California Health Benefits Review Program

Executive Summary

Analysis of Senate Bill 189: Wellness Programs

A Report to the 2013-2014 California Legislature April 25, 2013

CALIFORNIA
HEALTH BENEFITS REVIEW PROGRAM

A Report to the 2013–2014 California State Legislature

Analysis of Senate Bill 189
Wellness Programs

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Suggested Citation:

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

EXECUTIVE SUMMARY

California Health Benefits Review Program Analysis of Senate Bill 189

The California Senate Committee on Health requested on February 28, 2013, that the California Health Benefits Review Program (CHBRP) conduct an evidence-based assessment of the medical, financial, and public health impacts of Senate Bill (SB) 189. In response to this request, CHBRP undertook this analysis pursuant to the provisions of the program's authorizing statute.[1]

In 2014, CHBRP estimates that approximately 25.9 million Californians (67%) will have health insurance that may be subject to a health benefit mandate law passed at the state level.[2] Of the rest of the state's population, a portion will be uninsured (and so will have no health insurance subject to any benefit mandate), and another portion will have health insurance subject to other state laws or only to federal laws.

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

DMHC-regulated group plans and CDI-regulated group policies would be subject to SB 189, but individual market plans and policies would not be. The regulator, DMHC, and the purchaser, the California Department of Health Care Services, have indicated that by referencing "group" plans SB 189 would not require compliance from plans enrolling Medi-Cal beneficiaries into Medi-Cal Managed Care.[5,6] Therefore, the mandate would affect the health insurance of approximately 16.5 million enrollees (43% of all Californians).

Developing Estimates for 2014 and the Effects of the Affordable Care Act

The Affordable Care Act (ACA)[7] is expected to dramatically affect health insurance and its regulatory environment in California, with many changes becoming effective in 2014. Beginning in 2014, an expansion of the Medicaid program to cover people up to 133% of the federal

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[1] Available at: www.chbrp.org/docs/authorizing_statute.pdf.
[2] CHBRP's estimates are available at: www.chbrp.org/other_publications/index.php.
[3] The California Department of Managed Care (DMHC) was established in 2000 to enforce the Knox-Keene Health Care Service Plan of 1975; see Health and Safety Code (H&SC) Section 1340.
[4] The California Department of Insurance (CDI) licenses "disability insurers." Disability insurers may offer forms of insurance that are not health insurance. This report considers only the impact of the benefit mandate on health insurance policies, as defined in Insurance Code (IC) Section 106(b) or subdivision (a) of Section 10198.6.
[5] Personal communication, S. Lowenstein, Department of Managed Health Care, March 2013.
[6] Personal communication, C. Robinson, Department of Health Care Services, March 2013, citing Sec. 2791 of the federal Public Health Service Act.
[7] The federal "Patient Protection and Affordable Care Act" (P.L.111-148) and the "Health Care and Education Reconciliation Act" (P.L 111-152) were enacted in March 2010. Together, these laws are referred to as the Affordable Care Act (ACA).

poverty level (FPL)[8] and the availability of subsidized and nonsubsidized health insurance coverage purchased through newly established state health insurance exchanges are expected to significantly increase the number of people with health insurance in the United States.

State exchanges will sell health insurance in the small-group and individual market[9] through qualified health plans (QHPs), which will be certified by and sold in a state's exchange. QHPs sold through California's state exchange, Covered California,[10] will be DMHC-regulated plans or CDI-regulated policies, and as such will be subject to California state benefit mandates.

It is important to note that CHBRP's analyses of proposed benefit mandate bills typically address the marginal effects of the proposed bills—specifically, how the proposed mandate would impact benefit coverage, utilization, costs, and public health, holding all other factors constant. CHBRP's estimates of these marginal effects are presented in this report. Because expanded enrollment will not occur until January 2014, CHBRP relies on projections from the California Simulation of Insurance Markets (CalSIM) model[11] to help set baseline enrollment for 2014. From this projected baseline, CHBRP estimates the marginal impact of proposed benefit mandates that could be in effect after January 2014. CHBRP's methods for estimating baseline 2014 enrollment from CalSIM projections are provided in further detail in Appendix D.

