the intervention group (-82.3) times the baseline average for all subjects (7.15)

Expected reduction in days absent (-4.77) = the expected difference in the intervention group (-5.88) - the expected difference in the control group (-1.12)

Expected days absent in the control group (6.03) = baseline average (7.15) + expected difference in the control group (-1.12).

Proportionate reduction in days absent in intervention group (-79.0%) = expected reduction in days absent (-4.77)/expected days absent in the control group (6.03). This last calculation compares the results for the intervention and control groups. Even if the intervention group experiences a reduction in days absent, this calculation may appear to indicate an increase in the number of absences in the intervention group, if the control group experiences a greater reduction in absences than the intervention group.

For studies that publish only post-intervention data, the proportionate reduction = (control - intervention)/control (see Table 10-4).

Table 10-4. Calculating Proportionate Reduction in School Absences With Post-Intervention Results Only

Trial		Intervention Group	Control Group	Difference
Fireman et al., 1981	Post-intervention	0.5	4.6	-89.1%

- e. Next, a weighted average calculation is made to estimate the overall proportionate reduction in days absent for the intervention groups in the studies being pooled. The results for each study are weighted by sample size so that results from studies with more subjects will be weighted more heavily. Table 5 illustrates the weighted average for the effect of asthma education on school absences.

Table 10-5. Calculating the Weighted Average to Find the Overall Proportionate Reduction in School Absences

Trial	Total Subjects	% Reduction	(Weighted)
Clark 2004	835	0.0%	0
Christiansen et al., 1997	42	-19.8%	-0.3
Evans et al., 1987	204	-3.8%	-0.3
Fireman et al., 1981	26	-89.1%	-1.0
Horner 2004	44	18.3%	0.3
Morgan 2004	937	-50.1%	-19.6
Perrin et al., 1992	56	-79.1%	-1.8
Persaud et al., 1996	36	-15.8%	-0.2
Rubin et al., 1986	54	-0.9	0.0
Velsor-Friedrich 2004	102	-28.0%	-1.2
Wilson et al., 1996	59	-60.0%	-5.0
Total	2395		-25.7%

5. After a new, pooled estimate of the effect of an intervention on an outcome has been completed, a sensitivity analysis is conducted to determine whether the pooled estimate is highly sensitive to the results of one or two studies. If one or two studies have samples that are much larger than those of other studies with which they are pooled, the pooled estimate will be dominated by the results of those studies. Pooled estimates may also be sensitive to studies with anomalous results, regardless of sample size, particularly if the total number of studies pooled is small.²⁴ Sensitivity analyses are performed by omitting each study sequentially, repeatedly recalculating the pooled estimate, and comparing the pooled estimate obtained when all studies are included to the pooled estimate obtained when a study is omitted. If one or two studies to which a pooled estimate is highly sensitive are large, well-implemented RCTs, the medical effectiveness team may choose to rely on estimates reported in these studies rather than on the pooled estimate from the larger group of studies. If the studies in question are not large, well-implemented RCTs, the team reports the pooled estimate but also reports the results of the sensitivity analysis.

²⁴ For example, in the analysis of AB 264 the pooled estimate of the effect of pediatric asthma self-management education on mean hospitalizations for asthma is highly sensitive to the results of the one study of this outcome that found no association between the intervention and the outcome. All other studies found a reduction in mean hospitalizations. If the study with anomalous results were omitted from the pooled estimate, the estimated size of the effect would be 15 percentage points greater.



Appendix 11: The California Cost and Coverage Model: CHBRP’s Analytic Tool for Examining the Financial Impacts of Benefit Mandates

Introduction

CHBRP's authorizing statute requests that CHBRP provide two sets of financial information to assist the Legislature’s consideration of benefit proposed health benefit mandates: (1) current coverage, utilization and cost (premandate); and (2) projected changes in coverage, utilization and costs after the implementation of a mandate (postmandate). Table 11-1 below describes information requested by the Legislature in CHBRP’s authorizing statute:

Table 11-1. Cost Information Requested by the Legislature

Premandate	Postmandate
<ul style="list-style-type: none"> • Existing benefit coverage for the test/treatment/service in the current insurance market; • Current utilization of the test/treatment/service; • Cost of providing the test/treatment/service; • Public demand for coverage of the test/treatment/service among self-insured plans; and • Current costs borne by insurers, relevant to the test/treatment/service. 	<ul style="list-style-type: none"> • Changes in benefit coverage for the test/treatment/service if the proposed mandate is enacted; • Changes in utilization of the test/treatment/service; • Changes in the per unit cost of the test/treatment/service; • Changes in administrative costs; • Impact on total health care costs; • Costs or savings for different types of insurers; and • Impact on access and availability of tests/treatments/services.

California Cost and Coverage Model

CHBRP developed the California Cost and Coverage Model (aka Cost Model) to produce baseline and postmandate financial impacts requested by the Legislature. CHBRP’s Cost Model is primarily an actuarial forecasting model. Each year, a team of economists and researchers from a number of UC campuses, along with actuaries from Milliman and CHBRP staff, update and refine the CHBRP Cost Model.

This summary first describes the methods and assumptions developed by CHBRP to respond to these requests. Then it will describe adjustments that CHBRP has had to make to this model to account for changes resulting from the Affordable Care Act (ACA).

Baseline

Before CHBRP can measure an incremental change resulting from a proposed mandate, it must first establish a starting point, or baseline. This is a two-step process: (1) first requiring CHBRP

to estimate current overall health insurance coverage for California; (2) and then, estimating current coverage for a specific proposed mandate.

Current coverage overall

To establish a baseline, CHBRP determines:

- **Enrollment:** Number of Californians currently enrolled in state-regulated health plans in relevant market segments (individual, small group, large group), CalPERS HMO plans, and Medi-Cal Managed Care;¹
- **Premiums:** Current premiums by market segment (split by DMHC-regulated or CDI-regulated Individual, small group, and large group).

A comprehensive list of CHBRP’s sources for coverage and demographic data can be found in Coverage and Demographic Data Sources section of this Appendix, but in short, CHBRP relies on both public administrative data, as well as an annual survey of the state’s seven largest insurance carriers (representing 97% of the state-regulated market).

Baseline adjustments to account for the ACA

For the 2013 Legislative cycle, CHBRP made adjustments to its cost model in order to account for changes that would occur as a result of the ACA. Because ACA-induced market changes would not take place until January 1, 2014, CHBRP’s 2013 cost model was constructed to make estimates for a market that did not yet exist. Key changes were made to:

- **Enrollment:** CHBRP relied on the California Simulation of Health Insurance Markets (CalSIM), a microsimulation model, in addition to its usual sources of enrollment data, to estimate how enrollment would change post-ACA implementation of the individual mandate and subsidies.¹
- **Premiums:** The 2012 CHBRP Annual Enrollment and Premium Survey asked the seven largest insurance carriers in California to provide their average premium rates separately for grandfathered and nongrandfathered plans. The ratios from the carrier survey data are then applied to a national survey of aggregate premium rates,¹ to estimate premium rates for grandfathered and non-grandfathered plans that were consistent with the national premium results. The incremental impact of ACA on 2014 premiums was established as follows:
 - For non-grandfathered small-group and individual market segments, a 3% increase in medical costs is applied to reflect the total cost of requiring each plan to cover the essential health benefits.
 - For non-grandfathered small-group plans, a 5% increase in medical costs is applied to reflect the other additional costs of ACA (e.g., age rating, health status, increased premium taxes and fees, change in actuarial value, etc.).

¹ For details on data sources, see “Coverage and Demographic Data Sources” at the end of this section.

- For DMHC-regulated individual plans and CDI-regulated individual policies, an increase of 20% and 31%, respectively, in medical costs is applied to reflect the other additional costs of ACA.
- **Market segments:** The ACA imposes additional requirements on health insurance products created after March 23, 2010. These plans are considered “non-grandfathered.” Health insurance that existed before that date is considered “grandfathered” and the ACA has limited authority over those plans. In order to determine enrollment and premium costs associated with enrollees in grandfathered versus non-grandfathered health insurance, CHBRP’s 2012 Annual Enrollment and Premium Survey asked the state’s seven largest health plans to include that detail as part of its annual survey instrument. Beyond grandfathered and nongrandfathered plans, the addition of an Exchange, where Californians could purchase federally subsidized insurance, was also included as a market segment in the 2013 CHBRP Cost Model. CHBRP estimated Exchange enrollment using CalSIM.

Mandate-specific baseline

Coverage: For each proposed mandate, CHBRP surveys each of the state’s seven largest insurance carriers on specific tests, treatments, and services relevant to the mandate. These surveys provide CHBRP with baseline coverage for a proposed mandate (as opposed to baseline coverage for health insurance generally), which would change based on the details of proposed legislation.

Utilization and unit cost: CHBRP must also determine how frequently a treatment or service is currently used—whether or not an individual has benefit coverage—and how much each unit of the test, treatment, or service costs. This is determined using a variety of sources, including actuary Milliman’s Health Cost Guidelines, academic literature related to health costs, and other sources.

Incremental Change

Once CHBRP has estimated a baseline for coverage of a proposed mandate, and how frequently services associated with the proposed mandate are utilized, and how much they cost, CHBRP must then estimate how the volume of utilization would change if a mandate were to be enacted.

Changes in utilization of health care services are driven by several factors, namely: changes in benefit levels; levels of cost-sharing; enrollees demand and awareness of benefit coverage; providers' practice patterns; and level of health care management. CHBRP takes these factors into account when producing estimates. Similarly, CHBRP must also determine the unit cost for each unit of the proposed mandate, and whether that would change postmandate if demand for the treatment or service is expected to change. Together, CHBRP’s estimates of changes in utilization and cost provides an estimate of the incremental change a specific proposed mandate would have on the state-regulated health insurance market.

Other important considerations:

- **Long-term impacts.** CHBRP has limited its impact analysis to a one-year horizon for several reasons: 1) CHBRP cost impacts model for premium and total expenditure estimates mimics most insurers' internal processes for determining premiums changes in a given year. 2) CHBRP has limited capacity for modeling the long-term cost and health consequences of benefit mandates. To conduct such analyses usually requires sophisticated, disease-specific simulation models that permit analysis of the progression of a disease (and the disease treatment's technological advancement) over the course of individual lifetimes, and allows for individual variability in disease progression, health outcomes, and subsequent costs. 3) Given the specific nature of most mandates analyzed by CHBRP, the long-term cost or public health impact as a result of the mandate are not necessarily addressed in the literature. Given these constraints, CHBRP will make a long-term cost estimate, when the literature and data permit. Please see [Criteria and Guidelines for the Analysis of Long-Term Impacts](#) for more information.
- **Impact on the number of uninsured individuals.** CHBRP also considers a proposed mandate's potential impact on the number of uninsured individuals. CHBRP models this impact if a proposed mandate's estimated increase in premiums exceeds 1 percent. For details, please see [Criteria and Methods for Estimating the Impact of Mandates on the Number of Individuals Who Become Uninsured in Response to Premium Increases](#).

Definitions/Components of the Cost and Coverage Model

Cost: Cost is defined as the aggregate expenditures for health care services. (It is not the costs incurred by health care providers.) The rationale for this definition of "cost" is that legislators are ultimately interested in evaluating the financial impact of mandates on each of the major *payors* for health care services in the state.

In evaluating aggregate expenditures, CHBRP includes:

- Insurance [premiums](#) (paid by employers, government, and enrollees);
- Enrollee [cost sharing](#) (copayments, deductibles, co-insurance);
- Total cost of [covered benefits](#) (paid by insurer);
- Non-covered health expenses (paid by enrollees who have health insurance, but whose insurance does not cover specified services); and
- Total expenditures for [health insurance](#) premiums, enrollee cost sharing, and noncovered health expenses.

Utilization: Utilization is defined as the frequency or volume of use of a mandated service.

Coverage: Coverage is defined as the extent to which the mandated services are covered by state-regulated health insurance.

The model includes two types of health insurance plans or policies:

1. "Knox-Keene" plans: These include Health Maintenance Organizations (HMO), Point-of-Service (POS) health plans, and certain Preferred Provider Organization (PPO) health plans subject to the requirements of the Knox-Keene Health Care Service Plan Act of

1975. These plans are regulated by the Department of Managed Health Care and are included in one category because they are similar in type and regulatory requirements.
2. "Insurance" policies: These include PPOs and fee-for-service (FFS) health insurance products subject to the California Insurance Code, which are regulated by the California Department of Insurance.

These plan types are divided into three market segments representing private purchaser categories:

- Large group (51 or more employees),
- Small group (two to 50 employees), and
- Individual market (direct purchase).

Because some requirements of the Affordable Care Act (ACA) do not apply to “grandfathered” health insurance that existed before March 23, 2010, CHBRP’s California Cost and Coverage Model also makes a distinction between “grandfathered” and “nongrandfathered” plans.

Coverage and Demographic Data Sources.

The following bullets and Table 11-2 provide an enumeration of all data sources in California’s Cost and Coverage Model:

- The California Simulation of Insurance Markets (CalSIM) is used to estimate health insurance status of Californians aged 64 and under in 2014. CalSIM is a microsimulation model that was created to project the effects of the Affordable Care Act on firms and individuals.² CalSIM relies on data from the Medical Expenditure Panel Survey (MEPS) Household Component and Person Round Plan, the California Health Interview Survey (CHIS) 2009, and the most recent California Employer Health Benefits Survey.
- The California Health Interview Survey (CHIS) is used to estimate the number of Californians aged 65 and older, and the number of Californians dually eligible for both Medi-Cal and Medicare coverage. CHIS is a continuous survey collected annually that provides detailed information on demographics, health insurance coverage, health status, and access to care. CHIS surveys approximately 23,000 households and is conducted in multiple languages by the UCLA Center for Health Policy Research.
- The most recent California Health Care Foundation/National Opinion Research Center (CHCF/NORC) survey of California employers is used to obtain estimates of the characteristics of the employment-based insurance market, including firm size, plan type, self-insured status, and premiums. The CHCF/NORC survey, collected annually since 2000, is based on a representative sample of California’s employers.
- CalPERS premiums and enrollment are obtained annually from CalPERS administrative data for active state and local government public employees and their family members

² UC Berkeley Center for Labor Research and Education and UCLA Center for Health Policy Research. *Methodology & Assumptions, California Simulation of Insurance Markets (CalSIM) Version 1.7*, June 2012. Available at http://www.healthpolicy.ucla.edu/pubs/files/calsim_methods.pdf. Accessed October 19, 2012.

who receive their benefits through CalPERS. Enrollment information is provided for fully-funded, Knox-Keene licensed health care service plans covering non-Medicare beneficiaries, which comprise nearly 70%³ of CalPERS total enrollment. CalPERS self-funded plans – approximately 25% of enrollment – are not subject to state mandates.

- The California Department of Health Care Services (DHCS) supplies CHBRP with the statewide average premiums negotiated for the Medi-Cal Managed Care Two-Plan Model and generic contracts with health plans participating in Medi-Cal Managed Care program. Administrative data for the Medicare program is obtained online from the federal agency, the Centers for Medicare and Medicaid Services (CMS).
- CHBRP also conducts a survey of the seven largest health plans in California comprising 97% of enrollees in the state-regulated market: Aetna, Blue Cross of California, Blue Shield of California, CIGNA, Health Net, Kaiser Permanente, and UnitedHealth/ PacifiCare. These surveys provide data to determine baseline enrollment in the non-group (individual) market, and distributions between grandfathered and nongrandfathered insurance plans.

Utilization and expenditure data sources.

The utilization and expenditure data for the California Cost and Coverage Model are drawn primarily from multiple sources of data used in producing the Milliman Health Cost Guidelines (HCGs). The HCGs are a health care pricing tool used by actuaries in many of the major health plans in the United States. The guidelines provide a flexible but consistent basis for estimating health care costs for a wide variety of commercial health insurance plans. The HCGs are used nationwide and by several California HMOs and insurance companies, including at least five of the largest plans. It is likely that these organizations would use the HCGs, among other tools, to determine the initial premium impact of any new mandate. Thus, in addition to producing accurate estimates of the costs of a mandate, the HCG-based values should also be reasonable estimates of the premium impact as estimated by the HMOs and insurance companies.

The baseline analyses performed by Milliman start with PPOs in the large-group national market, which are then adjusted to account for differences by type of insurance, size of market, and geographic location. The process of applying adjustments to arrive at estimates of baseline utilization and expenditures in each of the market segments, and the process of estimating changes in utilization due to mandates, are both described in the detailed model description, [*The California Cost and Coverage Model: An Analytic Tool for Examining the Financial Impact of Benefit Mandates.*](#)⁴

³ CalPERS enrollment as of September 30 of the previous year.

⁴ Kominski, Gerald, Jay Ripps, Miriam Laugesen, Robert Cosway and Nadereh Pourat, *The California Cost and Coverage Model: An Analytic Tool for Examining the Financial Impact of Benefit Mandates*, Health Services Research, Volume 41, Issue 3p2, pages 1027–1044, June 2006.

Table 11-2. Population and Cost Model Data Sources and Data Items

Data Source	Items
California Simulation of Insurance Markets (CalSIM)	Uninsured, age: 0–17; 18–64 Medi-Cal (non-Medicare) (a), age: 0–17; 18–64 Other public (b), age: 0–64 Individual market, age: 0–17; 18–64 Small group, age: 0–17; 18–64 Large group, age: 0–17; 18–64
California Health Interview Survey, 2011 (CHIS 2011)	Uninsured, age: 65+ Medi-Cal (non-Medicare), age: 65+ Other public, age: 65+ Employer-sponsored insurance, age: 65+
CalPERS data, annually, enrollment as of September 30	CalPERS HMO and PPO enrollment • Age: 0–17; 18–64; 65+ HMO premiums
California Employer Survey, conducted annually by NORC and funded by CHCF	Enrollment by HMO/POS, PPO/indemnity self-insured, fully insured, Premiums (not self-insured) by: • Size of firm (3–25 as small group and 25+ as large group) • Family vs. single • HMO/POS vs. PPO/indemnity vs. HDHP employer vs. employer premium share
DHCS administrative data for the Medi-Cal program, annually, 11-month lag from the end of November	Distribution of enrollees by managed care or FFS distribution by age: 0–17; 18–64; 65+ Medi-Cal Managed Care premiums
CMS administrative data for the Medicare program, annually (if available) as of end of September	HMO vs. FFS distribution for those 65+ (noninstitutionalized)
CHBRP enrollment survey of the seven largest health plans in California, annually as of end of September	Enrollment by: • Size of firm (2–50 as small group and 51+ as large group), • DHMC vs. CDI regulated • Grandfathered vs. non-grandfathered Premiums for individual policies by: • DMHC vs. CDI regulated • Grandfathered vs. non-grandfathered
Department of Finance population projections, for intermediate CHIS years	Projected civilian, noninstitutionalized CA population by age: 0–17; 18–64; 65+
Medical trend influencing annual premium increases	Milliman estimate



Appendix 12: Public Health Impact Analysis and Research Approach

Background

California Health Benefits Review Program (CHBRP) reports present three types of information about proposed health benefit mandates or repeals: (1) the medical effectiveness of screening, diagnostic, treatment, and other health services addressed in the legislation; (2) the financial impacts of the legislation; and (3) the impact on public health. This document describes the research approach used to analyze the impact on public health. In 2006, CHBRP’s public health methodology was published in the *Health Services Research Journal*. Since then, additional refinements—including analysis of long-term impacts—have been incorporated into the public health methodology. Details of these methods are found in the following sections below:

- I. Relevant baseline incidence and prevalence information
- II. Estimating public health impacts of a mandate
- III. Estimating the impact on gender and racial disparities
- IV. Estimating the impact on premature death and economic loss
- V. Criteria and guidelines for estimating short- and long-term public health impacts

The public health team conducts literature reviews on the topics covered in the public health analysis. Keywords and search terms used in these reviews are included in *Appendix B: Literature Review Methods* of every report.

I. Baseline Incidence and Prevalence and Related Health Outcomes

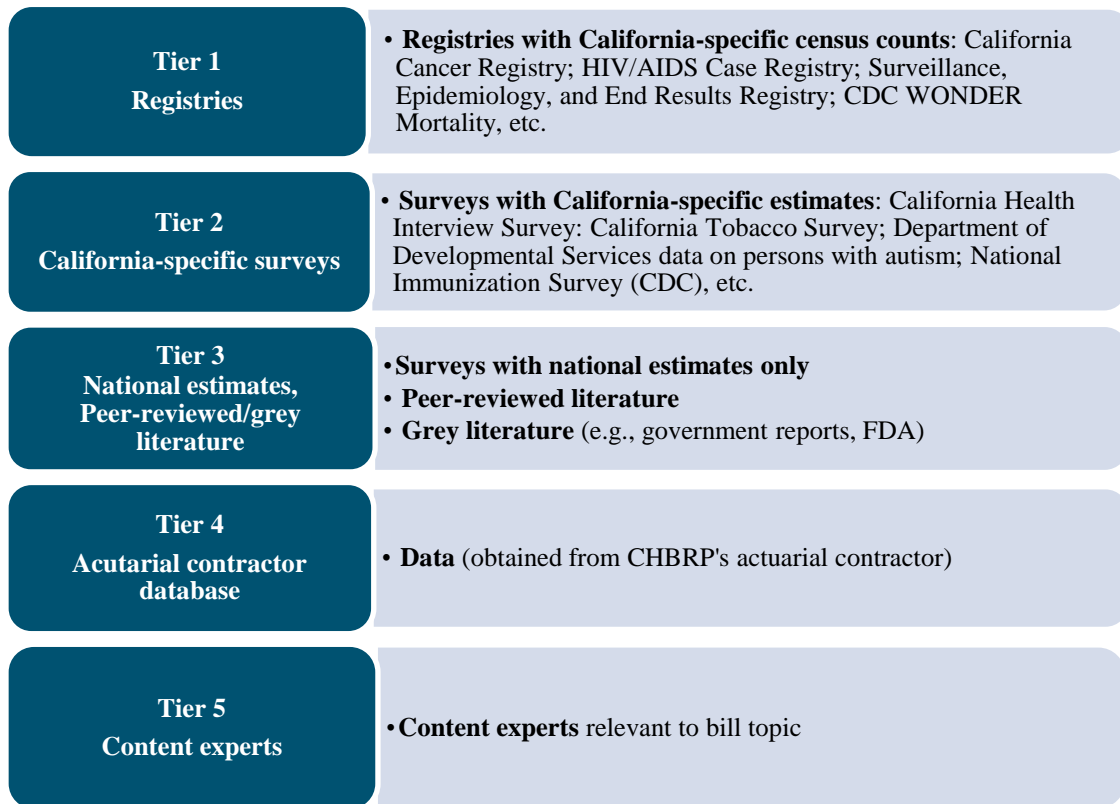
Information on the baseline prevalence and incidence of the disease or condition as well as health outcomes (e.g., morbidity or mortality) provides an overview of the portion of the California population potentially affected by the mandate. Additionally, it provides the overall context for the medical effectiveness, cost and utilization, and public health sections of CHBRP analyses.

CHBRP’s public health team uses a five-tiered hierarchy of evidence to prioritize sources of incidence and prevalence data. Using the following sources, the public health team conducts primary and secondary research depending on the availability of the data and ability to meet the 60-day report deadline imposed by CHBRP’s authorizing statute. The following table and bullets outline the hierarchy of evidence for incidence and prevalence data:

- Tier 1. Registries with California-specific census counts

- Tier 2. Surveys with California-specific estimates
- Tier 3. Surveys with national estimates only, peer-reviewed, or grey literature
- Tier 4. Actuarial contractor database
- Tier 5. Content experts

Figure 12-1. Hierarchy of Evidence for Public Health Impact Analyses



Registries reporting California-specific data (Tier 1) are the preferred source for prevalence and incidence data as they represent the entire population of persons with a disease or condition in the state. These sources may be located within a California agency (e.g., California's Cancer Registry, newborn and prenatal screening program registry, and HIV/AIDS Case Registry) or at the federal level (e.g., CDC WONDER Mortality Database and SEER Registry).

CHBRP's second choice for data (Tier 2) is population-based surveys with California-specific estimates. The main source of estimates of health conditions and illnesses is the California Health Interview Survey (CHIS). CHIS, a statewide survey of approximately 50,000 households, is conducted every two years by the UCLA Center for Health Policy Research and includes questions addressing the health status, health-related behaviors, insurance coverage, access to health care, and use of health care services of California children, adolescents, and adults. Data from CHIS can be stratified by gender, age, race, and ethnicity, and by insurance status. When

data on a specific condition or disease are unavailable in the CHIS dataset, CHBRP searches for other relevant population- or telephone-based surveys (e.g., the National Center for Health Statistics' NHANES or National Immunization Survey [NIS]) that capture the California population. For example, CHBRP's analysis of Assembly Bill 2064 (CHBRP, 2012) used the NIS to determine the number of California children and adolescents who received immunizations.

Tier 3 includes national estimates from population- or telephone-based surveys that are used for conditions or illnesses where no California-specific data exist. Summary data maintained by the National Center for Health Statistics such as the National Health Interview Survey and the National Health and Nutrition Examination Survey are examples of sources that may be reviewed. In addition, the Centers for Disease Control and Prevention (CDC) and National Institutes of Health websites may be searched for potential sources of data, as are websites of national associations affiliated with the disease or condition of interest. Also, literature searches may be conducted to find studies of California-specific or national incidence and prevalence rates published in peer-reviewed journals or in the grey literature. For example, in its analyses of Assembly Bill 171 and Senate Bill TBD-1 (CHBRP, 2011), CHBRP estimated the prevalence of autism and related disorders based on a report issued by the California Department of Developmental Services.

Tier 4 includes data obtained from the actuarial contractor. To date, CHBRP rarely uses these data. However, the Assembly Bill 214 report on durable medical equipment (DME) (CHBRP, 2009) is one example where CHBRP found that no sources ably captured the use of all types of DME. The claims data from CHBRP's actuarial contractor provided a proxy for total DME use in California's insured population.

CHBRP strives to provide the legislature with the best evidence-based estimates possible, but in rare instances where no data can be found—perhaps because it has never been studied formally—CHBRP relies on content experts (Tier 5) to advise staff on reasonable assumptions. In the case of Assembly Bill 428 (CHBRP, 2011), CHBRP consulted with experts about the use of fertility preservation services to determine the best possible assumptions given the limited literature available.

The report also includes data on health outcomes associated with the disease such as morbidity and mortality. In consultation with the medical effectiveness team and a content expert, a list of relevant health outcomes for each disease is developed. Morbidity data are searched using the same procedure outlined above for incidence and prevalence data. Cancer-specific mortality rates are available from the California Cancer Registry. Data on other mortality rates can be found through CDC's WONDER database query system, which contains mortality data from all death certificates filed in the United States for the years 1979 through 2009. Annual data on the number of deaths and death rates are available by underlying cause of death and can be stratified by state, age, race, and gender. CDC WONDER also offers links to multiple public health reports and data systems sponsored by government and nongovernment organizations.

II. Estimating the Public Health Impacts of a Mandate

CHBRP's authorizing statute requires the public health impact analysis to estimate "the impact on the health of the community, including the reduction of communicable disease and the benefits of prevention such as those provided by childhood immunizations and prenatal care." The data elements needed to estimate the public health impact on the overall health of the community are the medical effectiveness of the mandated health benefit, the impact on coverage and utilization due to the mandate, and baseline incidence and health outcomes of the relevant condition(s).

The medical effectiveness team bases its conclusions regarding the medical impact of the health benefit mandate on thorough literature reviews conducted with medical librarians and in consultation with content experts. The methods used to conduct the literature search are presented in the Medical Effectiveness Analysis summary.

The cost and utilization team estimates changes in the insured population that would be directly affected by the mandate, including those who currently have coverage for the health benefit mandate and the number of Californians who would be newly covered as a result of the mandate. Additionally, the cost team estimates the utilization impacts for insured Californians who are presently covered for the proposed health insurance benefit and for those who will be newly covered for the benefit in the first year postmandate. (Details on the methodology used to make these adjustments can be found in the Cost Impact Analysis summary.) These estimates are critical to the public health impact analysis.

If all these data elements are available, the overall change in health outcomes in the affected population can be estimated. The public health impact calculations combine the estimated change in coverage and/or utilization of the health benefit mandate for the relevant population and the rate of effectiveness derived from the medical effectiveness literature review. The results for each health outcome are compiled to produce an overall mean estimate that can be used to calculate the health effects of the benefit mandate. For each specific health outcome reviewed in the literature for which there are baseline data available and a mean effect calculated, the estimated impact on each health outcome is applied to the population of new users to determine the overall change in outcomes resulting from the mandate.

Summary data and estimates are presented in every report's public health section and detailed calculations are included in an appendix when impacts can be quantified. Figure 12-2 below explains the logic supporting the calculations.

Figure 12-2. Appendix in CHBRP Reports: Calculations of Estimated Public Health Impacts (Short-Term)

<p><u>Premandate</u></p> <p>Step 1. <i>Calculate baseline population of interest:</i></p> <ul style="list-style-type: none">• Total population already covered for service/treatment in proposed health benefit mandate (CHBRP/actuarial data)<ul style="list-style-type: none">○ Of the total covered population, the number with relevant disease/condition (registries, state or national surveys, medical or public health literature) <p>Step 2. <i>Calculate baseline expected outcome estimates without mandate for a one-year period:</i></p> <ul style="list-style-type: none">• Use of services/treatment by this population (CHBRP/actuarial data/literature)<ul style="list-style-type: none">○ Medical effectiveness of the service/treatment (literature)<ul style="list-style-type: none">▪ Total number of persons with averted (or improved) health outcomes <p><u>Postmandate</u></p> <p>Step 3. <i>Calculate estimate of newly covered population in the first postmandate year:</i></p> <ul style="list-style-type: none">• Total population, with no or partial coverage, who would be covered for service/treatment by the proposed health benefit mandate.<ul style="list-style-type: none">○ Of the total newly covered population, the number with relevant disease/condition (registries, state or national surveys, medical or public health literature) <p>Step 4. <i>Calculate baseline expected outcome estimates with mandate for a one-year period:</i></p> <ul style="list-style-type: none">• Use of services/treatment by this population (CHBRP/actuarial data/literature)<ul style="list-style-type: none">○ Medical effectiveness of the service/treatment (literature)<ul style="list-style-type: none">▪ Total number of persons with averted (or improved) health outcomes <p>Step 5. <i>Calculate expected difference(s) in outcome(s) between premandate and postmandate in the first postmandate year:</i></p> <ul style="list-style-type: none">• Report the difference between the total number of persons with averted (or improved) health outcomes premandate (Step 2) and the total number of persons with averted (or improved) health outcomes postmandate (Step 4).

Conclusions about the public health impacts of a mandate are categorized as follows:

- *Quantitative or qualitative public health impacts are estimated* when the following conditions are met:
 - The medical effectiveness team finds “clear and convincing” or a “preponderance of” evidence that the service or treatment is effective, AND
 - The cost team estimates a change in number of persons covered and/or a change in utilization of the relevant service or treatment.

When estimates of changes in coverage or utilization are considered too uncertain for a single point estimate, public health impacts may be estimated with an upper and/or lower bound (quantitative) or directionally (qualitative).

- “Zero or no public health impacts” are estimated when “clear and convincing” or “a preponderance of” evidence suggests that no improvement in health outcomes occur due to the service or treatment or when insurance coverage or utilization is not expected to change.
- “Unknown public health impacts” are estimated if medical effectiveness evidence is insufficient, conflicting, or ambiguous; if the cost team cannot estimate a change in utilization (i.e., some parity laws, unknown response by insurance market); or if no sufficient prevalence or incidence data are available.

Harms

When relevant evidence exists, the public health team also reports a service or treatment’s potential harms. These potential adverse outcomes from a public health perspective are weighed against the overall potential benefits, and include both long-term and short-term harms to physical and psychological health, and well as adverse financial effects. Harms reported in the medical effectiveness section focus primarily on short-term adverse health effects of a service or treatment.

III. Estimating the Impact on Gender and Racial/Ethnic Disparities

CHBRP’s authorizing statute specifically requests that analyses assess the extent to which a mandated benefit will have an “impact on the health of the community, including diseases and conditions where gender and racial disparities in outcomes are established in peer-reviewed and scientific literature.” Several competing definitions of “health disparities” exist and CHBRP relies on the definition proposed by Braveman (2006):

“A health disparity/inequality is a particular type of difference in health or in the most important influences of health that could potentially be shaped by policies; it is a difference in which disadvantaged social groups (such as the poor, racial/ethnic minorities, women, or other groups that have persistently experienced social disadvantage or discrimination) systematically experience worse health or greater health risks than more advantaged groups.”

Because health benefit mandates affect the insured population, it is important to examine whether health disparities exist within the insured population. Although insurance status (insured vs. uninsured) has been found to be an important factor in health disparities, particularly in explaining racial health disparities (Kirby et al., 2006; Lillie-Blanton and Hoffman, 2005), there is less research addressing disparities within the insured population. CHIS data provide one indication that disparities among the insured population persist. Among the insured population (2009) of Californians aged 18 to 64, blacks, Hispanics, and other minorities reported worse overall health status compared with non-Hispanic whites (CHIS, 2009). This finding is consistent with much of the academic literature and policy reports that document racial and ethnic disparities in overall health status and disparities within specific health conditions (e.g., CDC, 2007; Ren and Amick, 1996).

When possible, the CHBRP reports detail differences in disease prevalence, health services utilization, and health outcomes by gender and race/ethnicity, preferably in the insured population. Four steps are used to assess whether disparities exist and whether the proposed mandate will have an impact on gender and/or racial disparities:

1. *Conduct literature review*: Using keywords, the public health team searches the academic literature for gender and racial/ethnic differences by: (a) prevalence of relevant health conditions or diseases; (b) utilization of relevant health services; and (c) relevant health outcomes. The medical effectiveness literature is also reviewed for any relevant gender or racial disparity information.
2. *Review data sources*: The team also identifies sources that contain relevant prevalence/incidence, health care utilization, and outcomes data by gender and race/ethnicity, preferably in California's insured population. The public health team applies the same hierarchy of evidence for disparities as that used to search for general incidence and prevalence data.
3. *Determine whether a mandate will impact disparities*: There are four main conclusions regarding the potential for mandates to impact gender or racial/ethnic disparities:
 - Evidence suggests that no disparities exist for the disease/condition/health outcome;
 - Impact is unknown due to a lack of evidence of disparities;
 - The mandate may increase disparities; or
 - The mandate may decrease disparities.
4. *Determine whether a change in disparities can be quantified*: Ideally, when a change in disparities is deemed possible, CHBRP attempts to quantify the marginal effect of the proposed mandate on gender and racial/ethnic disparities in the insured population. In order to accomplish this, the following information is needed:
 - Baseline incidence or prevalence of a condition by gender and/or race within the insured population;
 - Coverage impacts by gender and/or race (the gender and/or racial breakdown of the population affected by the specific mandate);
 - Utilization impacts by gender and/or race (the gender and/or racial breakdown of increased use of the benefit due to the mandate); and
 - Medical impacts by gender and/or race (gender- and/or race-specific calculations of the medical effectiveness of the mandate in improving health outcomes).

The public health team remains challenged by the limited data regarding the racial/ethnic breakdown of the California insured population and the lack of utilization data by gender or race. Therefore, in cases where baseline data and medical effectiveness information are available, CHBRP indicates direction of effect on existing disparities (qualitative assessment). CHBRP continues to explore alternatives to providing quantitative estimates of a health benefit mandate's impact on disparities in the insured population.

IV. Estimating Impacts on Premature Death and Economic Loss Associated with Disease

CHBRP's public health team is also tasked with analyzing "the extent to which the proposed service reduces premature death and the economic loss associated with disease." Economists and

public health experts use the following measures, which expand beyond direct medical care costs, to assess societal costs and quality of life impacts (indirect costs) of a health care service or treatment on the community.

Premature death

Premature death is often defined as death before age 75 (Cox, 2006). The overall impact of premature death due to a particular disease can be measured in years of potential life lost (YPLL) (Cox, 2006; Gardner and Sanborn, 1990). This is a common measure used by public health researchers that essentially weights deaths occurring at younger ages more heavily than deaths in the older population. This measure complements crude and age-adjusted mortality rates, which are usually dominated by the underlying disease process in the elderly (CDC, 1986). To measure the impact of premature death across the population impacted by a proposed mandate, CHBRP first collects baseline mortality rates, usually from state or national vital statistics data sets. Medical effectiveness literature is also examined to determine if the proposed mandated benefit reduces mortality. If so, the public health team conducts a literature review to determine if the YPLL has been established for that condition. The analysis may conclude one of the following:

- Premature death is not relevant to the disease (disease does not result in death);
- The impact of the mandate on premature death is unknown due to insufficient/ambiguous evidence or because CHBRP is unable to estimate a change in utilization;
- Mandate would have no impact (per evidence); or
- Mandate would likely impact premature death (per evidence).

In order to calculate an expected impact on premature death, the following criteria must be met:

- Mortality must be a relevant health outcome (per peer-reviewed literature);
- Treatment/service must be medically effective at reducing mortality (per peer-reviewed literature); and
- The mandate would increase coverage or utilization of the benefit (estimates from the CHBRP cost team)

Economic loss

Economic loss associated with disease is commonly presented in the literature as an estimation of the value of the YPLL in a dollar amount (e.g., valuation of years of work life lost). In addition, morbidity associated with the disease can be quantified as lost productivity, absenteeism, and quality of life (e.g., lost days of work due to illness for patient or caregiver). Similar to the process used to estimate the premature death impact, the public health team conducts a literature review to determine if societal costs of illness (indirect costs) have been established and uses the evidence to support one of four conclusions:

- Disease/condition is not relevant to economic loss.
- Impact of mandate on economic loss is unknown due to insufficient/ambiguous evidence or because CHBRP is unable to estimate a change in utilization.
- Mandate has no impact on economic loss (per evidence).
- Mandate is estimated to decrease/increase economic loss (per evidence).

CHBRP presents the indirect cost of illness when available, but also notes where data on the economic loss associated with a disease are not published. This economic loss analysis is separate from the cost analysis, which calculates the direct, incremental cost of a mandate that expands (or rescinds) coverage of a health benefit.

In order to carry out a calculation of a mandate's affect on economic loss associated with disease, the following must be true:

- The mandate would increase coverage or utilization of the benefit; and
- The economic loss associated with disease can be calculated with either California or national data.

V. Criteria and Guidelines for the Analysis of Short-Term and Long-Term Impacts

CHBRP must report on the cost and public health impacts of a health benefit mandate per statute; however, the law does not specify a time period in which to consider the impacts. When estimating the public health impacts of a mandate, the public health team focuses on the short term (1 year) timeframe in parallel with the cost team estimates (see *Short-Term Analysis* below). For those mandates with benefits that manifest beyond 12 months (i.e., preventive services such as screenings or vaccinations), CHBRP includes long-term estimates based on literature reviews and actuarial data. Additionally, the public health team reports the estimated number of uninsured in cases where a proposed mandate could result in a change in the number of uninsured as a result of an increase in annual premiums. Losing health insurance has many harmful consequences including reduced access to needed health care and increased stress due to lack of insurance (and possible financial instability if health problems arise) (Hadley, 2003; Kasper et al., 2000; Lave et al., 1998).

Short-term analysis

In the past, CHBRP limited its postmandate cost and public health impact analysis to one-year time horizon for several reasons:

1. The CHBRP cost impact model for premium and total expenditure estimates mimics most insurers' internal processes for determining premium changes in a given year and provides the legislature with the "real world" perspective on how decisions are made by health insurers.
2. The 60-day timeframe limits CHBRP's capacity for modeling the long-term cost and health consequences of benefit mandates, which requires sophisticated, disease-specific simulation models.
3. Given the specific nature of most mandates analyzed by CHBRP, the long-term cost impacts or public health impacts attributable to the mandate are not necessarily addressed in the literature.
4. The longer the time horizon, the greater the uncertainty due to compounding factors including changes in the practice, organization, and delivery of medical care, and changes

in technology, demographics, and the economy; therefore, estimates beyond the 12-month timeframe may be unstable.

Long-term analysis

Nevertheless, some health benefit mandates involve diseases or conditions with significant long-term health consequences and costs that are well-documented in the literature—screening (e.g., breast cancer) and other preventive (e.g., immunizations, tobacco cessation treatments) or disease management services are good examples. Ignoring these long-term consequences may result in analyses that substantially underreport the health benefits and possible cost savings associated with a proposed mandate. Therefore, CHBRP now follows these guidelines and criteria when examining the potential long-term impacts of a proposed mandate:

1. During the initial assessment of a proposed mandate, the CHBRP analytic team determines whether there are likely to be long-term health impacts and cost savings based on consultation with content experts.
2. The faculty lead for the mandate analysis works with the medical effectiveness, public health, and cost teams, as well as the medical librarian, to determine search terms and parameters that identify key literature on the possible long-term cost and public health impacts of the proposed mandate. This includes economic loss associated with the disease and cost-effectiveness studies (which typically analyze lifetime health benefits and costs, as well as longitudinal epidemiological cohort studies).
3. The cost team reviews relevant literature, including cost-effectiveness studies that may have modeled long-term costs. The literature on cost-effectiveness analysis is summarized by the public health team to inform the reader as to what are the costs associated with a life saved (or a “quality-adjusted life year” saved).
4. The public health team quantifies the effect of a mandate on lifetime morbidity and mortality, if data are available. As mentioned, if sufficient information is not available to quantify impacts, the public health team may indicate a direction of effect based on qualitative information.