Bill-Specific Analysis of SB Bill 189

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.

SB 189 would (unless the wellness program predated January 1, 2014):

- Prohibit group market plans/insurers from operating wellness programs that may impact premiums or cost sharing;
- Prohibit group market plans/insurers (regardless of who operates the wellness program) from altering premiums (through either discounts or rebates) or cost sharing (through deductibles, copayments, coinsurance) based on either wellness program participation or attaining goals set by a wellness program.

[8] The Medicaid expansion, which California will pursue, is to 133% of the federal poverty level (FPL)—138% with a 5% income disregard.
[9] Effective 2017, states may allow large group purchasing through the exchange, which may make some large-group plans and policies subject to EHB requirements [ACA Section 1312(f)(2)(B)].
[10] The California Health Benefits Exchange Authorizing Statute is available here: www.healthexchange.ca.gov/Documents/California%20Codes%20Governing%20the%20Health%20Benefit%20Exchange.pdf.
[11] CalSIM was developed jointly and is operated by the University of California, Los Angeles, Center for Health Policy Research and the University of California, Berkeley, Center for Labor Research. The model estimates the impact of provisions in the ACA on employer decisions to offer, and individual decisions to obtain, health insurance.

As of January 1, 2014, SB 189 would require the following of any new wellness program operated by group market plans or insurers:

- A reasonable design to promote health or prevent disease;
- No incentives or rewards based on either participation in a wellness program or based on attaining goals set by a wellness program that alter premiums (through either discounts or rebates) or cost sharing (through deductibles, copayments, coinsurance);
- Be voluntary for participants;
- Not specify that receipt of an incentive or award be related to a participant satisfying a standard related to a health status factor;
- Be offered to all similarly situated enrollees;
- Provide reasonable accommodation for enrollees with disabilities who seek to participate;
- Assess (in design) the cultural competency needs of enrollees in the plan/policy;
- Provide language assistance for limited-English–speaking enrollees;
- Not result in any decrease in benefit coverage;
- Not result in an increase in premiums for the product;
- Not include an incentive or reward determined to be unreasonable; and
- Not include an incentive or reward that exceeds what is permissible by current or future federal law or regulation.

Analytic Approach and Key Assumptions

For this analysis, CHBRP has considered a wellness program that could impact premiums or cost sharing and is operated by a plan or insurer to be a *health insurance benefit* that is covered for some enrollees. Whether a wellness program is operated by a plan/insurer, an employer, or other, for this analysis, CHBRP has considered any alteration by a plan or insurer of premiums or cost sharing based on either participation in a wellness program or based on attaining goals set by a wellness program a *term of benefit coverage*. Examples of plan/insurer alterations of premiums or cost sharing based on wellness programs in California's fully insured markets include (but are not limited to):

- Premium rebates from plans/insurers to employers based on retrospective review of employee participation in a wellness program.
- Contributions made by plans/insurers to an enrollee's health savings account (HSA) as an incentive for either participation in a wellness program or meeting a goal set by a wellness program. HSA contributions may be used to fund copayments or other cost-sharing requirements.

Defining "wellness program"

SB 189 explicitly defines wellness programs as "programs designed to promote health or prevent disease." SB 189 offers three examples of wellness programs: programs that reimburse part or all

of the cost for membership in a fitness center; diagnostic testing programs; and programs that provide health education seminars. Through prohibitions, SB 189 implicitly indicates that some wellness programs may involve offering of rewards or incentives, measurement of health status factors, or both.