Examples of Long-Term Impact Analyses in CHBRP Reports

CHBRP analyzed the long-term cost and health outcomes for Senate Bill 1245 (CHBRP, 2006), a bill enacted in September 2006. This bill required insurers and health plans to cover the test for the human papillomavirus (HPV) for cervical cancer screening. Although CHBRP did not estimate any cost or public health impact attributable to the mandate, the analysis offered an alternative scenario in the case that the mandate would indirectly increase utilization (by 1 percentage point) as a result of a public awareness campaign and more providers adopting the new guidelines regarding HPV testing and Pap screenings.

Based on existing cost-effectiveness models, CHBRP reported the following:

“It is estimated that 7.6 million women are in health insurance plans affected by this mandate. Therefore, a hypothesized 1 percentage point increase in HPV triage screening would result in 76,000 more women shifting from lifetime conventional Pap tests to lifetime HPV triage screening. A shift from lifetime conventional Pap screening to HPV triage would result in a 29% reduction in lifetime cervical cancer risk and a 9% increase in lifetime costs.

In this scenario, for each increase by 1 percentage point in the rate of women screened for cervical cancer using the HPV triage screening strategy (compared to lifetime conventional Pap tests), over the lifetime of the 76,000 women newly subject to this screening strategy, this would result in a reduction in cervical cancer cases from 290 to 205 with an associated cost increase of 14.3 million dollars.

It is estimated that 6.0 million women age 30 or older are in health plans affected by this mandate. Therefore, a hypothesized 1 percentage point increase in HPV primary screening would result in 60,000 more women shifting from lifetime conventional Pap tests to HPV/Pap primary screen at age 30 and older. A shift in the rate of HPV/Pap primary screening in women ages 30 and older (compared to lifetime conventional Pap tests) would result in a 39% reduction in lifetime cervical cancer risk and a 45% increase in lifetime costs. For each increase by 1 percentage point in the rate of women screened for cervical cancer with Pap and HPV concurrent screening (compared to lifetime conventional Pap tests) over the lifetime of the 60,000 women newly subject to this screening strategy, this would result in a reduction in cervical cancer cases from 224 to 137 with an associated cost increase of 57.6 million dollars.”

Taking the total lifetime projected costs, the public health team included an expected present day value in an alternative estimate on impacts to premiums and total expenditures. Details of the analysis were presented in Appendix C of the report.

CHBRP also considered long-term costs and health outcomes in its report on Assembly Bill 1429 (CHBRP, 2007), a bill that passed the Legislature and was vetoed by the Governor in 2008. In that analysis, CHBRP provided the following information regarding long-term costs and benefits:

“HPV vaccination will likely produce several important health benefits, including reductions in CIN 2 and 3 [pre-cancerous lesions], cases of cervical cancer, and cervical cancer deaths. Several cost-effectiveness studies have been published recently examining both the long-term costs of vaccination as well as the long-term savings associated with reductions in these adverse health events (Goldie et al., 2004; Sanders and Taira, 2003). These studies found that the lifetime costs and benefits of HPV vaccination for a hypothetical cohort of females aged 12 years, where the vaccine is most effective, produces incremental cost-effectiveness ratios (ICERs) of \$22,755 and \$20,600 per quality-adjusted life-year (QALY) saved. These estimates mean that the net cost, after accounting for all savings associated with the reductions in adverse health events, ranges from about \$20,600 to \$22,755 per additional QALY saved, using different assumptions on length of immunity and other such details. Although there is no consensus about the most appropriate threshold, policy makers have routinely accepted technologies with estimated ICERs much higher than these.” In addition, CHBRP estimated that the new mandate would add coverage for a subset of the insured population and “...approximately 1,000 cases of HPV could be averted over the lifetime of the women impacted by Assembly Bill 1429, thereby preventing almost 30 cases of cervical cancer and 10 cervical cancer-related deaths.”

Conclusion

Understanding the scope of the public health impacts of health insurance benefit mandates through evidence-based analysis is critical to public policymaking; inclusion of the community

health perspective in these reports helps capture the potential value of a mandate (what is achieved at what cost). The public health team continually works with its CHBRP colleagues to refine the research methods and apply relevant, evidence-based data sources to support the California legislature with the most timely, accurate, non-partisan estimates of the impacts of proposed health benefit mandates.

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Appendix 13: CHBRP 60-Day Timeline of the Analytical Process

CHBRP’s authorizing statute requires that CHBRP provide the Legislature with its analysis within 60 days of having received a request from the referring committee. To meet this deadline, a timeline was developed to coordinate the various analytical processes. Below is an abbreviated version of the CHBRP 60-day timeline that describes in broad terms the steps taken to produce a report.

Days 0-3	
CHBRP Staff	<p>CHBRP staff work with faculty to:</p> <ol style="list-style-type: none"> 1. Identify and screen content expert per protocol 2. Convene conference call so that all potential faculty/staff recusals can be identified 3. Post analysis request on website (including solicitation for information from interested parties by day 19) 4. Work with faculty and with bill author’s office to clarify intent of the bill
Vice Chairs, Task Force Members, Leads	<p>Task Force conference call to:</p> <ol style="list-style-type: none"> 1. Establish leads 2. Select peer faculty reviewer 3. Discuss bill and issues particular to the analysis including content expert 4. Identify areas of draft bill warranting clarification from bill author’s office 5. Discuss conflicts and potential recusals
Cost Team/Actuaries	<ol style="list-style-type: none"> 1. Discuss with internal faculty/staff any potential conflicts so recusals can be identified 2. Confer with content expert and others on call about scope, strategy, and search terms for cost literature review 3. Provide to ME team any mandate-specific questions to add as part of literature review/effectiveness analysis
Medical Effectiveness (ME) Team	<ol style="list-style-type: none"> 1. Work with faculty/staff leads to contact content expert and conduct initial (verbal) conflict-of-interest (COI) screening and complete COI form 2. Discuss with internal faculty/staff any potential conflicts so recusals can be identified 3. Begin to identify search terms 4. In consultation with clinical/content expert, provide librarians with essential bibliography and determine scope of search, search terms, and strategies for librarians 5. Develop a diagram of likely effects of the mandate (e.g., increase in use of treatment vs. increased screening, true and false positives, possible treatment, etc.)
Public Health (PH) Team	<ol style="list-style-type: none"> 1. Discuss with internal faculty/staff any potential conflicts so recusals can be identified 2. Confer with content expert and others on call about scope, strategy, and search terms for public health literature review 3. Provide questions to the ME team regarding literature needed for PH analysis (e.g., prevalence, incidence, racial disparities)
Librarians	<p>Conduct literature search iteratively under direction of ME team with input from content expert (days 0–4)</p>

Days 4-6	
CHBRP Staff	<ol style="list-style-type: none"> 1. Send information regarding subject background, bill intent, and clarifying language to all teams 2. Consult with faculty lead, ME team, content expert, cost team, PH team, and actuaries on health plan/insurer bill-specific coverage survey
Vice Chairs, Task Force Members, Leads	<ol style="list-style-type: none"> 1. Review and comment on health plan/insurer bill-specific coverage survey 2. Suggest any additional (beyond National Advisory Council [NAC]) external reviewers if bill requires specific types of reviewers
Cost Team/Actuaries	<p>► Launch cost literature search:</p> <ol style="list-style-type: none"> 1. Conduct cost literature review (days 4–7) 2. Review and comment on health plan/insurer bill-specific coverage survey
ME Team	<p>► Essential bibliography due:</p> <ol style="list-style-type: none"> 1. Provide UCSF librarians with essential bibliography (key, seminal research) 2. Identify types of services and outcomes to be examined; review search results with content expert and provide feedback to librarian on any additions/modifications needed
PH Team	<p>► Launch public health literature search:</p> <ol style="list-style-type: none"> 1. Conduct public health impact literature review (days 4–7)
Days 7-10	
CHBRP Staff	<ol style="list-style-type: none"> 1. Send bill-specific coverage survey to health plans/insurers 2. Contact NAC reviewers 3. Collect coverage information from available sources and send to cost team/actuaries 4. Compile benefit coverage information for public programs subject to the mandate (such as managed care options offered by CalPERS, Healthy Families, and Medi-Cal) 5. Compile information regarding labor groups' negotiations and CalPERS PPO benefit coverage to assess public demand
Vice Chairs, Leads	Faculty to review benefit coverage information sent by CHBRP staff
Cost Team/Actuaries	<ol style="list-style-type: none"> 1. Decide on strategy for projecting post-mandate utilization 2. Review coverage information sent by CHBRP team
ME Team	<ol style="list-style-type: none"> 1. Identify articles that clinical content expert wants to read in full text 2. Report on search and key literature 3. Continue to collect, review, and synthesize literature for medical impacts (days 10–13)
PH Team	Collect baseline data (e.g., prevalence, incidence, racial disparities, etc.) (days 10–14); provide actuaries information on how data should be cut to meet PH team's needs for analysis
Librarians	<p>► Refined bibliography due:</p> <ol style="list-style-type: none"> 1. Provide ME team and content expert with refined bibliography 2. Provide PH teams and cost team literature search findings per request

	Days 11–14
CHBRP Staff	Health plan/insurer benefit coverage data due; ensure all proprietary information is masked, aggregated, and sent to analysis teams
Vice Chairs, Leads	Review health plan/insurer responses to bill-specific coverage survey
Cost Team/Actuaries	<ol style="list-style-type: none"> 1. Provides utilization data 2. Review health plan/insurer responses to bill-specific coverage survey and identify any gaps 3. Provide PH team with coverage and utilization impacts
ME Team	Prepare draft medical effectiveness analysis tables of key findings including info needed by cost and public health teams.
PH Team	Prepare draft public health tables with baseline information.

	Days 15–20
CHBRP Staff	<ol style="list-style-type: none"> 1. Review information submitted by interested parties and highlight any that would need to be considered by any team(s) in particular 2. Review public health and cost tables from actuaries; provide comments/questions
Vice Chairs, Leads	<ol style="list-style-type: none"> 1. Review information submitted by interested parties and highlight any that would need to be considered by any team(s) 2. Review and comment on draft introduction/background 3. Review public health and cost tables from actuaries; provide comments/questions
Cost Team/Actuaries	<ol style="list-style-type: none"> 1. Review information submitted by interested parties 2. Draft cost tables due from actuaries to cost team/CHBRP staff/faculty 3. Draft tables/data pulls due to PH team/CHBRP staff/faculty 4. Compile information from cost literature (e.g., offsets, substitution effects, shifts to other programs) 5. Draft cost section with placeholders for final cost tables and final cost estimates
ME Team	Review information submitted by interested parties
PH Team	<ol style="list-style-type: none"> 1. Review information submitted by interested parties 2. Decide parameters for public health impact estimate (e.g., outcome measures) 3. Review the public health data pulls and tables; consult with actuaries on proposed revisions

Days 21–25	
CHBRP Staff	<ol style="list-style-type: none"> 1. Review and comment on draft effectiveness section 2. Check for consistency with cost tables; provide comments to ME team
Vice Chairs, Leads	<ol style="list-style-type: none"> 1. Review and comment on draft effectiveness section 2. Check for consistency with cost tables; provide comment to staff lead to compile
Cost Team/Actuaries	<p>FINAL cost tables due from actuaries to cost team/CHBRP staff/faculty FINAL tables/data pulls due to PH team/CHBRP staff/faculty ► 1st draft cost section due</p>
ME Team	► 1st draft medical effectiveness section due
PH Team	► 1st draft public health impact section due

Days 26–31	
CHBRP Staff	<ol style="list-style-type: none"> 1. Check for consistency and content between cost tables and text, and underlying assumptions, as well as consistency among effectiveness, public health, and cost sections 2. Prepare full integrated draft with executive summary and introduction
Vice Chairs, Leads	Check for consistency and content between cost tables and text, and underlying assumptions, as well as consistency among effectiveness, public health, and cost sections
Cost Team/Actuaries	► Revised cost impact section due
ME Team	► Revised medical effectiveness section due
PH Team	► Revised public health impact section due

Days 32–40	
CHBRP Staff	<p>► Full draft due</p> <ol style="list-style-type: none"> 1. Send to content expert, full task force, peer faculty reviewer 2. Revise based on comments from task force, content expert, cost team/actuaries
Vice Chairs, Leads	Review and send comments to CHBRP staff to compile integrated draft report
Cost Team/Actuaries	Review and send comments to CHBRP staff to compile integrated draft report

Days 41-45	
CHBRP Staff	► Revised full draft sent to NAC, editor, and any other external expert reviewer. Send NAC review version to faculty lead and analytic team. Editor's review will happen concurrently with NAC review, with a final proofread by the editor on day 50

	Days 46–49
CHBRP Staff	<ol style="list-style-type: none"> 1. Comments received by NAC, editor, designated task force members, other external reviewers 2. Forward comments to faculty lead, Vice Chairs, teams, and actuaries
Vice Chairs, Leads	<ol style="list-style-type: none"> 1. Faculty lead to review NAC and editor comments and work with teams to ensure all comments are addressed
Cost Team/Actuaries	<p>► Final revised cost section due:</p> <ol style="list-style-type: none"> 1. Work with CHBRP staff and faculty to revise in response to reflect NAC and editor comments 2. Send final revised section to CHBRP staff by day 49
ME Team	<p>► Final revised cost section due:</p> <ol style="list-style-type: none"> 1. Work with CHBRP staff and faculty to revise in response to reflect NAC and editor comments 2. Send final revised section to CHBRP staff by day 49
PH Team	<p>► Final revised cost section due:</p> <ol style="list-style-type: none"> 1. Work with CHBRP staff and faculty to revise in response to reflect NAC and editor comments 2. Send final revised section to CHBRP staff by day 49
	Days 50-54
CHBRP Staff	<p>Report editing, layout, and production</p> <ol style="list-style-type: none"> 1. Send draft to editor for final proofread 2. CHBRP staff sends draft to faculty lead and vice chairs with editor’s final proofread comments
Vice Chairs, Leads	Review and sign-off on revised, edited report or specify remaining changes
	Days 55-59
CHBRP Staff	<ol style="list-style-type: none"> 1. Revisions to incorporate final Vice Chair changes 2. Provide final version to Provost, SVP of Health Sciences and Services; final formatting and proofing and any changes in response to SVP’s review
	Day 60
CHBRP Staff	<p>► Final report sent to State Legislature:</p> <ol style="list-style-type: none"> 1. Electronic version of report (.PDF format) transmitted to bill authors, to requesting committees by e-mail, and posted on website 2. CHBRP mailing list notified



Appendix 14: Content Expert Identification, Screening, and Selection Protocol

This document clarifies the process and serves as a guideline by which the California Health Benefits Review Program (CHBRP) identifies, screens, selects, and compensates content experts for each bill analysis.

This process should be undertaken as early as possible—preferably 1 week before the Legislature’s request for the CHBRP bill analysis. If that is not possible, then this process should occur during days 0 to 4 of the 60-day time period.

Not all bill analyses require the use of a content expert. For example, for a bill that may have a small number of providers (e.g., transplant centers that conduct surgeries for HIV+ patients), the need for a content expert might be filled by conducting a survey of those providers, making use of in-house expertise or a combination of the above. This determination will be made on a case-by-case basis.

I. Criteria for Selecting the Content Expert

1. In general, content experts need clinical and/or health services research experience in order to:
 - Advise the medical effectiveness team and other members of the analytic team on:
 - Key literature to facilitate literature review and analysis to determine whether mandated benefit/service/treatment is clinically effective (e.g., state-of-the-art research, research specific to California, summary of evidence on effectiveness)
 - Search criteria for literature review (e.g., medical conditions and outcomes) to assure that the team is using the appropriate search terms to identify key articles
 - Research in progress that could affect the final conclusions of the effectiveness analysis
 - Clinical care management, controversies in practice, and knowledge of specialty society positions and guidelines
 - Advise the cost and public health teams on:
 - Incidence and prevalence rates of medical condition(s) addressed by the mandate
 - Bundle of services utilized, and the associated CPT codes, ICD-9 codes, pharmaceuticals, and devices
 - Will those newly covered by the mandate be likely to change utilization?
 - How would the mandate change physician practice patterns?
 - Will utilization of mandated benefit/service produce offsets in current or future utilization? In other words, does mandated benefit/service replace old interventions or become add-ons, complements, or substitute? Is there an associated time-horizon for those cost offsets (i.e., how long would it take for the health care system to realize the cost of those savings—1 year, 5 years, etc.)?

2. Content experts need to be interested in and willing to work in what may be a controversial area. CHBRP reports are sometimes used in an adversarial context. CHBRP needs to treat both sides of an issue in a balanced and fair manner in its reports.
 - Are they clearly identified with one side or another? It does not necessarily disqualify them but CHBRP may want to get a second reviewer identified with the other side.
 - How comfortable would they be if they were criticized by advocates on one side or another?
3. Content experts need to be available for consultation during the full 60-day analytic timeframe.
4. Content experts need to be available for at total of a least two working days during the first three weeks of the analytic timeframe.
5. Content experts must not have a financial, business, or professional conflict of interest. (See section below for Conflict-of-Interest Screening Questions.)

II. Process for Identifying Potential Content Experts

CHBRP staff will initiate the search for content experts by taking the following steps as needed:

1. Query full Faculty Task Force for recommendations
2. Query other research centers (e.g., Public Health Institute, RAND)
3. Query Milliman for suggestions
4. Identify NIH grant recipients in subject area
5. Identify those who may be affiliated with an Agency for Healthcare Research and Quality (AHRQ) Evidence-based Practice Center conducting related research
6. Work with librarian to search for most frequent and/or most recent authors of articles on subject, especially those who have been involved in Cochrane Collaboration reviews or have participated in the development of clinical guidelines
7. Solicit help from state and national specialty societies
8. Search Academy Health's expertise directory

III. Process for Screening Potential Content Experts' Qualifications, Interests, Availability

1. Initial Screening: CHBRP staff will conduct initial screening of content experts based on:
 - Clinical and/or health services research experience
 - Strengths and weaknesses of potential expert and how/whether best to use him/her. For example, if he/she would not be a good clinical expert but may be knowledgeable about insurance, access, and the health services research as it relates to the mandate, CHBRP may consider him/her as a potential reviewer.
 - Interest and willingness to work in a potentially controversial area
 - Availability in general but particularly during the first 3 or 4 days after CHBRP request and for review of draft report
 - Potential conflicts-of-interest (see following section)
2. Staff will follow up via fax/e-mail if a written explanation is requested by content expert's assistant.

3. CHBRP staff may interview several potential content experts.
4. CHBRP staff will forward CVs and pertinent information about potential content experts to medical effectiveness, public health, and cost teams for consideration.
5. Once a potential content expert is identified and the analytic teams agree that the content expert meets criteria, CHBRP staff will forward questions to the content expert. A standard set of questions is below.

Standard Content Expert Questions to Support Literature Review, Cost & Utilization Baseline Analysis, and Public Health Baseline Analysis

- a. What medical condition(s) related to this mandated benefit, service, treatment have the highest prevalence?
- b. What is your view of the clinical effectiveness of this mandated benefit, service, or treatment for this condition(s)?
- c. What is your view of the cost effectiveness of this mandated benefit, service, or treatment for this condition(s)?
- d. Are there alternatives that are already generally covered services?
- e. What key literature will help facilitate literature review and analysis document evidence of the effectiveness of the mandated benefit/service/treatment (e.g., state of the art research, research in progress, research specific to California)?
- f. What are search criteria for literature review (e.g., conditions and outcomes) and search terms?
- g. What research in progress could affect the final conclusions of the effectiveness analysis?
- h. What are the clinical care management standards or practices associated with the mandate?
- i. What are the controversies in practice associated with this mandate?
- j. What are the specialty societies related to this mandated benefit and do they have positions or guidelines regarding the mandated benefit?
- k. Can you provide CHBRP with the names of any professional or trade journals that are specific to the medical condition or profession involved in delivering the treatment/service that may not be included in databases such as PubMed?
- l. What are the incidence and prevalence rates of the medical condition addressed by the mandate? What is the population used in the denominator to calculate these rates (entire population, women ages 50+, etc.)?
- m. Are there losses in productivity or economic losses associated with the medical condition?
- n. Based on your knowledge of the evidence, are you aware of disparities in the health status and outcomes for subpopulations (e.g., uninsured versus the insured, by gender, race, language, or socioeconomic status)?
- o. Are you aware of access issues to care for this benefit or service and if so, what do you see as the major barriers to access?
- p. Who are current users of care for the medical condition addressed by the mandate (e.g., women ages 50+)? What bundle of services do they utilize, and the associated CPT codes, ICD-9 codes, pharmaceuticals, devices, etc.?
- q. Who will be newly covered by the mandate? Specifically, how will utilization change as a result of the mandate? Will there be more users (change in utilization rates per 1,000), a different mix of services among current users (change in intensity of care per user), or both?
- r. Will utilization of the mandated benefit produce offsets in current or future utilization?

- s. Are you aware of any studies that look at the long-term benefits (i.e., greater than one year timeframe) for those who have received this benefit?

IV. Process for Screening Potential Content Experts' Potential Conflicts of Interest

The questions below are designed to prod the potential content expert to think of and flag potential conflicts of interest (COI) before they undergo the formal written COI review process. CHBRP staff will bring any issues that could potentially prohibit an individual from participating as an expert (but are not obvious grounds for recusal) to the CHBRP Director's (or the designee's) attention immediately.

1. Do you have any financial interest in the proposed mandated benefit?
 - Examples of financial conflicts: investments in pharmaceutical companies or medical device manufacturers; relations with drug company with products related to mandate, research funding or own investments related to this mandate?
2. Do you have an interest from an insurance perspective in the proposed mandated benefit?
 - Examples: Have they acted as expert witness, if so, for one or both sides? Member of a task force that has voted on benefit being mandated, testified or taken a public position on mandate?
3. Could your existing research create a perception of bias as it pertains to the proposed mandate?
 - This might arise if a content expert authored research that included recommendations that are substantially similar to or directly oppose the proposed mandate. CHBRP would not want to place a content expert in the position of having to objectively evaluate their own research. This is to limit the possibility that outside observers could perceive that our experts may have a documentable, preexisting bias that the outcome of the CHBRP review be consistent with their own research finding and prior recommendations. Since they are a content expert, it is likely that their name will come up in literature search; however, their work would need to be evaluated to determine whether there is potential for bias.

V. Selecting the Content Expert

1. If the content expert candidate indicates his/her ability, interest, willingness, availability to answer questions, then CHBRP staff will provide a COI form to complete and sign.
2. The content expert candidate completes the COI form and forwards it to CHBRP staff.
3. The COI application is reviewed by CHBRP's Director and, if necessary, legal staff at the University of California, Office of the President (UCOP).
4. CHBRP staff notifies the content expert candidate, and the CHBRP analytic teams of COI status.
5. A content expert candidate whose COI disclosures are cleared is eligible to provide his/her services. The final selection decision will be made in consensus with the analytic teams with greatest emphasis on the preferences of the medical effectiveness team.



Appendix 15: CHBRP’s Conflict-of-Interest Policies: General Disclosure Form and NAC Disclosure Form

In order to avoid conflicts of interest, the Legislature requested the University of California to develop and implement conflict-of-interest provisions to prohibit a person from participating in any analysis in which the person knows or has reason to know he or she has a material financial interest, including but not limited to a person who has a consulting or other agreement with a person or organization that would be affected by the legislation.

CHBRP’s authorizing statute includes the following provision:

Section 127663. In order to avoid conflicts of interest, the Legislature requests the University of California to develop and implement conflict-of-interest provisions to prohibit a person from participating in any analysis in which the person knows or has reason to know he or she has a material financial interest, including, but not limited to, a person who has a consulting or other agreement with a person or organization that would be affected by the legislation.

The following clarifies the process by which the California Health Benefits Review Program (CHBRP) implements this provision.

General request for conflict-of-interest (COI) form completion process:

- When a new CHBRP staff or faculty member is hired or designated to work on CHBRP analyses, the CHBRP Director sends them the standard form letter requesting them to complete a COI form. This letter contains instructions and the due date.
- The same applies for content experts or special reviewers requested to conduct analyses-specific work. However, the lead analyst may also send a request letter. In addition, the lead analyst and/or the lead from the CHBRP medical effectiveness team should initially screen the potential content expert by querying him/her about any potential conflicts of interest. (See Appendix 9: Content Expert Identification, Screening, and Selection Protocol)
- The CHBRP Program Specialist, and the CHBRP Director and the lead CHBRP analyst (if specific to a bill) should be carbon copied on the COI request e-mail.

General submission process:

- When a new or revised COI form is submitted, the original goes to the CHBRP Program Specialist, who will provide it to the CHBRP Director.
- The CHBRP Director will update the tracking database with the new information, and contact the person submitting the COI form to clarify any questions, if necessary.

- The CHBRP Director will consult the Academic Affairs, Director of Research Policy Development if there are any potential conflicts that require further vetting.

Ongoing Review of potential conflicts– reviewing and tracking:

- *Bill-specific conflicts of interest:* When the Legislature requests a new bill analysis, as part of the initial Faculty Task Force conference calls, CHBRP staff will ask potential team members for the bill analysis to assess potential conflicts of interest, and update their file, if necessary, before the analysis starts. Files can be updated with an e-mail providing information about the conflict. Both potential conflicts and recusals from a specific bill analysis should be documented in the file. The CHBRP Director will notify CHBRP staff (and sometimes the Faculty Task Force) when a conflict has been identified and when a recusal is confirmed. If a recusal applies for a specific bill analysis, the lead analyst is responsible to ensure that the appropriate recusal notations are made in the preface or back matter of the final report.
- *Ongoing tracking:* The CHBRP Program Specialist and the CHBRP Director are to check the database regularly to identify any missing forms or individuals that need follow up. They are to identify who must submit a form and keep track of who has/has not submitted their form. Appropriate follow up will be done to ensure completed and updated COI forms are maintained.
- *Annual Updates of COI forms:* Updates of all COI forms occur on an annual basis.
 - The CHBRP Director will review the current form and determine whether updates need to be made.
 - The CHBRP Program Specialist and CHBRP Director will work together to complete an update request to all CHBRP affiliated faculty and staff during the last quarter of the calendar year. If the information that was submitted the previous year is the same, individuals may check a box that stated “same as last year” and return it with their signature page.
 - CHBRP Program Specialist will e-mail to faculty, CHBRP staff, NAC members, and other affiliated researchers and contractors a request to update and return all COI forms by the end of the calendar year.
 - CHBRP Director will complete a review of all updates by the beginning of the Legislative session, or no later than January 30 of each year.

Forms:

- All CHBRP staff, faculty, affiliated researchers, analyst, actuaries, librarians, and content experts will complete the Standard COI Disclosure form (Attachment 1)
- All NAC members will complete NAC COI Disclosure form (Attachment 2).

Attachment 1: STANDARD COI DISCLOSURE FORM

**University of California (UC)
Form for Obtaining Background Information and Conflict-of-Interest Disclosure for
Activities Related to the California Health Benefits Review Program¹**

NAME: _____

TELEPHONE: _____

ADDRESS: _____

E-MAIL ADDRESS: _____

CURRENT
EMPLOYER: _____

THE DECLARATIONS IN THE ATTACHED FORM APPLY TO DECLARANT’S CONFLICTS OF INTERESTS IN REGARD TO HEALTH INSURANCE BENEFIT MANDATE REVIEWS CONDUCTED UNDER THE AUSPICES OF THE CALIFORNIA HEALTH BENEFITS REVIEW PROGRAM (CHBRP) BEGINNING JANUARY 1, 2013 AND ENDING DECEMBER 31, 2013.

There are two parts to this form, Part I—Background Information, and Part II—Conflict of Interest Disclosure. Please complete both parts, **sign** and **date** this form on the last page, and return the form to the CHBRP administrator who requested your participation in the activity to which this form applies. **Please retain a copy for your records.**

You may opt to submit a copy of your curriculum vitae as your response, to Questions I-V, which follow on the next page.

PART I—BACKGROUND INFORMATION

Please provide the information requested below regarding **relevant** organizational affiliations, government service, public statements and positions, research support, and additional

¹ This form was modeled closely on a background and conflict of interest disclosure form designed by the National Academies of Sciences (NAS) for use with respect to studies relating to government regulation. The University of California and CHBRP are grateful to the NAS for extending its permission to use the NAS form. This CHBRP form may be subject to change. A substantially similar version of this form, “*For Activities Related to Government Regulation*”, is to be used for members of scientific advisory panels that UC convenes at the request of the State and for UC-recommended experts whose reports and/or advice are to be provided to the state for official use in a government regulatory process. CHBRP is grateful also to the UC Office of Research for its assistance in developing this form.

This form and the information provided by you therein may be disclosable to the public under applicable state laws and regulations.

information (if any). Information is “relevant” if it is related to—and might reasonably be of interest to others concerning—your knowledge, experience, and personal perspectives regarding the subject matter and issues to be addressed by the activity (e.g., service as a health insurance benefits mandate evaluator) for which this form is being prepared.

I. ORGANIZATIONAL AFFILIATIONS. Report your *relevant* business relationships (as an employee, owner, officer, director, consultant, etc.) and your relevant remunerated or volunteer non-business relationships (e.g., professional organizations, trade associations, public interest or civic groups, etc.).

II. GOVERNMENT SERVICE. Report your *relevant* service (full-time or part-time) with federal, state, or local government in the United States (including elected or appointed positions, employment, advisory board memberships, military service, etc.).

III. RESEARCH SUPPORT. Report *relevant* information regarding both public and private sources of research support (other than your present employer), including sources of funding, equipment, facilities, etc.

IV. PUBLIC STATEMENTS AND POSITIONS. List your *relevant* articles, testimony, speeches, etc., by date, title, and publication (if any) in which they appeared, or provide relevant representative examples if numerous. Provide a brief description of relevant positions of any organizations or groups with which you are closely identified or associated.

V. ADDITIONAL INFORMATION. If there are *relevant* aspects of your background or present circumstances not addressed above that might reasonably be construed by others as affecting your judgment in matters within the assigned task of the committee or other activity in which you have been invited to participate, and therefore might constitute an actual or potential source of bias, please describe them briefly.

PART II—CONFLICT-OF-INTEREST DISCLOSURE

Instructions: When the State of California requests the University of California’s assistance in convening scientific advisory committees, such as the California Health Benefits Review Program, (CHBRP) or asks UC for recommendations of scientific experts to produce reports, such as CHBRP’s evaluations of health insurance mandates, for the purpose of providing expert advice intended to be used by the State in formulating state laws or regulations, it is essential that the work of the participants in such activities not be compromised by any significant conflict of interest.

For this purpose, **the term “conflict of interest” means any financial or other interest which conflicts with the service of the individual because it (1) could significantly impair the individual’s objectivity or (2) could create an unfair competitive advantage for any person or organization.**

Except for those situations in which UC and/or the government agency requesting UC’s and CHBRP’s assistance determines that a conflict of interest is unavoidable and publicly discloses the conflict of interest, no individual can be appointed to serve (or continue to serve) on a UC-convened scientific advisory committee, such as CHBRP, or serve as a UC- or CHBRP-recommended expert evaluator when the report(s) developed by such service are intended to be used by the State as part of the official process for developing government laws or regulations, if the individual has a conflict of interest that is relevant to the functions to be performed.

The term “conflict of interest” means something more than individual bias. There must be an *interest*, ordinarily financial, that could be directly affected by the work of CHBRP or the UC- or CHBRP-recommended expert evaluator.

Conflict of interest requirements are *objective* and *prophylactic*. They are not an assessment of one’s actual behavior or character, one’s ability to act objectively despite the conflicting interest, or one’s relative insensitivity to particular dollar amounts of specific assets because of one’s personal wealth. Conflict-of-interest requirements are objective standards designed to eliminate certain specific, potentially compromising situations from arising, and thereby to protect the individual, the other members of the committee, the institution, and the public interest. The individual, the committee, and the institution should not be placed in a situation where others could reasonably question, and perhaps discount or dismiss, the work of the committee simply because of the existence of conflicting interests.

The term “conflict of interest” applies only to *current interests*. It does not apply to past interests that have expired, no longer exist, and cannot reasonably affect current behavior. Nor does it apply to possible interests that may arise in the future but do not currently exist, because such future interests are inherently speculative and uncertain. For example, a pending formal or informal application for a particular job is a current interest, but the mere possibility that one might apply for such a job in the future is **not** a current interest.

The term “conflict of interest” applies not only to the personal interests of the individual but also to the *interests of others* with whom the individual has substantial common financial interests if

these interests are relevant to the functions to be performed. Thus, in assessing an individual's potential conflicts of interest, consideration must be given not only to the interests of the individual but also to the interests of the individual's spouse and dependent children, the individual's employer, the individual's business partners, and others with whom the individual has substantial common financial interests.

Consideration must also be given to the interests of those for whom one is acting in a fiduciary or similar capacity (e.g., being an officer or director of a corporation, whether profit or nonprofit, or serving as a trustee).

This disclosure form is used for members of CHBRP, an entity that UC has convened at the request of the state, and for CHBRP-recommended experts whose reports and/or advice are to be provided to a state agency or to the Legislature for official use to evaluate proposed health insurance benefit mandates legislation. For such activities, *the focus of the conflict-of-interest inquiry is on the identification and assessment of any interests that may be directly affected by the use of such reports in the regulatory process.*

For example, if CHBRP or the CHBRP-recommended expert evaluator were conducting a study of a proposed health insurance benefit mandate requiring coverage for a particular medical technology, the focus of the conflict-of-interest-inquiry would be on the identification and assessment of any interests that would be directly affected by that regulatory process if the report were to provide the basis for regulatory action or inaction. The concern is that if an individual (or others with whom the individual has substantial common financial interests) has specific interests that could be directly affected by the regulatory process, the individual's objectivity could be impaired.

Such interests could include an individual's significant stock holdings in a potentially affected medical technology company or being an officer, director, or employee of the company. Serving as a consultant to the company could constitute such an interest if the consulting relationship with the company could be directly affected or is directly related to the subject matter of the regulatory process.

An individual's other possible interests might include, for example, relevant patents and other forms of intellectual property, serving as an expert witness in litigation directly related to the subject matter of the regulatory process, or receiving research funding from a party that would be directly affected by the regulatory process if the research funding could be directly affected or is directly related to the subject matter of the regulatory process and the right to independently conduct and publish the results of this research is limited by the sponsor. Consideration would also need to be given to the interests of others with whom the individual has substantial common financial interests—particularly spouses, employers, clients, and business or research partners.

Questions: The following questions are designed to elicit information from you concerning possible conflicts of interest that may be relevant to the function(s) you have been asked to serve in regard to CHBRP's evaluation of proposed health insurance mandates.

1. EMPLOYMENT. (a) If the reports resulting from CHBRP's health insurance benefit mandate evaluations were to provide the basis for government regulatory action or inaction with respect to the matters addressed in the reports:

(i) if you are employed or self-employed, could your current employment or self-employment (or the current employment or self-employment of your spouse, registered domestic partner, or dependent children) be directly affected?

YES NO NOT APPLICABLE

If "Yes," briefly describe the circumstances here (continuing on the last page of the form if necessary).

(ii) to the best of your knowledge, could any financial interests of your (or your spouse's or dependent children's) employer or, if self-employed, your (or your spouse's or dependent children's) clients and/or business partners be directly affected?

YES NO NOT APPLICABLE

If "Yes," briefly describe the circumstances here (continuing on the last page of the form if necessary).

(iii) if you are an officer, director or trustee of any corporation or other legal entity, could the financial interests of that corporation or legal entity be directly affected?

YES NO NOT APPLICABLE

If "Yes," briefly describe the circumstances here (continuing on the last page of the form if necessary).

(iv) if you are a consultant (whether full-time or part-time), could there be a direct effect on any of your current consulting or advisory relationships?

YES NO NOT APPLICABLE

If "Yes," briefly describe the circumstances here (continuing on the last page of the form if necessary).

(v) regardless of the potential effect on the consulting relationship, do you have any current or continuing consulting relationships (including, for example, commercial and professional consulting and service arrangements, scientific and technical advisory board memberships,

serving as an expert witness in litigation, or providing services in exchange for honorariums and travel expense reimbursements, but excluding consulting relationships for which you received less than \$5,000 in fees, honorariums, reimbursements or other compensation) that are directly related to the subject matter of the possible government regulatory action or inaction?

YES NO NOT APPLICABLE

If “Yes,” briefly describe the circumstances here (continuing on the last page of the form if necessary).

(b) If you are or have ever been a government employee (either civilian or military), to the best of your knowledge are there any federal or state conflict of interest restrictions that may be applicable to your service in connection with your activities on behalf of CHBRP?

YES NO NOT APPLICABLE

If “Yes,” briefly describe the circumstances here (continuing on the last page of the form if necessary).

(c) If you are a government employee, are you currently employed by a state or federal agency that is sponsoring proposed health insurance benefit mandates? If you are not a government employee, are you an employee of any other sponsor (e.g., advocacy group, private foundation, etc.) of proposed health insurance benefit mandates?

YES NO NOT APPLICABLE

If “Yes,” briefly describe the circumstances here (continuing on the last page of the form if necessary).

2. INVESTMENT INTERESTS. Taking into account stocks, bonds, and other financial instruments and investments including partnerships - excluding broadly diversified mutual funds and any investment or financial interest valued at less than \$5,000, but including any equity interest in non-publicly traded entity - if the reports resulting from CHBRP’s health insurance benefit mandate evaluations were to provide the basis for government regulatory action or inaction with respect to the matters addressed in the reports –

(a) Do you or your spouse or dependent children own directly or indirectly (e.g., through a trust or an individual account in a pension or profit-sharing plan) any stocks, bonds or other financial instruments or investments that could be affected, either directly or by a direct effect on the business enterprise or activities underlying the investments?

YES NO NOT APPLICABLE

If “Yes,” briefly describe the circumstances here (continuing on the last page of the form if necessary).

(b) Do you have any other significant financial investments or interests such as commercial business interests (e.g., sole proprietorships), investment interests (e.g., stock options), or personal investment relationships (e.g., involving parents or grandchildren) that could be affected, either directly or by a direct effect on the business enterprise or activities underlying the investments?

YES **NO** **NOT APPLICABLE**

If “Yes,” briefly describe the circumstances here (continuing on the last page of the form if necessary).

3. PROPERTY INTERESTS. Taking into account real estate and other tangible property interests, as well as intellectual property (patents, copyrights, etc.) interests, if the reports resulting from CHBRP’s health insurance benefit mandate evaluations were to provide the basis for government regulatory action or inaction with respect to the matters addressed in the reports

(a) Do you or your spouse or dependent children own directly or indirectly any such property interests that could be directly affected?

YES **NO** **NOT APPLICABLE**

If “Yes,” briefly describe the circumstances here (continuing on the last page of the form if necessary).

(b) To the best of your knowledge, do any others with whom you have substantial common financial interests (e.g., employer, business partners, etc.) own directly or indirectly any such property interests that could be directly affected?

YES **NO** **NOT APPLICABLE**

If “Yes,” briefly describe the circumstances here (continuing on the last page of the form if necessary).

4. RESEARCH FUNDING AND OTHER INTERESTS. (a) Taking into account your research funding (including gifts, if used for research, grants and contracts) and other research support (e.g., equipment, facilities, industry partnerships, research assistants and other research personnel, etc.), if the reports resulting from CHBRP’s health insurance benefit mandate

evaluations were to provide the basis for government regulatory action or inaction with respect to the matters addressed in the reports –

(i) could the research funding and support for you or your close research colleagues and collaborators be directly affected, **or**

(ii) if you have any research agreements for current or continuing research funding (including gifts, grants and contracts) or support from any party whose financial interests could be directly affected, and such funding or support is directly related to the subject matter of the regulatory process, do such agreements significantly limit your ability to independently conduct and publish the results of your research (other than for reasonable delays in publication, as defined by UC policy or, if you are not UC faculty, 30 days, in order to file patent applications)?

YES **NO** **NOT APPLICABLE**

If “Yes,” briefly describe the circumstances here (continuing on the last page of the form if necessary).

(b) Is the central purpose of CHBRP’s health insurance benefit mandate evaluations for which this disclosure form is being prepared a critical review and evaluation of your own work or that of your employer?

YES **NO** **NOT APPLICABLE**

If “Yes,” briefly describe the circumstances here (continuing on the last page of the form if necessary).

(c) Do you have any existing professional obligations (e.g., as an officer of a scientific or engineering society) that effectively require you to publicly defend a previously established position on an issue that is relevant to the functions to be performed in CHBRP’s health insurance benefit mandate evaluations?

YES **NO** **NOT APPLICABLE**

If “Yes,” briefly describe the circumstances here (continuing on the last page of the form if necessary).

(d) To the best of your knowledge, will your participation in CHBRP’s health insurance benefit mandate evaluations enable you to obtain access to a competitor's or potential competitor's confidential proprietary information?

YES NO NOT APPLICABLE

If “Yes,” briefly describe the circumstances here (continuing on the last page of the form if necessary).

(e) Could your participation in CHBRP’s health insurance benefit mandate evaluations create a specific financial or commercial competitive advantage for you or others with whom you have substantial common financial interests?

YES NO NOT APPLICABLE

If “Yes,” briefly describe the circumstances here (continuing on the last page of the form if necessary).

(f) If the CHBRP health insurance benefit mandate evaluations for which this form is being prepared involve reviews of specific applications and proposals for contract, grant, fellowship, etc. awards to be made by sponsors, do you or others with whom you have substantial common financial interests, or a familial or substantial professional relationship, have an interest in receiving or being considered for awards that are currently the subject of the reviews that are being conducted?

YES NO NOT APPLICABLE

If “Yes,” briefly describe the circumstances here (continuing on the last page of the form if necessary).

(g) If CHBRP’s health insurance benefit mandate evaluations for which this form is being prepared involve developing requests for proposals, work statements, and/or specifications, etc., are you interested in seeking an award under the program for which the committee on which you have been invited to serve is developing the request for proposals, work statement, and/or specifications, or, are you employed in any capacity by, or do you have a financial interest in or other economic relationship with, any person or organization that to the best of your knowledge is interested in seeking an award under this program?