Analytic approach

As noted in Table 1, plans and insurers operate wellness programs that may impact premiums or cost sharing, but employers and other entities may also operate wellness programs, and employers may do so without involving plans or insurers. Employers often contract with other entities (companies other than plans/insurers that specialize in running wellness programs) in order to provide wellness programs for their employees.[12] Employers may operate wellness programs that may impact enrollee premiums or cost sharing—and may do so without involving any plan or insurer, even when the employer is purchasing fully insured health insurance. As with establishing and running the wellness program (which an employer may do on its own or with another entity, rather than engaging a plan or insurer to do so), an employer may establish and distribute incentives to employees, regardless of which entity runs the wellness program. Although plans and insurers may make wellness program–related contributions to enrollee HSAs, which may impact employee cost sharing (deductibles, co-pays, coinsurance), so may employers with or without the involvement of a plan or insurer. Although plans and insurers may alter premiums in the group markets based on enrollee participation in wellness programs, it is the plan/policy purchaser (usually an employer) who either does or does not alter the share of premiums that an enrollee (usually an employee) must pay—and the purchaser may do so without involving a plan or insurer. Employers are also increasingly utilizing incentives related to wellness programs. Employer-generated impacts on enrollee premiums or cost sharing related to wellness programs attached to self-insured plans or policies would not be subject to SB 189's prohibitions.

[12] Personal communication, G. Loewenstein, Carnegie Mellon University, April 2013.

Table 1. SB 189 Requirements Regarding Wellness Programs That May Alter Premiums and/or Cost Sharing

Wellness Programs (WPs)	SB 189 Would Prohibit	SB 189 Would Allow	SB 189 Unclear
Current and pre-2014 WPs		Plans/insurers regulated by DMHC or CDI **may** • Operate *current and pre-2014 WPs* that may alter premiums and/or cost sharing • Alter premiums and/or cost sharing based on *current and pre-2014 WPs* operated by an employer, or other Employers/others (a) **may** • Operate *current and pre-2014 WPs* that may alter premiums and/or cost sharing (may do so directly or may do so through plans/insurers) • Engage more enrollees in *current and pre-2014 WPs* that may alter premiums and/or cost sharing	Plans/insurers regulated by DMHC or CDI **may or may not** be able to • Engage more enrollees in *current and pre-2014 WPs* operated by plans/insurers • Contract with other entities (companies other than plans/insurers that specialize in running WPs) in order to make *pre-2014 WPs* available to enrollees
WPs new in 2014	Plans/insurers regulated by DMHC or CDI **may not** • Establish or operate *WPs new in 2014* that may alter premiums and/or cost sharing • Alter premiums and/or cost sharing based on *WPs new in 2014* operated by an employer or other Employers (b) **may not** • Alter premiums and/or cost sharing based on *WPs new in 2014* through plans/insurers subject to SB 189 (an indirect effect due to SB 189 prohibiting the plans and insurers from such actions)	Employers/others (a) **may** • Establish and operate *WPs new in 2014* that may alter premiums and/or cost sharing (employers must directly alter premiums and/or cost sharing directly) • Engage more enrollees in *WPs new in 2014* that may alter premiums and/or cost sharing	

Source: California Health Benefits Review Program, 2013.
Note: (a) Employers and entities other than plans/insurers are not subject to health insurance benefit mandates, which would include SB 189.
(b) SB 189 would have an indirect effect on employers, as it would prohibit plans/insurers from altering premiums and/or cost sharing, even if the employer requested it be done.
Key: CDI=California Department of Insurance; DMHC=California Department of Managed Health Care; WPs=wellness programs.

Requirements in Other States

Several states (New Hampshire, Rhode Island, and Michigan) have passed legislation promoting use of wellness programs;

Several states (New York, Wisconsin, Alaska, and Georgia) have passed legislation that provides protections from state discrimination or unfair trade practices related to wellness programs; and

One state (Colorado) requires consumer protections that exceed what is required by federal rules: wellness program must be accredited by a nationally recognized nonprofit organization; individuals are allowed to request an independent external review if the plan/insurer denies a request for an alternative standard or waiver of a standard; penalties for nonparticipation or failure to satisfy a standard are prohibited.

Background on Health Behaviors and Health Status

Wellness programs target many external (nongenetic) modifiable health behaviors (also referred to as the "actual causes of death") such as tobacco use, poor diet/physical inactivity, and excessive alcohol consumption, which are prevalent in California. These modifiable health behaviors are risk factors for many of the leading causes of death in California, including heart disease, stroke, cancer, diabetes, chronic liver disease, and obesity.