YES NO NOT APPLICABLE

If “Yes,” briefly describe the circumstances here (continuing on the last page of the form if necessary).

FURTHER EXPLANATION OF “YES” RESPONSES:

*During your period of service, **January 1, 2013 through December 31, 2013**, for which the preceding disclosures apply, any changes in the information reported, or any new information that needs to be reported, must be reported promptly by written or electronic communication to the responsible CHBRP administrator.*

SIGNATURE

DATE

PRINT NAME

Reviewed by Name/Title:

Responsible California Health
Benefits Review Program Administrator

DATE



Appendix 16: NAC Review Criteria and Guidelines

A National Advisory Council (NAC) reviews the California Health Benefits Review Program's (CHBRP's) analyses for quality and objectivity before they are transmitted to the Legislature. This document provides the criteria and guidelines used for these reviews.

Guidelines for NAC Review of Draft Bill Analyses

Purpose of the review: To help assure the accuracy, responsiveness, completeness, and clarity of CHBRP analyses of proposed health insurance benefit mandates and repeals undertaken for the California legislature.

Structure of bill analyses: The bill analyses are structured around specific issues mentioned in CHBRP's authorizing statute, which asks the University of California to address the medical impacts of mandated services, as well as the estimated financial and public health impacts, of each bill. When a particular piece of legislation would mandate something other than the coverage of services (e.g., access to certain types of providers), CHBRP may decide to modify the structure of the written report. To provide the Legislature with other information it deems more relevant to the bill's potential impacts.

Audience: CHBRP's primary audience is the California State Legislature; CHBRP submits each report to the committee that requested it (either the Assembly Committee on Health or the Senate Committee on Health) as well as to the author(s) of the legislation analyzed. Other members and committees of the Legislature, as well as California state government agencies such as the Office of the Governor, the Departments of Managed Health Care and Insurance, and the California Public Employees Retirement System (CalPERS), may also be interested in our analyses. CHBRP's authorizing statute further requests CHBRP to make its written analyses available to the public on its website, www.chbrp.org. There may be additional interest in CHBRP reports both in California and nationally.

Review Criteria: CHBRP asks the Peer reviewer to comment on the extent to which the report meets the criteria of 1) accuracy and objectivity 2) responsiveness to the legislative request 3) completeness, and 4) clarity of presentation using the specific questions on the review form as a guide to the extent they are helpful.

Review of CHBRP Draft Bill Analysis

Date: _____

Reviewer Name: _____

Bill Number or Name of Draft Report: _____

Using as much space as you need, please comment in the boxes below on the extent to which the draft report meets each of the following criteria using the specific questions as a guide to the extent they are helpful. There is space at the bottom of the form for other general comments or mention of specific parts of the text about which you have comments. **When possible please indicate whether your comment might fall into the following categories 1) suggestions 2) issues or items that you identify that you want to make sure the authors are aware of or are considering 3) serious concerns that must be addressed.**

Accuracy and Objectivity:

- Are conclusions adequately supported with objective evidence?
- Does the analysis adequately discuss situations for which evidence does not exist and discuss the implications of this lack of evidence?
- Does the analysis avoid perceptions of bias, for instance, by noting when cited studies are conducted by interested parties or by properly framing findings that may have resulted from biased research or reporting?
- Are potentially politically-sensitive issues handled appropriately, using neutral language?

Responsiveness:

- Are the analyses, findings and conclusions relevant to the bill in question?

Completeness:

- Does the analysis adequately address each of the issues of medical, financial, and public health impacts specified in CHBRP's authorizing statute? If not, does the text or appendices offer an explanation? *(See attached Check list)*
 - To the best of your knowledge, does the report exclude any high-quality evidence that would alter the findings or conclusions of the report?
-

Clarity:

- Does the executive summary concisely and clearly summarize the findings described in the analysis?
 - Are the findings clearly and concisely stated in understandable language?
 - Is supporting evidence described in sufficient detail?
 - Upon first mention, are technical terms defined appropriately for an interested lay audience?
 - Is the organization of the report easy to follow and appropriate for the topic?
-

Other Comments:

The California Health Benefits Review Program: National Advisory Council Review Criteria

Issues to be Addressed in CHBRP Analyses (Source: California Health and Safety Code at Section 127660 et. seq.)

<p>(1) Public health impacts, including, but not limited to, all of the following:</p>	<p>(A) The impact on the health of the community, including the reduction of communicable disease and the benefits of prevention such as those provided by childhood immunizations and prenatal care.</p> <p>(B) The impact on the health of the community, including diseases and conditions where gender and racial disparities in outcomes are established in peer-reviewed scientific and medical literature.</p> <p>(C) The extent to which the proposed service or repeal of existing services impacts premature death and the economic loss associated with disease.</p>
<p>(2) Medical impacts, including, but not limited to, all of the following:</p>	<p>(A) The extent to which the benefit or service is generally recognized by the medical community as being effective in the screening, diagnosis, or treatment of a condition or disease, as demonstrated by a review of scientific and peer-reviewed medical literature.</p> <p>(B) The extent to which the benefit or service is generally available and utilized by treating physicians.</p> <p>(C) The contribution of the benefit or service to the health status of the population, including the results of any research demonstrating the efficacy of the benefit or service compared to alternatives, including not providing the benefit or service. <i>[Note that this is addressed in the Public Health Impacts section since the criterion is similar to (A).]</i></p> <p>(D) The extent to which the proposed services do not diminish or eliminate access to currently available health care services. <i>[Note that this is addressed in the Financial Impacts section since the criterion is similar to (G).]</i></p>
<p>(3) Financial impacts, including, but not limited to, all of the following:</p>	<p>(A) The extent to which the coverage, or repeal of coverage will increase or decrease the benefit or cost of the service.</p> <p>(B) The extent to which the coverage, or repeal of coverage will increase the utilization of the benefit or service, or will be a substitute for, or affect the cost of, alternative services.</p> <p>(C) The extent to which the coverage, or repeal of coverage will increase or decrease the administrative expenses of health care service plans and health insurers and the premium and expenses of subscribers,</p>

enrollees, and policyholders.

(D) The impact of this coverage, or repeal of coverage on the total cost of health care.

(E) The potential cost or savings to the private sector, including the impact on small employers as defined in paragraph (1) of subdivision (l) of Section 1357, the Public Employees' Retirement System, other retirement systems funded by the state or by a local government, individuals purchasing individual health insurance, and publicly funded state health insurance programs, including the Medi-Cal program[¶] and the Healthy Families Program.[§]

(F) The extent to which costs resulting from lack of coverage or repeal of coverage are shifted to other payers, including both public and private entities.

(G) The extent to which mandating or repealing the proposed benefit or service does not diminish or eliminate access to currently available health care services.

(H) The extent to which the benefit or service is generally utilized by a significant portion of the population.

(I) The extent to which health care coverage for the benefit or service is already generally available.

(J) The level of public demand for health care coverage for the benefit or service, including the level of interest of collective bargaining agents in negotiating privately for inclusion of this coverage in group contracts, and the extent to which the mandated benefit or service is covered by self-funded employer groups.

(K) In assessing and preparing a written analysis of the financial impact of a mandated benefit or legislation proposing to repeal a mandated benefit or service pursuant to this paragraph, the Legislature requests the University of California to use a certified actuary or other person with relevant knowledge and expertise to determine the financial impact.

[¶]Medi-Cal is California's Medicaid program. [§]Healthy Families is California's State Children's Health Insurance Program.



Appendix 17: Clarification of Bill Language and Legislative Intent (Bill Author Questionnaire)

For each analysis, the California Health Benefits Review Program (CHBRP) conducts an interview with the bill author's staff. Shortly after each bill request is received, CHBRP staff use this standardized questionnaire to confirm with the bill author's staff a mutual understanding of both the intent of the bill and the likely interpretations of the bill as written.

Health Insurance Mandate or Repeal Bill Questionnaire:
For Bills Referred to the *California Health Benefits Review Program*

[Bill Number, (Author) and Introduction Date] (Please use additional pages)

Date:

Prepared by:

- I. What issue or problem does the bill address?
- Please describe the issue or problem.
 - What is your sense of the scope of the problem? What groups in particular might be affected?
 - How did you obtain this information (for example, particular constituent, stakeholders, opinion polls, focus groups, etc.)?
 - In your view, what need does the [mandate/repeal] fill? Why is there a gap between the needs of persons with insurance and available services? For example:
 - Is there is lack of coverage for specific populations or under certain types of insurance?
 - Is a new or available technology not widely used?
 - Is there is a discrepancy between current medical practice and evidenced-based standards of care?
 - Are costs for persons with insurance prohibitive even if the service is covered?
 - Are there other barriers to access?
 - Are any legal requirements related to the benefit already in place? (Please provide references to citations in the Insurance Code, Health and Safety Code, Business and Professions Code, Welfare and Institutions Code, California Code of Regulations).
- II. What would the proposed [mandate/repeal] do?
- What service(s) or treatment(s) would be mandated as a covered benefit?
 - Which providers would be authorized to be reimbursed for providing the service (e.g., if the service falls within the scope of practice of multiple providers)?
 - Are there any limits on the service/benefit (e.g., whether health plans can apply their own utilization review criteria for determining eligibility or length of treatment)?
 - Would it affect the share of costs that are borne by the member for the service/benefit? Would there be any limitations on deductibles, copayments, coinsurance, or annual dollar limits?
- III. Does the bill have sponsors? If so, who are they? Can we contact them for additional information, if necessary? (Please provide contact information.)
- IV. Are you aware of any published medical standards of care for treatment of this condition? Do you know of any clinical benchmarks of acceptable medical care, such as published clinical guidelines or statements by medical societies?
- V. Has a similar [mandate/repeal] been proposed previously in California or in other states? (If so, please provide Bill Number and Legislative Session.)

VI. Is this bill intended to affect multiple segments of the health insurance market? Is it intended to affect both privately purchased health plans regulated by the Department of Managed Health Care (DMHC) and health insurance policies regulated by the California Department of Insurance (CDI)? Is it intended to affect publicly purchased plans regulated by DMHC? Please indicate all market segments the bill is intended to affect by the inserting an X in the appropriate cells in the tables below.

A. DMHC-Regulated Health Plans—purchased from the commercial market with **PRIVATE** funds

Private, Full-Service, Knox-Keene Health Plans			Private, Specialized Knox-Keene Health Plans ¹
Large-Group Purchaser	Small-Group Purchaser	Individual Purchaser	

¹ Includes plans such as vision-only, dental-only, or behavioral health-only insurance.

B. CDI-Regulated Health Insurance—purchased from the commercial market with **PRIVATE** funds

Private, Full-Service Health Insurance			Private, Specialized Health Insurance ¹	Private, “Non-Health Disability Insurance” ²
Large-Group Purchaser	Small-Group Purchaser	Individual Purchaser		

¹ Includes policies such as vision-only, dental-only, or behavioral health-only insurance.

² “Non-health disability insurance” includes policies such as Medicare supplement, hospital indemnity, TriCare (formerly known as CHAMPUS) supplement, specified disease insurance that does not pay benefits on a fixed-benefit or a fixed-cash-only basis, etc. “Health insurance” is defined per California Insurance Code Section 106(a)-(c), for statutes that become effective after 2002, and refers to forms of disability insurance that provide coverage for hospital, medical, or surgical benefits.

C. DMHC-Regulated Health Plans—purchased from the commercial market with **PUBLIC** funds

Public, Full-Service, Knox-Keene Health Plans				
CalPERS	Medi-Cal Managed Care	MRMIB ¹		
		Healthy Families Program	Major Risk Medical Insurance Program (MRMIP)	Access for Infants and Mothers (AIM) Program

¹ Major Risk Medical Insurance Board.

VII. Who are anticipated supporters, opponents?

VIII. Are there any plans to amend the bill? If so, can you provide information on what the amendment will be?

IX. Mandate- or repeal-specific questions: [Add here]



Appendix 18: Health Care Service Plans' and Health Insurers' Proprietary Data Retention and Destruction Policy

The California Health Benefits Review Program (CHBRP) acknowledges its responsibility to preserve information relating to litigation, audits, and investigations. It is a crime to alter, cover up, falsify, or destroy any document to prevent its use in an official proceeding. Failure on the part of employees to follow this policy can result in possible civil and criminal sanctions against CHBRP and the University of California and its employees, and possible disciplinary action against responsible individuals (up to and including termination of employment). Each employee has an obligation to contact the CHBRP Director of a potential or actual litigation, external audit, investigation, or similar proceeding involving CHBRP that may have an impact as well on the approved records retention and document destruction schedule.

Documents covered under this policy. This policy covers “proprietary data,” that is, all records and documents that may associate data with a specific health care service plan or health insurer, as referenced in Health and Safety Code Section 127662, that have been received by CHBRP from Health Plans in connection with CHBRP’s analytical activities under Health and Safety Code Sections 127660 -127664.

Document retention and destruction. CHBRP shall retain documents for the period of their immediate or current use. CHBRP is responsible for the ongoing process of identifying its records of proprietary data that have met a maximum retention period of 30 days after the relevant report is submitted to the legislature, and overseeing their destruction. Destruction of the proprietary data may be accomplished by shredding, burning, or sending them to the landfill.

Electronic documents. Electronic documents that reveal proprietary data shall be retained as if they were paper documents. Therefore, any electronic files that contain proprietary data shall be scheduled to be destroyed by the end of the maximum retention period. Destruction of electronic documents may be accomplished by deleting proprietary data from CHBRP’s electronic files. Data that has been de-identified by removing the health plan’s or health insurer’s name may be retained beyond the maximum retention period noted above.

Suspending document destruction. Upon any indication of an official investigation of CHBRP related to any legal proceeding or by any governmental entity, document destruction shall be suspended immediately. Destruction shall be reinstated upon conclusion of such proceeding.

Use of documents. CHBRP staff shall remove health plan or insurer identifiers prior to circulating it outside of the University of California, Office of the President (UCOP), including CHBRP-affiliated faculty and contracted actuaries.

Effective date of policy: 12/31/05



Appendix 19: Existing Mandates in California Law

This document has been prepared by the California Health Benefits Review Program (CHBRP). CHBRP responds to requests from the California Legislature to provide independent analyses of the medical, financial, and public health impacts of proposed health insurance benefit mandates and repeals. Updates to this list of health insurance benefit mandates current in California,¹ as well as additional information about CHBRP, can be found at www.chbrp.org.

Purpose of this list: This list is intended to alert interested parties of existing state legislation that may relate to the subject or purpose of a health insurance benefit mandate or repeal bill.

Benefit mandates listed: CHBRP defines health insurance benefit mandates as per its authorizing statute.² Therefore, the listed mandates fall into one or more of the following categories: (a) offer or provide coverage for the screening, diagnosis, or treatment of specific diseases or conditions; (b) offer or provide coverage for types of health care treatments or services, including coverage of medical equipment, supplies, or drugs used in a treatment or service; and/or (c) offer or provide coverage permitting treatment or services from a specific type of health care provider. Listed mandates also include those that (d) specify terms (limits, timeframes, copayments, deductibles, coinsurance, etc.) for any of the other categories. Table 19-1 includes California's state-level health insurance benefit mandate laws, and Table 19-2 includes federal health insurance benefit mandate laws.

Information included for listed mandates: Table 19-1 identifies relevant California statutes. The table specifies when the law mandates *an offer* of coverage for the benefit. The table also identifies which health insurance markets (group and/or individual) are subject to the mandate. Explanations of these terms are provided in Appendix 19-A. Table 19-2 identifies relevant federal statutes, both those in existence prior to passage of the Patient Protection and Affordable Care Act (ACA), as well as federal mandates in the

¹ Available at: http://www.chbrp.org/other_publications/index.php.

² Available at: www.chbrp.org/documents/authorizing_statute.pdf.

ACA. Like Table 19-1, Table 19-2 identifies the health insurance markets subject to the mandate. Because none of the federal mandates are mandates to *offer* coverage, this information is not included in Table 19-2.

Other important information:

- Not all health insurance is subject to state-level health insurance benefit mandate laws. CHBRP annually posts estimates³ of Californians’ sources of health insurance, including figures for the numbers of Californians with health insurance subject to state-level benefit mandates.
- California has a bifurcated legal and regulatory system for health insurance products. The Department of Managed Health Care (DMHC) regulates health care service plan contracts, which are subject to the Health and Safety Code. The California Department of Insurance (CDI) regulates health insurance policies, which are subject to the California Insurance Code. DMHC-regulated plan contracts and CDI-regulated policies may be subject to state-level benefit mandate laws, depending upon the exact wording of the law.
- DMHC-regulated plans and CDI-regulated policies may also be subject to federal benefit mandate laws. Federal benefit mandates may interact or overlap with state-level benefit mandates. Some known interactions are noted in the footnotes for Table 19-1.
- Federal benefit mandates can apply more broadly than state-level benefit mandates. For example, federal benefit mandates may apply to Medicare or to self-insured plans. Table 19-2 only lists federal benefit mandate laws that would be relevant to DMHC-regulated plans and CDI-regulated policies.
- DMHC-regulated health plans are subject to “minimum benefit” laws and regulations (also known as “Basic Health Care Services”) that may interact or overlap with state-level benefit mandate laws. The Basic Health Care Services requirement for DMHC-regulated health plans is noted in Table 19-1 and further explained in Appendix 19-B.
- Although CHBRP assesses the impacts of bills, not existing laws, CHBRP’s analysis of Assembly Bill 1214 (2007)⁴ required a review of mandate laws current at that time. That report and all other CHBRP analyses may be found at www.chbrp.org/completed_analyses/index.php.

³ Available at: www.chbrp.org/other_publications/index.php.

⁴ Available at: www.chbrp.org/completed_analyses/index.php.

Table 19-1. California Health Insurance Benefit Mandates⁵ (by Topic)

#	Topic	Health and Safety Code (DMHC)	California Insurance Code (CDI)	Mandate to “Offer”? ⁶	Markets (Regulated by DMHC or CDI) Subject to the Mandate	Mandate Category
DMHC-Regulated Health Care Service Plan “Minimum Benefits”						
0	Health plans regulated by the DMHC are required to cover medically necessary basic health care services, including: (1) physician services; (2) hospital inpatient services and ambulatory care services; (3) diagnostic laboratory and diagnostic and therapeutic radiologic services; (4) home health services; (5) preventive health services; (6) emergency health care services, including ambulance and ambulance transport services, out-of-area coverage, and ambulance transport services provided through the 911 emergency response system; (7) hospice care. See Appendix 19-B for further details.	Multiple sections—see Appendix 19-B	N/A ⁷		Group and individual	<i>Not a distinct mandate</i>
Essential Health Benefits						
1	In 2014, a federal mandate will require some plans and policies to cover essential health benefits (EHBs) and will place limits on cost sharing. These statutes define EHBs for California. ⁸	1367.005	10112.27		Small group ⁹ and individual ¹⁰ In 2017, large group sold via the Exchange ¹¹	a, b, d

⁵ CHBRP defines health insurance benefit mandates as per its authorizing statute, available at: www.chbrp.org/other_publications/index.php. This list includes laws that meet that definition and are known to CHBRP.

⁶ “Mandate to offer” indicates that all health care service plans and health insurers selling health insurance subject to the benefit mandate are required to *offer* coverage for the benefit. The health plan or insurer may comply: (1) by including coverage for the benefit as standard in its health insurance products; or (2) by offering coverage for the benefit separately and at an additional cost (e.g., a rider). See Appendix 19-A.

⁷ N/A indicates that the benefit mandate does not apply to products governed under that code.

⁸ Affordable Care Act (ACA), Section 1301, 1302, and Section 1201 modifying Section 2707 of the Public Health Service Act (PHSA). See Table 19-2 below.

⁹ The ACA defines a large group as >100 employees. California state law defines a large group as >50. However, the ACA [Section 1304(b)(3)] allows states to treat groups between 50 and 100 as large for plan years beginning before 2016.

¹⁰ The EHB coverage requirement will apply to non-grandfathered plans and policies sold outside of the exchange as well as to qualified health plans (QHPs, see ACA Section 1301) certified by and sold via an Exchange.

#	Topic	Health and Safety Code (DMHC)	California Insurance Code (CDI)	Mandate to "Offer"? ⁶	Markets (Regulated by DMHC or CDI) Subject to the Mandate	Mandate Category
Cancer Benefit Mandates						
2	Breast cancer screening, diagnosis, and treatment	1367.6	10123.8		Not specified ¹²	a
3	Cancer screening tests	1367.665	10123.20		Group and individual	b
4	Cervical cancer screening	1367.66	10123.18		Group and individual	a
5	Mammography	1367.65	10123.81		Not specified	a, c
6	Mastectomy and lymph node dissection (length of stay, complications, prostheses, reconstructive surgery)	1367.635	10123.86		Not specified	b, d
7	Patient care related to clinical trials for cancer	1370.6	10145.4		Not specified	d
8	Prostate cancer screening	1367.64	10123.835		Group and individual	a
Chronic Conditions Benefit Mandates						
9	Diabetes education, management, and treatment	1367.51	10176.61		Not specified	a, b, d
10	Diabetes education	N/A	10176.6	Offer	Not specified (CDI)	a
11	HIV/AIDS, AIDS vaccine	1367.45	10145.2		Group and individual (DMHC), not specified (CDI)	a
12	HIV/AIDS, HIV testing	1367.46	10123.91		Group and individual	a
13	HIV/AIDS, transplantation services for persons with HIV	1374.17	10123.21(a)		Not specified	d
14	Osteoporosis	1367.67	10123.185		Not specified	a
15	Phenylketonuria	1374.56	10123.89		Not specified	a
Hospice & Home Health Care Benefit Mandates						
16	Home health care	1374.10 (non-HMOs only ¹³)	10123.10	Offer	Group	b, d
17	Hospice care	1368.2	N/A		Group (DMHC)	b
18	Dementing illness exclusion prohibition	1373.14	10123.16		Group and individual	a, d
Mental Health Benefit Mandates						
19	Alcohol and drug exclusion prohibition	N/A	10369.12		Group (CDI)	d
20	Alcoholism treatment	1367.2(a)	10123.6	Offer	Group	a

¹¹ Effective 2017, states may allow large-group market qualified health plans (QHPs, see ACA Section 1301) to be certified by and sold via an Exchange [ACA Section 1312(f)(2)(B)]. Large-group QHPs would be subject the EHB coverage requirement.

¹² Not Specified indicates that the benefit mandate does not specify which market or markets are subject.

¹³ DMHC regulates some non-HMOs (health maintenance organizations) insurance products, including some PPOs (preferred provider organizations). Only non-HMOs are subject to this benefit mandate.

#	Topic	Health and Safety Code (DMHC)	California Insurance Code (CDI)	Mandate to "Offer"? ⁶	Markets (Regulated by DMHC or CDI) Subject to the Mandate	Mandate Category
21	Coverage and premiums for persons with physical or mental impairment	1367.8	10144		Group and individual	a, d
22	Coverage for persons with physical handicap	N/A	10122.1	Offer	Group (CDI)	a, d
23	Coverage for mental and nervous disorders, including care provided by a psychiatric health facility	N/A	10125	Offer	Group (CDI)	a
24	Care provided by a psychiatric health facility	1373(h)(1)	N/A		Not specified (DMHC)	b, d
25	Nicotine or chemical dependency treatment in licensed alcoholism or chemical dependency facilities	1367.2(b)	10123.6	Offer	Group	b, d
26	Coverage for severe mental illnesses (in parity with coverage for other medical conditions) ¹⁴	1374.72	10144.5 10123.15		Not specified	a, b, d
27	Prohibition on Determining Reimbursement Eligibility from Inpatient Admission Status	1374.51	10144.6		Not specified	d
28	Prohibition of Lifetime Waiver for Mental Health Services	1374.5	10176(f)		Individual	a, d
29	Behavioral health treatment for autism and related disorders	1374.73	10144.51 10144.52		Not specified	b
Orthotics & Prosthetics Benefit Mandates						
30	Orthotic and prosthetic devices and services	1367.18	10123.7	Offer	Group	b
31	Prosthetic devices for laryngectomy	1367.61	10123.82		Not specified	b
32	Special footwear for persons suffering from foot disfigurement	1367.19	10123.141	Offer	Group	b
Pain Management Benefit Mandates						
33	Acupuncture	1373.10 (non-HMOs only) ¹⁵	10127.3	Offer	Group	c, d
34	General anesthesia for dental procedures	1367.71	10119.9		Not specified	b
35	Pain management medication for terminally ill	1367.215	N/A		Not specified (DMHC)	b
Pediatric Care Benefit Mandates						
36	Asthma management	1367.06	N/A		Not specified (DMHC)	a

¹⁴ In addition to these state-level benefit mandates, the federal Mental Health Parity and Addition Equity Act of 2008 requires that *if* a group plan or policy covers mental health, it must do so at parity with coverage for medical and surgical benefits. See Table 19-2 below.

¹⁵ DMHC regulates some non-HMOs (health maintenance organizations) insurance products, including some PPOs (preferred provider organizations). Only non-HMOs are subject to this benefit mandate.

#	Topic	Health and Safety Code (DMHC)	California Insurance Code (CDI)	Mandate to "Offer"? ⁶	Markets (Regulated by DMHC or CDI) Subject to the Mandate	Mandate Category
37	Comprehensive preventive care for children aged 16 years or younger	1367.35	10123.5		Group	b
38	Comprehensive preventive care for children aged 17 or 18 years	1367.3	10123.55	Offer	Group	b
39	Coverage for the effects of diethylstilbestrol	1367.9	10119.7		Not specified	a
40	Screening children for blood lead levels	1367.3(b)(2)(d)	10119.8	Offer	Group (DMHC), group and individual (CDI)	b
Provider Reimbursement Mandates						
41	Emergency 911 transportation ¹⁶	1371.5	10126.6		Not specified	d
42	Medical transportation services—direct reimbursement	1367.11	10126.6		Not specified	d
43	OB-GYNs as primary care providers ¹⁷	1367.69 1367.695	10123.83 10123.84		Not specified	c, d
44	Pharmacists—compensation for services within their scope of practice	1368.5	10125.1	Offer	Not specified	c, d
Reproduction Benefit Mandates						
45	Contraceptive devices requiring a prescription	1367.25	10123.196		Group and individual	b
46	Participation in the statewide prenatal testing Expanded Alpha Feto Protein (AFP) program	1367.54	10123.184		Group and individual	b
47	Infertility treatments	1374.55	10119.6	Offer	Group	a, b, d
48	Maternity—minimum length of stay ¹⁸	1367.62	10123.87		Not specified (DMHC), group and individual (CDI)	d
49	Maternity—amount of copayment or deductible for inpatient services	1373.4	10119.5		Not specified	d
50	Prenatal diagnosis of genetic disorders	1367.7	10123.9	Offer	Group	b
51	Maternity services	N/A	10123.865 10123.866		Group and individual (CDI)	b
Sterilization						

¹⁶ The ACA (Section 1001 modifying Section 2719A of the PHSA) imposes a related requirement regarding coverage and cost-sharing for emergency services. Grandfathered health plans (ACA Section 1251) are not subject to this requirement. See Table 19-2 below.

¹⁷ The ACA (Section 1001 modifying Section 2719A of the PHSA) imposes a similar requirement prohibiting prior authorization for access to OB-GYNs. Grandfathered health plans (ACA Section 1251) are not subject to this requirement. See Table 19-2 below.

¹⁸ The federal Newborns' and Mothers' Health Protection Act of 1996 requires coverage for a minimum length of stay in a hospital after delivery *if* the plan covers maternity services. See Table 19-2 below.

#	Topic	Health and Safety Code (DMHC)	California Insurance Code (CDI)	Mandate to "Offer"? ⁶	Markets (Regulated by DMHC or CDI) Subject to the Mandate	Mandate Category
52	Sterilization rationale exclusion prohibition	1373	10120		Not specified	d
Surgery Benefit Mandates						
53	Jawbone or associated bone joints	1367.68	10123.21		Not specified (DMHC), group and individual (CDI)	a
54	Reconstructive surgery ¹⁹	1367.63	10123.88		Not specified	b
Other Benefit Mandates						
55	Authorization for nonformulary prescription drugs	1367.24	N/A		Not specified (DMHC)	d
56	Blindness or partial blindness exclusion prohibition	1367.4	10145		Group and individual	a, d
57	Prescription drugs: coverage for previously prescribed drugs	1367.22	N/A		Not specified (DMHC)	d
58	Prescription drugs: coverage of "off-label" use	1367.21	10123.195		Not specified (DMHC), group and individual (CDI)	d
59	Second opinions	N/A	10123.68		Not specified (CDI)	c
60	Preventive services without cost sharing (in compliance with federal laws and regulations) ²⁰	1367.002	10112.2		Group and individual	b, d

¹⁹ The federal Women's Health and Cancer Rights Act of 1998 requires coverage for postmastectomy reconstructive surgery. See Table 19-2 below.

²⁰ ACA, Section 1001 modifying Section 2713 of the PHSA. See Table 19-2 below.

Table 19-2. Federal Health Insurance Benefit Mandates²¹

#	Federal Law	Topic Addressed by Benefit Coverage Mandate ²²	Markets (Regulated by DMHC or CDI) Subject to the Mandate ²³	Mandate Category
Federal Mandates in Existence Prior to the Passage of the Affordable Care Act of 2010 (ACA)				
1	Pregnancy Discrimination Act of 1978 amending Title VII of the federal Civil Rights Act	Requires coverage for pregnancy and requires the coverage be in parity with other benefit coverage.	Group (15 or more)	d
2	Newborns' and Mothers' Health Protection Act of 1996	If maternity is covered, requires that coverage include at least a 48-hour hospital stay following childbirth (96-hour stay in the case of a cesarean section).	Group	d
3	Women's Health and Cancer Rights Act of 1998	If mastectomy is covered, requires coverage for certain reconstructive surgery and other postmastectomy treatments and services.	Group	b
4	Mental Health Parity and Addiction Equity Act of 2008, modified by the Affordable Care Act of 2010 [ACA Section 1311(j) and Section 1563(c)(4) modifying Section 2726 of the Public Health Services Act (PHSA)]	If mental health or substance use disorder (MH/SUD) services are covered, requires that cost-sharing terms and treatment limits be no more restrictive than the predominant terms or limits applied to medical/surgical benefits.	Group and individual	d
Federal Mandates in the Affordable Care Act of 2010 (ACA)				
5	Section 1001 modifying Section 2711 of the PHSA	Prohibits lifetime and annual limits (with certain exceptions ²⁴) on the dollar value of benefits.	Group and individual	d

²¹ CHBRP defines health insurance benefit mandates as per its authorizing statute, available at: www.chbrp.org/other_publications/index.php. This list includes laws that meet that definition and are known to CHBRP.

²² All listed federal health insurance benefit mandates are benefit coverage mandates. CHBRP is aware of no federal "mandates to offer."

²³ Unless otherwise noted, the federal mandates in the ACA do not apply to grandfathered health plans (Section 1251).

²⁴ Prior to 2014, a group or individual health plan or policy can establish a restricted annual limit. In addition, annual limits (and lifetime limits) apply to grandfathered plans, with the exception that grandfathered individual market plans are not subject to the prohibitions on annual limits [ACA Section 1251(a)(4)].

#	Federal Law	Topic Addressed by Benefit Coverage Mandate ²²	Markets (Regulated by DMHC or CDI) Subject to the Mandate ²³	Mandate Category
6	Section 1001 modifying Section 2713 of the PHSA	Preventive services without cost sharing. ²⁵ As soon as 12 months after a recommendation appears in any of three sources, benefit coverage is required. The four sources are: <ul style="list-style-type: none"> • ‘A’ and ‘B’ rated recommendations of the United States Preventive Services Task Force (USPSTF)²⁶; • Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC)²⁷; • For infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA)²⁸; and • For women, preventive care and screenings provided for in comprehensive guidelines supported by HRSA.²⁹ 	Group and individual	a, d
7	Section 1001 modifying Section 2719A(b) of the PHSA	If emergency services are covered, requires coverage for these services regardless of whether the participating provider is in or out of network, with the same cost-sharing levels out of network as would be required in network, and without the need for prior authorization.	Group and individual	d
8	Section 1001 modifying Section 2719A(d) of the PHSA	Prohibits requiring prior authorization or referral before covering services from a participating health care professional who specializes in obstetrics or gynecology.	Group and individual	d
9	Section 1201 modifying Section 2704 of the PHSA	For children, prohibits “pre-existing condition” benefit coverage denials. In 2014, the prohibition will also impact benefit coverage for adults.	Group and individual ³⁰	d

²⁵ California law requires compliance with this mandate. See Table 19-1 above (categorized with “Other Benefit Mandates”).

²⁶ Available at: www.uspreventiveservicestaskforce.org/uspstf/uspstabrecs.htm.

²⁷ Available at: www.cdc.gov/vaccines/pubs/ACIP-list.htm.

²⁸ Appears in two charts: Periodicity Schedule of the Bright Futures Recommendations for Pediatric Preventive Health Care, available at: <http://brightfutures.aap.org/pdfs/AAP%20Bright%20Futures%20Periodicity%20Sched%20101107.pdf>; and Uniform Panel of the Secretary’s Advisory Committee on Heritable Disorders in Newborns and Children, available at: www.hrsa.gov/advisorycommittees/mchbadvisory/heritabledisorders/recommendedpanel/uniformscreeningpanel.pdf.

²⁹ Available at: www.hrsa.gov/womensguidelines/.

³⁰ Applies to grandfathered group market health plans and grandfathered individual market plans [ACA Section 1251(a)(4)].

#	Federal Law	Topic Addressed by Benefit Coverage Mandate ²²	Markets (Regulated by DMHC or CDI) Subject to the Mandate ²³	Mandate Category
10	Section 1301, 1302, and Section 1201 modifying Section 2707 of the PHS	In 2014, will require coverage of essential health benefits (EHBs), and, for plans and policies that provide coverage for EHBs, will place limits on cost sharing. The 10 EHB categories are: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services, including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care. ³¹	Small group ³² and Individual ³³ In 2017, large group sold via the Exchange ³⁴	a, b, d

³¹ California has laws in place to define EHBs for the state. See Table 19-1 above (categorized with “Essential Health Benefits”).

³² The ACA defines a large group as >100 employees. California state law defines a large group as >50. However, the ACA [Section 1304(b)(3)] allows states to treat groups between 50 and 100 as large for plan years beginning before 2016.

³³ The EHB coverage requirement will apply to nongrandfathered plans and policies sold outside of the exchange as well as to qualified health plans (QHPs, see ACA Section 1301) certified by and sold via an Exchange.

³⁴ Effective 2017, states may allow large-group market qualified health plans (QHPs, see ACA Section 1301) to be certified by and sold via an Exchange [ACA Section 1312(f)(2)(B)]. Large-group QHPs would be subject the EHB coverage requirement.

APPENDIX 19-A: Terms and Categories for Table 19-1 and Table 19-2

Code—A health insurance benefit mandate is a law requiring health insurance products (plans and policies) to provide, or in specified cases simply to offer, coverage for specified benefits or services. Because California has a bifurcated regulatory system for health insurance products, a benefit mandate law may appear in either of two codes or in both:

- Health & Safety Code: The California Department of Managed Health Care (DMHC) regulates and licenses health care services plans as per the California Health and Safety Code.³⁵
- Insurance Code: The California Department of Insurance (CDI) licenses disability insurance carriers and regulates disability insurance, which includes health insurance policies, per the California Insurance Code.³⁶

Mandated Benefit Coverage or Mandated Offer of Benefit Coverage—In the language of either code section, the law may mandate coverage of benefits or may mandate that coverage for the benefits be offered.

- “Mandate to cover” means that all health insurance subject to the law must cover the benefit.
- “Mandate to offer” means all health care service plans and health insurers selling health insurance subject to the mandate are required to offer coverage for the benefit for purchase. The health plan or insurer may comply with the mandate either (1) by including the benefit as standard in its health insurance products, or (2) by offering coverage for the benefit separately at an additional cost (e.g., a rider).

Markets Subject to the Mandate—In the language of either code section, the law may (or may not) specify which market or markets are subject to the mandate.

- The group market includes health insurance products issued to employers (or other entities) to provide coverage for employees (or other persons) and/or their dependents.
- The individual market includes health insurance products issued to an individual to provide coverage for a person and/or his/her dependents.

³⁵ Available at: www.leginfo.ca.gov/cgi-bin/calawquery?codesection=hsc&codebody=&hits=20.

³⁶ Available at: www.leginfo.ca.gov/cgi-bin/calawquery?codesection=ins&codebody=&hits=20.

Mandate Category—As per CHBRP’s authorizing statute,³⁷ the listed mandates fall into one or more types. A particular mandate law can require that subject health insurance do one or more of the following:

- (a) Offer or provide coverage for the screening, diagnosis, or treatment of a particular disease or condition. An example would be a mandate that requires coverage for all health care services related to the screening and treatment of breast cancer.
- (b) 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. An example would be a mandate to cover reconstructive surgery.
- (c) Offer or provide coverage for services from a specified type of health provider that fall within the provider’s scope of practice. An example would be a mandate that requires coverage for services provided by a licensed acupuncturist.
- (d) Offer or provide any of the forms of coverage listed above per specific terms and conditions. For example, the mental health parity law requires coverage for serious mental health conditions to be *on par* with other medical conditions, so that mental health benefits and other benefits are subject to the same copayments, limits, etc.

³⁷ Available at: www.chbrp.org/docs/authorizing_statute.pdf.

APPENDIX 19-B: Basic Health Care Services for DMHC-Regulated Health Care Service Plans³⁸

The California Department of Managed Health Care (DMHC) regulates health care service plans, which are subject to the Knox-Keene Health Care Service Plan Act of 1975, as amended, which was codified in the Health and Safety Code.³⁹ The Knox-Keene Act requires all health care service plans, except specialized health care service plans, to provide coverage for all medically necessary basic health care services.

This requirement is based on several sections of the Knox-Keene Act rather than one straightforward provision, and so is not technically a health insurance benefit mandate, as benefit mandates are defined by CHBRP's authorizing statute. Specifically, subdivision (b) of Section 1345 defines the term "basic health care services" to mean all of the following: (1) physician services, including consultation and referral; (2) hospital inpatient services and ambulatory care services; (3) diagnostic laboratory and diagnostic and therapeutic radiologic services; (4) home health services; (5) preventive health services; (6) emergency health care services, including ambulance and ambulance transport services and out-of-area coverage and ambulance transport services provided through the 911 emergency response system; (7) hospice care pursuant to Section 1368.2. "Basic health care services" are also further defined in Section 1300.67 of Title 28 of the California Code of Regulations.

In addition, subdivision (i) of Section 1367 of the Health and Safety Code provides the following: A health care service plan contract shall provide to subscribers and enrollees all of the basic health care services included in subdivision (b) of Section 1345, except that the director may, for good cause, by rule or order exempt a plan contract or any class of plan contracts from that requirement. The director shall by rule define the scope of each basic health care service that health care service plans are required to provide as a minimum for licensure under this chapter. Nothing in this chapter shall prohibit a health care service plan from charging subscribers or enrollees 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 director and set forth to the subscriber or enrollee pursuant to the disclosure provisions of Section 1363. Although the Act does not explicitly state that "basic health care services" means all "medically necessary" basic health care services, there are numerous provisions within the Knox-Keene Act that reference "medical necessity" and that place requirements on plans in terms of what they must do when denying, delaying, or modifying coverage based on a decision for medical necessity (Section 1367.01). In addition, Section 1300.67 of Title 28 of the California Code of Regulations, which further defines "basic health care services," does further clarify that "the basic health care services required to be provided by a health care service plan to its enrollees shall include, where medically necessary, subject to any co-payment, deductible, or limitation of which the Director may approve..."

The entire Knox-Keene Act and the applicable regulations can be accessed online on the DMHC's website at www.dmhc.ca.gov.

³⁸ The text in this appendix was adapted from a document prepared by a representative of the Department of Managed Health Care (S. Lowenstein).

³⁹ Health and Safety Code Section 1340 et seq.

APPENDIX 19-C: California Mandates (by Health and Safety Code Section)

The following table is presented to allow easy comparison of the mandates listed in Table 19-1.

#	Health and Safety Code (DMHC)	California Insurance Code (CDI)	#	Health and Safety Code (DMHC)	California Insurance Code (CDI)	#	Health and Safety Code (DMHC)	California Insurance Code (CDI)
22	N/A ⁴⁰	10122.1	12	1367.46	10123.91	24	1373(h)(1)	N/A
59	N/A	10123.68	9	1367.51	10176.61	33	1373.1	10127.3
51	N/A	10123.865	46	1367.54	10123.184	18	1373.14	10123.16
51	N/A	10123.866	2	1367.6	10123.8	49	1373.4	10119.5
23	N/A	10125	31	1367.61	10123.82	16	1374.1	10123.1
10	N/A	10176.6	48	1367.62	10123.87	13	1374.17	10123.21(a)
19	N/A	10369.12	54	1367.63	10123.88	28	1374.5	10176(f)
60	1367.002	10112.2	6	1367.635	10123.86	27	1374.51	10144.6
1	1367.005	10112.27	8	1367.64	10123.835	47	1374.55	10119.6
36	1367.06	N/A	5	1367.65	10123.81	15	1374.56	10123.89
42	1367.11	10126.6	4	1367.66	10123.18	26	1374.72	10144.5
30	1367.18	10123.7	3	1367.665	10123.2	26	1374.72	10123.15
32	1367.19	10123.141	14	1367.67	10123.185	29	1374.73	10144.51
20	1367.2(a)	10123.6	53	1367.68	10123.21	29	1374.73	10144.52
25	1367.2(b)	10123.6	43	1367.69	10123.83			
58	1367.21	10123.195	43	1367.695	10123.84			
35	1367.215	N/A	50	1367.7	10123.9			
57	1367.22	N/A	34	1367.71	10119.9			
55	1367.24	N/A	21	1367.8	10144			
45	1367.25	10123.196	39	1367.9	10119.7			
38	1367.3	10123.55	17	1368.2	N/A			
40	1367.3(b)(2)(d)	10119.8	44	1368.5	10125.1			
37	1367.35	10123.5	7	1370.6	10145.4			
56	1367.4	10145	41	1371.5	10126.6			
11	1367.45	10145.2	52	1373	10120			

⁴⁰ An N/A in either the Health and Safety Code column or the California Insurance Code column indicates that a mandate does not apply to products covered under that code.