Medical Effectiveness

The medical effectiveness review presents findings from randomized controlled trials (RCTs) of work-based wellness programs that address two topics pertinent to SB 189:

- The impact of work-based wellness programs on the health behaviors and health status of participants; and
- The effects of financial incentives on participation in work-based wellness programs and on the health behaviors and health status of participants.

The work-based wellness programs included in the medical effectiveness review provided one or more of the following interventions: a health risk appraisal, group activities, group counseling, individual counseling, self-help/educational materials, fitness center memberships, and Web-based educational materials, classes, and/or coaching. Some work-based wellness programs also incorporated modifications to the work environment, such as adding healthy foods and drinks to vending machines, increasing healthy dining options in onsite cafeterias, and creating walking paths.

Types of financial incentives assessed by studies included in the medical effectiveness review include gift cards, lotteries, competitions for prizes, contingent payments (e.g., pay participants $10 per month for each month they abstain from smoking), and deposit contracts (e.g., persons deposit $100 at the beginning of wellness program and are refunded the money at the end of the program if they complete it).

Study Findings

CHBRP terminology for grading evidence of medical effectiveness

CHBRP uses the following terms to characterize the strength of the evidence it identifies regarding the medical effectiveness of a treatment for which a bill would mandate coverage.

- Clear and convincing evidence;
- Preponderance of evidence;
- Ambiguous/conflicting evidence; and
- Insufficient evidence.

A grade of *clear and convincing evidence* indicates that there are multiple studies of a treatment and that the large majority of studies are of high quality and consistently find that the treatment is either effective or not effective.

A grade of *preponderance of evidence* indicates that the majority of the studies reviewed are consistent in their findings that treatment is either effective or not effective. This can be further subdivided into preponderance of evidence from high-quality studies and preponderance of evidence from low-quality studies.

A grade of *ambiguous/conflicting evidence* indicates that although some studies included in the medical effectiveness review find that a treatment is effective, a similar number of studies of equal quality suggest the treatment is not effective.

A grade of *insufficient* evidence indicates that there is not enough evidence available to know whether or not a treatment is effective, either because there are too few studies of the treatment or because the available studies are not of high quality. It does not indicate that a treatment is not effective.

Effects of work-based wellness programs on health behaviors and health status

- Health behaviors
  - There is clear and convincing evidence from RCTs that participating in work-based wellness programs that address tobacco cessation increases the likelihood of abstinence from smoking.
  - The preponderance of evidence from RCTs suggests that participating in work-based wellness programs that address alcohol use reduces the frequency of alcohol use.
  - The preponderance of evidence from RCTs suggests that participation in work-based wellness programs is associated with lower intake of fats, but findings for other dietary outcomes, such as intake of fruit and vegetables, are ambiguous.
  - Findings from RCTs regarding the impact of participating in work-based wellness programs on frequency or amount of physical activity are ambiguous.
- Health status

- Findings from RCTs regarding the impact of participating in work-based wellness programs on body mass index and other indicators used to identify obesity are ambiguous.
- The preponderance of evidence from RCTs suggests that participating in work-based wellness programs does not lower the following risk factors for disease: blood pressure, blood sugar, or cholesterol.
- Findings from RCTs regarding the effect of participating in work-based wellness programs on stress level are ambiguous.

Effects of financial incentives on participants' health behaviors and health status

- **CHBRP identified no RCTs that have assessed the impact of financial incentives linked to premiums or cost sharing for health insurance on participation in work-based wellness programs or the health behaviors or health status of persons who participate in work-based wellness programs.**
- The preponderance of evidence from two RCTs suggests that financial incentives other than those linked to premiums or cost sharing increase participation in work-based wellness programs, but there is insufficient evidence to assess the relative effectiveness of different types of financial incentives.
- Most RCTs on the impact of financial incentives other than those linked to premiums or cost sharing on the health behaviors and health status of persons participating in work-based wellness programs have addressed tobacco cessation.
- The preponderance of evidence suggests that work-based tobacco cessation programs that provide financial incentives for abstaining from smoking are no more effective than programs that do not provide financial incentives.
- Findings from RCTs and quasi-experimental studies of financial incentives for weight loss were inconsistent perhaps due to differences in comparison groups across studies.
- A single RCT found that behavioral counseling plus financial incentives was more effective than behavioral counseling alone in reducing blood pressure in the short term but that counseling without incentives was more effective at 12 months post-intervention.
- Two RCTs on the impact of financial incentives on cholesterol level reached opposite conclusions.