APPENDIX 19-D: California Mandates (by Insurance Code Section)

The following table is presented to allow easy comparison of the mandates listed in Table 19-1.

#	Health and Safety Code (DMHC)	California Insurance Code (CDI)	#	Health and Safety Code (DMHC)	California Insurance Code (CDI)	#	Health and Safety Code (DMHC)	California Insurance Code (CDI)
36	1367.06	N/A ⁴¹	53	1367.68	10123.21	41	1371.5	10126.6
35	1367.215	N/A	13	1374.17	10123.21(a)	33	1373.1	10127.3
57	1367.22	N/A	37	1367.35	10123.5	21	1367.8	10144
55	1367.24	N/A	38	1367.3	10123.55	26	1374.72	10144.5
17	1368.2	N/A	20	1367.2(a)	10123.6	29	1374.73	10144.51
24	1373(h)(1)	N/A	25	1367.2(b)	10123.6	29	1374.73	10144.52
60	1367.002	10112.2	59	N/A	10123.68	27	1374.51	10144.6
1	1367.005	10112.27	30	1367.18	10123.7	56	1367.4	10145
49	1373.4	10119.5	2	1367.6	10123.8	11	1367.45	10145.2
47	1374.55	10119.6	5	1367.65	10123.81	7	1370.6	10145.4
39	1367.9	10119.7	31	1367.61	10123.82	28	1374.5	10176(f)
40	1367.3(b)(2)(d)	10119.8	43	1367.69	10123.83	10	N/A	10176.6
34	1367.71	10119.9	8	1367.64	10123.835	9	1367.51	10176.61
52	1373	10120	43	1367.695	10123.84	19	N/A	10369.12
22	N/A	10122.1	6	1367.635	10123.86			
16	1374.1	10123.1	51	N/A	10123.865			
32	1367.19	10123.141	51	N/A	10123.866			
26	1374.72	10123.15	48	1367.62	10123.87			
18	1373.14	10123.16	54	1367.63	10123.88			
4	1367.66	10123.18	15	1374.56	10123.89			
46	1367.54	10123.184	50	1367.7	10123.9			
14	1367.67	10123.185	12	1367.46	10123.91			
58	1367.21	10123.195	23	N/A	10125			
45	1367.25	10123.196	44	1368.5	10125.1			
3	1367.665	10123.2	42	1367.11	10126.6			

⁴¹ An N/A in either the Health and Safety Code column or the California Insurance Code column indicates that a mandate does not apply to products covered under that code.



Appendix 20: Media Citations of CHBRP or Its Work

This appendix includes a compilation of publicly available news articles, reports, or other media that cites or references CHBRP or its work since 2009.

Begley S. ‘Workplace wellness’ fails bottom line, waistlines—RAND. *Reuters*. May 24, 2013. Available at: <http://uk.reuters.com/article/2013/05/24/us-wellness-idUKBRE94N0XX20130524>. Accessed September 6, 2013.

Editorial: covering maternity care in California. *Los Angeles Times*. October 4, 2011. Available at: <http://articles.latimes.com/2011/oct/04/opinion/la-ed-maternity-20111004>. Accessed September 6, 2013.

Frazier J. Limit insurer-imposed ‘step therapy.’ *San Francisco Chronicle*. July 11, 2013. Available at: www.sfchronicle.com/opinion/openforum/article/Limit-insurer-imposed-step-therapy-4658629.php. Accessed September 6, 2013.

Frazier J. Putting patients back at the center of sensible health care policy. *Antioch Herald*. August 2013. Available at: <http://antiochherald.com/2013/07/putting-patients-back-at-the-center-of-sensible-health-care-policy/>. Accessed August 22, 2013.

Gorn D. California mandates 48 specific areas of coverage. *California Healthline*. March 9, 2012. Available at: www.californiahealthline.org/capitol-desk/2012/3/health-mandates-could-apply-to-32-million. Accessed August 22, 2013.

Gorn D. Dozens of bills down, dozens to go. *California Healthline*. March 23, 2011. Available at: www.californiahealthline.org/capitol-desk/2011/3/full-steam-ahead-for-california-reform. Accessed August 22, 2013.

Gorn D. Mandate bills merit independent review. *California Healthline*. January 21, 2011. Available at: www.californiahealthline.org/capitol-desk/2011/1/under-the-radar-agency-briefing. Accessed August 22, 2013.

Hart S. Study: pediatric vision, dental ACA coverage in limbo. *California Healthline*. October 10, 2012. Available at: www.californiahealthline.org/capitol-desk/2012/10/study-vision-dental-plans-lacking-for-kids.aspx. Accessed April 2, 2013.

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Johnston P. Protecting patients and managing costs. *California Healthline*. August 26, 2013. Available at: www.californiahealthline.org/think-tank/2013/pros-and-cons-of-step-therapy. Accessed August 26, 2013.

Lazarus D. Autism treatment law again shows insurers' need for therapy. *Los Angeles Times*. October 11, 2011. Available at: <http://articles.latimes.com/2011/oct/11/business/la-fi-lazarus-20111011>. Accessed September 6, 2013.

Munro D. RAND Corporation (briefly) publishes sobering report on workplace wellness programs. *Forbes*. May 28, 2013. Available at: www.forbes.com/sites/danmunro/2013/05/28/rand-corporation-briefly-publishes-sobering-report-on-workplace-wellness-programs/. Accessed September 6, 2013.

National Business Group on Health. *Cancer Continuum of Care: employer Strategies for Managing the Modern Disease*. Available at: www.businessgrouphealth.org/cancer/planbenefits/fertility.cfm. Accessed September 6, 2013.

National Patient Advocate Foundation. National Patient Advocate Foundation cautions California lawmakers and governor: amendments to oral cancer bill significantly increase cost of treatment, will detrimentally impact vulnerable segment of patient population. September 6, 2013. Available at: http://www.npaf.org/files/Press%20Release%20on%20CoPay%20amendment_CA%20AB%20219%20-%20Final_0.pdf. Accessed September 6, 2013.

Rosenberg A. CHBRP guides state lawmakers in health benefit policy. *UC Newsroom*. July 6, 2010. Available at: www.universityofcalifornia.edu/news/article/23668. Accessed August 22, 2013.



Appendix 21: Published Literature Citations of CHBRP or Its Work

This appendix includes a compilation of published literature that cites or references the California Health Benefits Review Program (CHBRP) or its work since 2009.

America's Health Insurance Plans (AHIP). *Statement on Essential Health Benefits*. Washington, DC; AHIP; 2011.

Baton Rouge Area Chamber. *Issue Brief: The True Effects of Comprehensive Coverage: Examining State Health Insurance Mandates*. Baton Rouge, LA: BRAC; 2009.

California Association of Health Plans. *Research Highlight: Estimated Sources of Health Insurance in California in 2014*. Sacramento, CA: CAHP; 2013.

California HealthCare Foundation. *California Health Care Almanac: California Health Plans and Insurers*. Oakland, CA: CHCF; 2010.

California HealthCare Foundation. *California's Individual and Small Group Markets on the Eve of Reform*. Oakland, CA: CHCF; 2011.

Cano GS, Puigpinós i Riera R, Garrido IR, Pons-Vigués M, Borrell C. Satisfaction and expectations of the women participants and not participants in the breast cancer screening programme in Barcelona after 10 years of operation [Spanish]. *Revista Española de Salud Pública*. 2010;84:717-729.

Center for Consumer Information and Insurance Oversight (CCIIO). *Essential Health Benefits Bulletin*. Baltimore, MD: CCIIO; 2011.

Clemans-Cope L, Blumberg LJ, Feder J, Pollitz K. *Protecting High-Risk, High-Cost Patients: "Essential Health Benefits," "Actuarial Value," and Other Tools in the Affordable Care Act*. Washington, DC: Urban Institute; 2012.

Coffman JM. *Policy Brief: Reforming the Private Insurance Market: Lessons from California for National Health Reform*. Berkeley, CA: Berkeley Center on Health, Economic, and Family Security; 2009.

Coffman JM, Ojeda G. *Impact of National Health Care Reform on California's Health Care Workforce*. California Program on Access to Care White Paper. Berkeley, CA: CPAC; 2010.

Coffman JM, Cabana MD, Yelin EH. Do school-based asthma education programs improve self-management and health outcomes? *Pediatrics*. 2009;124:729-742.

Coffman JM, Hong MK, Aubry WM, Luft HS, Yelin E. Translating medical effectiveness research into policy: lessons from the California Health Benefits Review Program. *The Milbank Quarterly*. 2009;87:863-902.

Curtis R, Neuschler E. Designing health insurance market constructs for shared responsibility: insights from California. *Health Affairs (Millwood)*. 2009;28:w431-w445.

Diamond F. IOM likes its CER list; others might if it suits them. *Biotechnology Healthcare*. 2009;6(5):45-48.

Diamond F. *Research Topics Underpin Comparative Effectiveness*. *Managed Care* 2009;18(11):45-48.

Division of Health Care Finance and Policy (DHCFP). *Review and Evaluation of Proposed Legislation Entitled: An Act to Provide Coverage for Hearing Aids, House Bill 3598*. Boston, MA: DHCFP; 2010.

Grau J, Giesa K. *Impact of the Patient Protection and Affordable Care Act on Costs in the Individual and Small-Employer Health Insurance Markets*. New York, NY: Oliver Wyman, Health & Life Sciences; 2009.

Institute of Medicine. *Essential Health Benefits: Balancing Coverage and Cost*. Washington, DC: The National Press; 2011.

Lavarreda SA, Brown RE, Cabezas L, Roby D. *Number of Uninsured Jumped to More Than Eight Million From 2007 to 2009*. UCLA Health Policy Research Brief. Los Angeles, CA: UCLA Center for Health Policy Research; 2010.

Ling DS. (2012). *Examining Issues of Cost, Target Populations, and Collaborative Implementation of Medication Therapy Management Services Interventions* [dissertation]. Los Angeles, CA: University of California, Los Angeles.

McManus P, Fox H, National Alliance to Advance Adolescent Health. *Issue Brief: Private Coverage Under California's Affordable Care Act: Benefit and Cost-Sharing Requirements Affecting Children and Adolescents With Special Health Care Needs*. Palo Alto, CA: Lucile Packard Foundation for Children's Health; 2013.

Meng YY, Pourat N, Cosway R, Kominski GF. Estimated cost impacts of law to expand coverage for self-management education to children with asthma in California. *Journal of Asthma*. 2010;47:581-586.

Russ LW, Takahashi LM, Ho W, Tseng W, Ponce NA. Bridging academic-legislative divides: models of policy-relevant health research and practice by the University of California. *Progress in Community Health Partnerships: Research, Education and Action*. 2012;6:95-102.

Texas Department of Insurance. *Patient Cost Disparity Between Orally and Intravenously Administered Chemotherapies*. Report on Senate Bill 1143, Section 3, 81st Legislature, Regular Session, 2009.

Texas Health and Human Services Commission. *Rider 55 Report: Report on Telemonitoring in the Texas Medicaid Program*. Austin, TX: Texas Health and Human Services Commission; 2012.

University of Connecticut, Center for Public Health and Health Policy. *Connecticut Mandated Health Insurance Benefits Reviews 2010, Volume II*. East Hartford, CT: University of Connecticut; 2011.

University of Connecticut, Center for Public Health and Health Policy. *Review and Evaluation of Certain Health Benefit Mandates in Connecticut*. East Hartford, CT: University of Connecticut; 2012.

Washington State Department of Public Health. *Information Summary and Recommendations: Oral Chemotherapy Drug Coverage Mandated Benefit Sunrise Review*. Publication number 631-014. Olympia, WA: Washington State Department of Public Health; 2010.

Washington State Department of Health. *Information Summary and Recommendations: Prosthetics and Orthotics Coverage Mandated Benefit Sunrise Review*. Publication number 631-024. Olympia, WA: Washington State Department of Public Health; 2011.

Weil A. The value of federalism in defining essential health benefits. *The New England Journal of Medicine*. 2012;366::679-681

Weimer D. *Medical Governance: Values, Expertise, and Interests in Organ Transplantation*. Washington, DC: Georgetown University Press; 2010.

Welch J, Bender K, Kerr D, Fitzpatrick R, Maryland Health Care Commission. *Annual Mandated Health Insurance Services Evaluation*. Milwaukee, WI: Oliver Wyman; 2011.

Methodology of Review of CHBRP Citations From Articles 2009–Present

The articles were found through a Google Scholar search with the following keywords:

- California Health Benefits Review Program
- California Health Benefit Review Program

More articles were found through a standard Google search. All searches were searched twice, first with “California Health Benefits Review Program” and then with “CHBRP.” The searches used the following keywords:

- Estimates of Health Insurance
- California’s State Benefit Mandates and the Affordable Care Act “Essential Health Benefits”
- Federal Preventive Services Benefit Mandate and California Benefit Mandates
- Current Mandates: Health Insurance Benefit Mandates in California State Law"
- Pediatric Dental and Pediatric Vision Essential Health Benefits
- Immunization Mandates, Benchmark Plan Choices, and Essential Health Benefits
- Mammography Mandates, Benchmark Plan Choices, and Essential Health Benefits
- Memorandum to CCIIO: Regarding Essential Health Benefits Bulletin
- Survey and Analysis of Other States' Health Benefit Review Programs
- Assembly Bill 219
- Assembly Bill 460
- Assembly Bill 912
- Senate Bill 126
- Senate Bill 189
- Senate Bill 320
- Senate Bill 799
- Assembly Bill 1000
- Assembly Bill 1738
- Assembly Bill 1800
- Assembly Bill 2064
- Assembly Bill 72
- Assembly Bill 137

- Assembly Bill 154
- Assembly Bill 171
- Assembly Bill 185
- Assembly Bill 310
- Assembly Bill 369
- Assembly Bill 428
- Assembly Bill 652
- Senate Bill 136
- Senate Bill 155
- Senate Bill 173
- Senate Bill 255
- Senate Bill 770
- Senate Bill TBD 1
- Assembly Bill 113
- Assembly Bill 754
- Assembly Bill 1600
- Assembly Bill 1825
- Assembly Bill 1826
- Assembly Bill 1904
- Assembly Bill 2587
- Senate Bill 220
- Senate Bill 890
- Senate Bill 961
- Senate Bill 1104
- Assembly Bill 56
- Assembly Bill 98
- Assembly Bill 163
- Assembly Bill 214
- Assembly Bill 244
- Assembly Bill 259
- Assembly Bill 513

- Assembly Bill 786
- Senate Bill 92
- Senate Bill 158
- Senate Bill 161

The results from the standard Google search were narrowed by changing the search date to search for documents that were published between 2009 and 2013. “CHBRP” is used in 34 different articles; CHBRP is cited in 24 articles, mentioned as a funder in 2 articles, and is referenced or is given a brief overview in 8 different articles. Every article that has a citation mentions a different report or table done by CHBRP, except for 4 articles that cite SB 161 (2009) Chemotherapy Treatment, 2 articles that cite SB TBD 1 (2011) Autism, 2 articles that cite Estimates of Sources of Health Insurance in California, 2011, 2 articles that cite AB 171 (2011) Autism, and 3 articles that cite AB 56 (2009) Mammography. There are about 57 citations, including citations of tables. There are 20 citations before 2009, and 37 citations during or after 2009. Seven of 34 articles are authored or partially authored by a current or former member of a CHBRP team.

Table 21-1. Summary of Results

Article Year	Title of Article	Publisher	How CHBRP Is Referenced in the Article
2013	<i>Estimated Sources of Health Insurance in California in 2014</i>	California Association of Health Plans	Estimates of Sources of Health Insurance in California, 2012 & 2014
2013	<i>Issue Brief: Private Coverage Under California’s Affordable Care Act: Benefit and Cost-Sharing Requirements Affecting Children and Adolescents With Special Health Care Needs</i>	Lucile Packard Foundation for Children’s Health	Issue Brief: Interaction Between California State Benefit Mandates and the Affordable Care Act’s “Essential Health Benefits (2012)
2012	“Bridging Academic–Legislative Divides: Models of Policy-Relevant Health Research and Practice by the University of California”	The Johns Hopkins University Press	CHBRP is referenced as a program that analyzes mandate and repeal bills.
2012	<i>Examining Issues of Cost, Target Populations, and Collaborative Implementation of Medication Therapy Management Services Interventions</i>	Dissertation	AB 310 (2011) Prescription Drugs AB 72 (2011) Health Care Coverage: Acupuncture AB 137 (2011) Mammography AB 154 (2011) Mental Health Services AB 171 (2011) Autism AB 185 (2011) Maternity Services AB 428 (2011) Fertility Preservation AB 1000 (2011) Cancer Treatment SB 136 (2011) Tobacco Cessation SB 1104 (2010) Diabetes-Related Complications

Article Year	Title of Article	Publisher	How CHBRP Is Referenced in the Article
2012	<i>Protecting High-Risk, High-Cost Patients: “Essential Health Benefits,” “Actuarial Value,” and Other Tools in the Affordable Care Act</i>	Robert Wood Johnson Foundation and Urban Institute	SB 161 (2009) Chemotherapy Treatment
2012	<i>Review and Evaluation of Certain Health Benefit Mandates in Connecticut</i>	University of Connecticut	AB 171 (2011) Autism SB 749 (2010) Health Care Coverage: Diagnosis of Autism SB 173 (2011) Mammograms
2012	<i>RIDER 55 REPORT: Report on Telemonitoring in the Texas Medicaid Program</i>	Texas Health and Human Services Commission	SB TBD 1 (2011) Autism
2012	“The Value of Federalism in Defining Essential Health Benefits”	<i>The New England Journal of Medicine</i>	ISSUE BRIEF: California’s State Benefit Mandates and the Affordable Care Act’s “Essential Health Benefits” (2011)
2011	<i>Annual Mandated Health Insurance Services Evaluation</i>	Maryland Health Care Commission	SB 161 (2009) Chemotherapy Treatment CHBRP Comparisons, 2009 v. 2008 By Delivery System With Riders (2009)
2011	<i>California’s Individual and Small Group Markets on the Eve of Reform</i>	California HealthCare Foundation	Estimates of Sources of Health Insurance in California, 2011
2011	<i>Essential Health Benefits: Balancing Coverage and Cost</i>	Institute of Medicine	CHBRP on Public Health Impact Analysis; CHBRP’s 2011 report on benefit mandate analysis programs in other states
2011	<i>Essential Health Benefits Bulletin</i>	Center for Consumer Information and Insurance Oversight	SB TBD 1 (2011) Autism
2011	<i>Prosthetics and Orthotics Coverage Mandated Benefit Sunrise Review</i>	Washington State Department of Public Health	AB 1212 (2006) Orthotic & Prosthetic Devices AB 1212 (2006) Orthotic & Prosthetic Devices (Amended)
2011	<i>Statement on Essential Health Benefits</i>	America’s Health Insurance Plans	CHBRP is referenced as a program that analyzes mandate and repeal bills.
2010	<i>California Health Care Almanac</i>	California HealthCare Foundation	Table 1: Health Insurance Coverage of Californians, 2008
2010	<i>California Health Plans and Insurers</i>	California HealthCare Foundation	Table 1: Health Insurance Coverage of Californians, 2008
2010	<i>Connecticut Mandated Health Insurance Benefits Reviews 2010, Volume II</i>	University of Connecticut	AB 56 (2009) Mammography AB 8 (2005) Health Care Coverage: Mastectomies and Lymph Node Dissections
2010	“Estimated Cost Impacts of Law to Expand Coverage for Self-Management Education to Children With Asthma in California”	<i>Journal of Asthma</i>	CHBRP is recognized as a funder of this article.
2010	Impact of National Health Care Reform on California’s Health Care Workforce	California Program on Access to Care	SB 890 (2010) Basic Health Care Services
2010	<i>Medical Governance: Values, Expertise, and Interests in Organ Transplantation</i>	Georgetown University Press	CHBRP is referenced as a program that analyzes mandate and repeal bills.

Article Year	Title of Article	Publisher	How CHBRP Is Referenced in the Article
2010	Number of Uninsured Jumped to More Than Eight Million From 2007 to 2009	UCLA Center for Health Policy Research	Estimates of Sources of Health Insurance in California, 2010
2010	Oral Chemotherapy Drug Coverage Mandated Benefit Sunrise Review	Washington State Department of Public Health	SB 961 (2010) Cancer Treatment
2010	Patient Cost Disparity Between Orally and Intravenously Administered Chemotherapies	Texas Department of Insurance	SB 161 (2009) Chemotherapy Treatment
2010	Review and Evaluation of Proposed Legislation Entitled: An Act to Provide Coverage for Hearing Aids, House Bill 3598	Massachusetts Division of Health Care Finance and Policy	AB 368 (2007) Mandate to Offer Coverage for Hearing Aids for Children
2010	“Satisfaction and Expectations of the Women Participants and Not Participants in the Breast Cancer Screening Programme in Barcelona After 10 Years of Operation”	<i>Revista Española de Salud Pública</i> (Spanish Journal of Public Health)	AB 56 (2009) Mammography
2009	“Designing Health Insurance Market Constructs for Shared Responsibility: Insights From California”	<i>Health Affairs (Millwood)</i>	Broken link referencing “Table 1: Insurance Coverage of Californians, 2006.”
2009	“Do School-Based Asthma Education Programs Improve Self-Management and Health Outcomes?”	<i>Pediatrics</i>	CHBRP is recognized as a funder of this article.
2009	Impact of the Patient Protection and Affordable Care Act on Costs in the Individual and Small-Employer Health Insurance Markets	Marsh, Mercer, Kroll, Guy Carpenter, Oliver Wyman	SB 1198 (2008) Health Care Coverage: Durable Medical Equipment
2009	“IOM Likes Its CER List; Others Might if It Suits Them”	<i>Managed Care</i>	CHBRP is referenced as a program that analyzes mandate and repeal bills.
2009	Reforming the Private Insurance Market: Lessons From California for National Health Reform	Berkeley Center on Health, Economic & Family Security	Table 1: Health Insurance Coverage of Californians, 2008” (2009) AB 1214 (2007) Waiver of Benefits AB 786 (2009) Individual Health Care Coverage: Coverage Choice Categories
2009	“Research Topics Underpin Comparative Effectiveness”	<i>Managed Care</i>	CHBRP is referenced as a program that analyzes mandate and repeal bills.
2009	The True Effects of Comprehensive Coverage: Examining State Health Insurance Mandates	Baton Rouge Area Chamber	CHBRP is briefly mentioned for its review criteria in this article.

Article Year	Title of Article	Publisher	How CHBRP Is Referenced in the Article
2009	“Translating Medical Effectiveness Research Into Policy: Lessons From the California Health Benefits Review Program”	<i>The Milbank Quarterly</i>	<p>AB 547 (2004) Ovarian Cancer Screening</p> <p>SB 415 (2005) Prescription Drugs for Alzheimer’s Disease</p> <p>SB 576 (2005) Health Care Coverage: Tobacco Cessation Services</p> <p>AB 1996 (2005) University of California Analysis of Legislation Mandating Health Care Benefits and Services</p> <p>AB 264 (2006) Pediatric Asthma Self-Management Training and Education Services</p> <p>AB 2281 (2006) High Deductible Health Care Coverage</p> <p>AB 30 (2007) Health Coverage: Inborn Errors of Metabolism</p> <p>AB 54 (2007) Health Care Coverage: Acupuncture</p> <p>AB 1774 (2008) Health Care Coverage: Gynecological Cancer Screening Tests</p> <p>AB 1894 (2008) HIV Testing</p> <p>AB 2234 (2008) Health Care Coverage: Breast Conditions</p> <p>Medical Effectiveness Analysis Research Approach (2008)</p> <p>AB 56 (2009) Mammography</p> <p>AB 163 (2009) Amino Acid-Based Elemental Formulas</p> <p>AB 214 (2009) Health Care Coverage: Durable Medical Equipment</p> <p>AB 244 (2009) Health Care Coverage: Mental Health Services</p> <p>AB 259 (2009) Certified Nurse Midwives: Direct Access</p> <p>SB 161 (2009) Chemotherapy Treatment</p>

Note: *Items listed in blue are authored or partially authored by a current or former member of a CHBRP team.



Appendix 22: Other States' Health Benefit Review Programs, 2013

In the summer of 2013, California Health Benefits Review Program (CHBRP) contacted every state and the District of Columbia to explore the status of benefit mandate review programs and processes outside of California. Similar surveys were completed in 2004, 2009, and 2011, but the 2013 iteration of the survey sought to both update that information and also obtain answers to new questions related to federal health reform. The following section outlines our findings, and provides some national context for how other states are reviewing benefits mandates, as well implementing the Affordable Care Act (ACA). Several states with notable changes from our last survey are highlighted.

CHBRP had several objectives in conducting interviews with other states' programs:

1. To provide an overview of the focus of other states' programs, as well as their similarities to and differences from CHBRP;
2. To catalog changes to other states' programs, and take note of changes in mission, process, or position within a host organization;
3. To better understand how programs in other states are responding to changes related to the ACA; and
4. To maintain contacts at benefit mandate review programs in other states that may be useful for informing CHBRP's work.

In total, 29 states had systematic programs or processes in place to study existing and proposed health benefit mandates in 2013 (see Table 22-1). State programs generally fell into one of three organizational categories: state insurance departments (or other executive branch departments); legislative research services; or independent councils, commissions, or university-based programs (see Table 22-2). Although many of these entities (most significantly insurance departments) reported spending a great deal of time on policy changes related to the ACA, none of the programs, in terms of benefit mandate review, reported a significantly changed mission, organizational structure, or analytical scope since 2011. As of 2013, only Maryland appears to have suspended its benefit mandate review program. In 2012, at least five states considered legislation that would have created a benefit mandate review program (see Table 22-4).

Methodology

CHBRP interviewed individuals in other states based on contact information obtained in 2011 or through contacts obtained in the course of CHBRP's efforts to analyze California benefit mandate bills. Where previous contacts had left or were no longer involved with benefit mandate review, CHBRP reached out to the former contact or to the relevant department to find the best

new contact. Contacts were asked about the establishment of their program, its organizational goals and structure, analytical process, and the scope of their analyses. Programs with formal procedures for determining cost and societal/public-health impacts were also asked more technical questions about their data collection processes and methodology. All contacts were asked about their organization's involvement in determining essential health benefits for the state and any changes to their work as a result of the ACA. Contacts in 38 states agreed to brief telephone interviews, a figure which includes all of the states with the most robust benefit mandate/repeal review programs (see Table 22-1).¹

Findings

Changes to states' programs since 2011

The largest change since the last iteration of CHBRP's survey is the implementation of parts of the ACA. In 2011, programs were unsure about their role in overseeing provisions of the law. However, in 2013, while many programs continue to express uncertainty about the regulation and enforcement of the ACA, roles are more clearly defined. Insurance departments reported the highest level of involvement with implementation; legislative research services often provided support to the legislature around essential health benefits (EHBs) and broader implementation of the ACA; and councils, commissions and university-based programs typically provided support in more limited ways. Only one program (the Maryland Health Care Commission) reported changes to their role regarding benefit mandate review, and all other programs continue to study and report on mandates in the same way they had in the past. States with notable changes are listed in the next section.

Several states reported that the total number of introduced benefit mandate bills had declined somewhat in the past two to three years. In 2012, nine of the states interviewed (Alabama, DC, Maryland, Maine, Montana, New York, Pennsylvania, Vermont, and Wisconsin) had not looked at mandates; in the case of Tennessee, Maryland, and Vermont, the states' legislatures had (formally or informally) frozen mandates due to the ACA's anticipated introduction of EHBs and the requirement that states pay the cost of any mandates that exceeded the state's EHBs. A contact at the Maryland Health Care Commission suggested that mandate bills may be tabled in many places until 2015, when markets have settled and the regulations and authority around the ACA have become clearer. However, as of 2013, on average, states that looked at mandate bills reported between two and five requested analyses.

States with notable changes

Maryland: The Maryland Health Care Commission (MHCC) is a public regulatory commission that annually assesses the medical, social, and financial impacts of proposed mandated health insurance services that fail passage during the preceding legislative session or that are submitted to the MHCC by a Legislator. When CHBRP contacted MHCC in 2013, the commission's director informed CHBRP that Maryland had suspended activity related to mandates as a result of the ACA, since states are required to pay for any mandates that exceed federal essential health

¹ Contacts in Alaska, Florida, Indiana, Kentucky, Louisiana, Michigan, Mississippi, North Carolina, Oklahoma, Rhode Island, South Dakota and Wyoming could not be reached.

benefits. MHCC's future role in performing the clinical, social, and financial impact of proposed mandates has not been defined.

Massachusetts: Previously, mandates in Massachusetts were reviewed by the Division of Health Care Finance and Policy (DHCFP), within the Massachusetts Executive Office of Health and Human Services. In 2012, the Division of Health Care Finance and Policy was reestablished as the Center for Health Information and Analysis (CHIA), an independent state agency with an executive director appointed by the Governor, State Auditor, and Attorney General. CHIA is charged with collecting and analyzing health care data for the state of Massachusetts. As part of its role, it also analyzes health benefit mandate bills as well as performs retrospective reviews of mandates that have passed (typically every four years). CHIA's process for bill analysis is generally the same as it was in 2011—CHIA contracts with an actuarial firm to analyze cost information, and staff members conduct literature reviews and write the medical effectiveness section of reports.

Virginia: The law authorizing Virginia's Special Advisory Commission on Mandated Health Insurance Benefits has been repealed, and the benefit mandate review program is being absorbed into Virginia's new Health Insurance Reform Commission (HIRC). The HIRC is charged with establishing the state's health insurance exchange, deciding Virginia's EHBs package, and providing assessments of existing and proposed mandate legislation. At this time, the transition is still in progress.

Delaware: In 2011, the Delaware Health Care Commission (HCC) was the main venue for policy discussions on the implementation of the ACA. Now, the HCC has become the primary site for state-wide implementation of the ACA. The HCC is in charge of determining EHBs and setting up the state's health insurance exchange. The commission still examines the effect of new mandates (in 2013 they looked at a bill regarding specialty tier drugs²), but its primary focus has shifted toward the implementation of the ACA.

Georgia: In 2011, Georgia passed legislation³ to create a new Mandated Benefits Commission, which was intended to go into effect in December 2012. However, the Assistant Director of the Life and Health Division at the Insurance Department, who was formerly responsible for benefit mandate analyses, has informed CHBRP that the Commission has not taken over this work yet, and that mandate analyses are still being completed by the Insurance Department.

New survey questions related to the Affordable Care Act

As part of its survey for 2013, CHBRP asked the following new questions of the benefit mandate review programs:

1. For 2013 bills, did you project 2014 enrollment as "baselines" (or for any other purpose)? If so, how did you make the projections? What about premiums?⁴

² Bill text of Delaware SB 35 available at

[http://legis.delaware.gov/LIS/lis147.nsf/vwLegislation/SS+1+for+SB+35/\\$file/legis.html?open](http://legis.delaware.gov/LIS/lis147.nsf/vwLegislation/SS+1+for+SB+35/$file/legis.html?open)

³ Bill text of Georgia SB 17 available at www.legis.ga.gov/Legislation/20112012/116650.pdf.

⁴ Most states had not projected 2014 enrollments or premiums. Those who did typically used an actuarial firm such as Milliman to make projections about a 2013 mandate's effect on 2014 premiums.

2. Was your office involved in selecting and/or defining the EHBs in your state? If so, how?
 - a. Has your office adjusted its analyses in any way to incorporate an analysis of a mandate's interaction with the ACA and/or EHBs? If yes, in what ways?
 - b. Have you encountered any mandates that you think will exceed EHBs?
 - c. Has there been any formal adjustment of your charge as a result of the ACA and/or EHBs?

Whether or not entities were involved in EHB selection generally depended on their institutional context. Typically, insurance departments and were highly involved in the selection of the benchmark plan that helped define their state's EHBs. Staff interviews with legislative research services generally revealed a lower level of involvement with EHBs; most research services provided support and information to the legislature about EHBs if requested. Independent health policy commissions and university programs, such as the New Jersey Mandated Health Benefits Advisory Commission, Pennsylvania's Health Care Cost Containment Council, and the University of Connecticut's Center for Public Health and Public Policy generally reported minimal involvement, although similar to CHBRP, these programs had provided briefs and reports to inform the decision making.

Of the benefit mandate review programs CHBRP interviewed, nearly all of them stated that they planned to incorporate an analysis of how a new mandate would interact with the state's EHBs. Many states interviewed believed that any new mandates in their state would exceed EHBs, a belief which does not perfectly align with CHBRP's expectations. For example, CHBRP has been asked to review benefit mandate bills that would restrict cost-sharing,⁵ a restriction that would not interact or exceed EHBs.⁶ Therefore, CHBRP expects that only some benefit mandate bills would exceed a state's EHBs. Other than adding consideration of a mandate's possible interaction with EHBs or other aspects of the ACA, none of the entities interviewed had adjusted their charge to review benefit mandates as the result of ACA.

Difficulties facing review programs

Programs generally reported similar problems to 2011, although many are dealing with more uncertainty due to changes from the ACA. The main issues facing programs are:

- Limited time—programs often find it difficult to complete their analyses in the period of time needed; in some legislative research services, the turnaround is sometimes as short as a matter of days.

⁵ For more information see http://chbrp.ucop.edu/index.php?action=read&bill_id=136&doc_type=3.

⁶ The Federal Department of Health and Human Services' proposed rule on essential health benefits, which was made final in February 2013, specified that "...state rules related to...cost-sharing...would not fall under our interpretation of state-required benefits. Even though plans must comply with those state requirements, there would be no federal obligation for states to defray the costs associated with those requirements," Department of Health and Human Services. Patient Protection and Affordable Care Act: Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation. Final Rule. *Federal Register*. Available at: www.gpo.gov/fdsys/pkg/FR-2012-11-26/pdf/2012-28362.pdf.

- ACA implementation—many state insurance departments are primarily concerned about the implementation of ACA provisions on a tight timeline. Some cited a lack of federal guidance, or large workloads, as their concerns.
- Financial resources—several programs cited issues with state hiring freezes or lack of resources to train staff or build skills.
- Mandate bill volume variability—several programs said that the number of introduced mandate bills fluctuates year to year, which can cause problems in regards to properly reserving adequate staff time.

Other states reports

Although all states had reports available upon request, several also make their products available online (see Table 22-3).

Table 22-1. States' Health Benefit Mandate Review Programs—Analytical Dimensions

State	Cost	Medical	Social/Public Health
Arizona	✓	✓	✓
California	✓	✓	✓
Connecticut	✓	✓	✓
Florida	✓		✓
Georgia	✓	✓	✓
Hawaii	✓		✓
Indiana	✓	✓	✓
Kansas	✓		✓
Kentucky	✓		
Louisiana	✓		
Maine	✓	✓	✓
Massachusetts	✓	✓	
Minnesota	✓	✓	✓
Missouri	✓		
Nevada	✓		
New Hampshire	✓	✓	✓
New Jersey	✓	✓	✓
North Dakota	✓		
Ohio	✓		✓
Oklahoma	✓	✓	
Oregon	✓	✓	✓
Pennsylvania	✓	✓	✓
South Carolina	✓		
Tennessee	✓		
Texas	✓		
Utah	✓	✓	✓
Virginia	✓	✓	✓
Washington	✓	✓	✓
Wisconsin	✓		

Table 22-2. States' Health Benefit Mandate Review Programs—Institutional Structure

State	State Agencies				Independent Programs		Other
	Insurance Department (a)	Other State Agency (b)	Legislative Research Services (c)	Health Insurance Exchange (d)	University (e)	Commission (f)	Sponsor (g)
Arizona							✓
California					✓		
Connecticut					✓		
Florida							✓
Georgia (h)	✓					✓	
Hawaii (i)			✓				
Indiana						✓	
Kansas	✓						
Kentucky	✓						
Louisiana (j)						✓	
Maine	✓						
Massachusetts		✓					
Minnesota		✓					
Missouri			✓				
Nevada			✓				
New Hampshire	✓						
New Jersey						✓	
North Dakota			✓				
Ohio	✓						
Oklahoma						✓	
Oregon		✓					
Pennsylvania						✓	
South Carolina	✓						
Tennessee			✓				
Texas	✓						
Utah	✓						
Virginia				✓		✓	
Washington		✓					
Wisconsin	✓						

Notes:

- (a) “Insurance Department” programs include the “Insurance Commissioner,” “Office of Insurance,” or the equivalent agency in that respective state. These are housed in the executive branch of the state government.
- (b) “Other State Agency” programs include those that are housed at another agency under the executive branch besides the Department of Insurance.
- (c) “Legislative Research Services” programs include those that are housed at the departments or agencies designed to support the legislature.
- (d) “State Exchange” refers to the state’s health insurance exchange. In Virginia, the mandated benefits commission has been repealed, and merged into the state’s exchange; as other states begin to implement their exchanges, we may see more programs subsumed into exchanges.
- (e) Health benefit review programs are housed at universities in California (CHBRP at the UC Office of the President) and in Connecticut (at University of Connecticut’s Center for Public Health and Public Policy).
- (f) Commission-based programs usually consist of individuals appointed by the executive or the legislative branch, and represent different industry and consumer interests. Commissions that evaluate health insurance benefits often conduct other types of analysis related to health care programs in the state.
- (g) The requirement for conducting evaluations falls primarily on the bill sponsors. Sponsors may mean a member of the state legislature but usually mean an outside organization or association advocating for passage of the bill.
- (h) Georgia passed legislation to create a new Mandated Benefits Commission, which was intended to go into effect in December 2012. However, the Assistant Director of the Life and Health Division at the Insurance Department, who was formerly responsible for benefit mandate analyses, has informed CHBRP that the Commission has not taken over this work yet, and that mandate analyses are still being completed by the Insurance Department.
- (i) Hawaii’s mandate evaluation is conducted by the State Auditor, who reports to and is considered part of the legislative branch
- (j) In 2010, Louisiana created the Louisiana Mandated Health Benefits Commission, to review mandate bills and report on the cost, social impact, and medical effectiveness of the proposed legislation. CHBRP has not been able to reach the commission for further information.

Table 22-3. States' Health Benefit Mandate Review Programs—Reports Available Online

State	Program	Website
Connecticut	Center for Public Health and Public Policy	www.publichealth.uconn.edu/connecticut-insurance-department.html
Hawaii	Office of the State Auditor	www.state.hi.us/auditor/Categories/HTH.htm
Maine	Bureau of Insurance	http://maine.gov/pfr/legislative/index.htm#insurance
Massachusetts	Center for Health Information and Analysis	www.mass.gov/chia/researcher/archived-publications.html#mandated_benefits
New Hampshire	New Hampshire Insurance Department	www.nh.gov/insurance/reports/
New Jersey	The New Jersey Mandated Health Benefits Advisory Commission	www.nj.gov/dobi/division_insurance/mhbac/mhbacdone.htm
Pennsylvania	Health Care Cost Containment Council	www.phc4.org/reports/mandates/
Texas	Texas Department of Insurance	www.tdi.texas.gov/reports/report5.html
Virginia	Joint Legislative Audit and Review Commission	http://jlarc.virginia.gov/reports.shtml
Washington	Department of Health Systems Quality Assurance	www.doh.wa.gov/AboutUs/ProgramsandServices/HealthSystemsQualityAssurance/SunriseReviews.aspx
Wisconsin	Commissioner of Insurance	http://oci.wi.gov/finimpct.htm

Table 22-4. States’ Health Benefit Mandate Review Programs—Proposals in Other States

State	Year	Bill	Description	Bill Status
Louisiana	2012	HB 954	Would place the Louisiana Mandated Health Benefits Commission within the Department of Insurance.	Enrolled July 2012
Montana	2012	HB 563	Would require cost-benefit analysis of mandated health insurance coverage of service. Any bill reported out of a committee of the legislature that contains a mandate for health insurance coverage of specific services or payment for specified providers of services would include a cost-benefit analysis incorporating an estimate of the extent to which the proposed mandate would: <ul style="list-style-type: none"> • Increase or decrease the cost of the coverage or the service; • Increase the appropriate use of the service; • Increase or decrease the administrative expenses of insurers and the premium and administrative expenses of insureds; and • Increase or decrease the total cost of health care. 	Died in committee
		HB 673	Would provide for a review of mandated health insurance benefits. The bill would require that a proposed mandated benefit, a proposed change to a mandated benefit, or an amendment to a proposal for a mandated benefit be reviewed by the commissioner. The commissioner would provide the legislature with information, including an actuarially based review, about the proposal's medical efficacy and cost benefits.	Died in committee
New York	2012	HB 2770	Would create a health benefit and cost commission to conduct a comprehensive review of all current mandated benefits and an accurate cost analysis of proposed benefits.	Died in committee
Rhode Island	2012	HB 7364	Would require a mandated benefit review by the health insurance commissioner of any mandated benefit introduced after January 1, 2013, contingent on the review being paid for by health care providers authorized to do business in Rhode Island.	Held back for further study
West Virginia	2012	HB 2214	Would amend the Code of West Virginia by adding a new article relating to the “Mandated Benefits Review Act.” The Act would also require the Insurance Commissioner to review and report to the Legislature in an actuarially-based fashion the financial and other related impacts of any proposed legislation to mandate medical or health-related benefits.	Died in committee