Benefit Coverage, Utilization, and Cost Impacts

As of March 2013, CHBRP estimates that:

- 948,000 (5.8% of enrollees in group market health insurance that would be subject to SB 189) have coverage for plan/insurer operated wellness programs that may impact premium or cost-sharing impacts. Distribution of these 948,000 enrollees is uneven:
    - All of these enrollees are in the large-group market and none are in the small-group market; and

    - All of these enrollees have privately funded health insurance. No enrollees associated with CalPERS have coverage for plan/insurer-operated wellness programs that may impact premiums or cost sharing.

- Of the estimated 948,000 enrollees in DMHC-regulated plans and CDI-regulated policies who have health insurance that includes coverage for wellness programs that could impact premiums or cost sharing, an estimated 114,000 participated in plan/insurer-operated wellness programs that could impact enrollee premiums or cost sharing at some point during the prior 12 months.

- No enrollees see premium or cost-sharing alterations from DMHC-regulated plans or CDI-regulated insurers that are related to wellness programs operated by employers or other entities (companies other than plans/insurers that specialize in running wellness programs).

It should be noted that these March 2013 estimates focus on wellness programs with financial incentives operated by or including financial incentives directly from DMHC-regulated plans or CDI-regulated insurers. Additional enrollees may have access to wellness programs operated by an employer/other entity without involvement of the enrollee's plan/insurer. Therefore, the total number of enrollees in DMHC-regulated plans or CDI-regulated policies with access to wellness programs that can impact premiums or cost sharing may be higher.

Baseline 2014 benefit coverage, utilization, and cost

In order to identify the marginal impacts attributable to a health insurance benefit mandate bill and not to some other factor, CHBRP projects a current (baseline) by holding constant all factors other than enactment of the mandate.

As noted in Table 1, SB 189 would have a complicated impact on wellness programs that can impact premiums or cost sharing.

- SB 189 would place requirements on group market DMHC-regulated plans and CDI-regulated insurers regarding their operation of and interaction with wellness programs established ***after*** *January 1, 2014.* The requirements would prohibit these plans/insurers from operating wellness programs that include fiscal incentives that may impact premiums or cost sharing. The requirements would also prohibit plans/insurers from altering premiums or cost sharing in conjunction with an employer/other-operated wellness program. However, the requirements would *not be applicable* to plan/insurer activity connected to wellness programs established by either the plan/insurer or an employer/other, so long as the wellness program was established ***prior to*** *January 1, 2014.* It is unclear whether SB 189 would prohibit plans and insurers from contracting with other entities to make pre-2014 wellness programs available to enrollees.
- It is also unclear whether SB 189 would prohibit additional enrollees from joining plan/insurer-operated wellness programs in existence prior to January 1, 2014. Similarly, it is unclear, after that date, whether SB 189 would prohibit plans/insurers from altering premiums or cost sharing for those additional enrollees.

Due to the complicated nature of the bill's impacts, SB 189 could have a dampening effect on plans and insurers establishing and operating wellness programs that can impact premiums or cost sharing. However, it is unclear as to whether or how much any such dampening effect may be offset by plans and insurers contracting with other entities to establish access to more pre-2014 wellness programs and/or engaging additional enrollees in currently available pre-2014 wellness programs.

Because the direct and indirect impacts of SB 189 would be so complicated and so varied, CHBRP is unable estimate a 2014 baseline for benefit coverage of wellness programs that could impact premiums or cost sharing by plans and policies that would be subject to SB 189.

In addition, it is important to re-emphasize that SB 189 would not be directly applicable to employers/other entities, who may continue to operate wellness programs with financial incentives that may impact enrollee premiums and cost sharing established prior to January 1, 2014, and may establish new ones. The pre-2014 wellness programs could be operated without involvement of the plans and policies that would be subject to SB 189, though these plans and policies would be prohibited from involvement with wellness programs established after January 1, 2014. Therefore, access by enrollees to these kinds of wellness programs could continue to change, regardless of SB 189.

Because CHBRP is unable to estimate 2014 benefit coverage for wellness programs that could impact premiums or cost sharing by plans and insurers that would be subject to SB 189, CHBRP is also unable to estimate related utilization, premiums, and expenditures, and whether a lack of benefit coverage shifts costs to other payers.

Postmandate benefit coverage, utilization, and cost

The impact of SB 189 on benefit coverage, utilization, and cost is unknown. For the reasons previously described, CHBRP is unable to estimate baseline 2014 benefit coverage for wellness programs that could impact premiums or cost sharing. Without baseline benefit coverage estimates, CHBRP cannot estimate baseline utilization or cost. Without baseline estimates, CHBRP cannot project marginal impacts. Therefore, the impact of SB 189 is unknown.

Public Health Impacts

- As CHBRP is unable to estimate any change in coverage or utilization of work-based wellness programs, the public health impact of SB 189 on health behaviors and outcomes such as tobacco use, excessive alcohol consumption, poor diet, physical inactivity, and related health outcomes is unknown.

- Although there are gender disparities in the prevalence of tobacco use, excessive alcohol consumption, poor diet, physical inactivity, and related health outcomes in California, CHBRP is unable to estimate any change in coverage and/or utilization of work-based wellness programs that may address these health behaviors and outcomes. Therefore, the impact of SB 189 on reducing gender disparities is unknown.

- There are racial/ethnic disparities in the prevalence of tobacco use, excessive alcohol consumption, poor diet, physical inactivity, and related health outcomes in California, but CHBRP is unable to estimate any change in coverage and/or utilization of work-based wellness programs that may address these health behaviors and outcomes. Therefore, the impact of SB 189 on reducing racial/ethnic disparities is unknown.

- Although tobacco use, excessive alcohol consumption, poor diet, physical inactivity, and related health outcomes may cause premature death, CHBRP is unable to estimate any change in coverage and/or utilization of work-based wellness programs that may address these health behaviors and outcomes. Therefore, the impact of SB 189 on reducing premature death is unknown.

- Tobacco use, excessive alcohol consumption, poor diet, physical inactivity, and related health outcomes are contributors to economic loss. However, CHRBP is unable to estimate any change in coverage and/or utilization of work-based wellness programs that may address these health behaviors and outcomes. Therefore, the impact of SB 189 on reducing economic loss is unknown.

Interaction With the Federal Affordable Care Act

A number of ACA provisions have the potential to or do interact with state benefit mandates. This does not appear to be the case for SB 189.

Essential Health Benefits

Because SB 189's focus is on wellness programs and because wellness programs are not listed in the 10 specified categories of essential health benefits (EHBs) under the ACA, CHBRP assumes that SB 189 would have no interaction with EHBs.

Wellness Programs

For wellness programs established after January 1, 2014, SB 189 would place more limits on DMHC-regulated plans and CDI-regulated polices than do either the ACA or the Health Insurance Portability and Accountability Act of 2006 (HIPAA).

Among other requirements, where the HIPAA and ACA would allow plans and policies to alter premiums and/or cost sharing based on wellness program participation, SB 189 would, in some instances, prohibit such actions.

ACKNOWLEGMENTS

This report provides an analysis of the medical, financial, and public health impacts of Senate Bill 189. In response to a request from the California Senate Committee on Health on February 28, 2013, the California Health Benefits Review Program (CHBRP) undertook this analysis pursuant to the program's authorizing statute.

Janet Coffman, MPP, PhD, Chris Tonner, MPH, and Gina Evans-Young, of the University of California, San Francisco, prepared the medical effectiveness analysis. Bruce Abbott, MLS, of the University of California, Davis, conducted the literature search. Stephen McCurdy, MD, MPH, and Meghan Soulsby, MPH, of the University of California, Davis, prepared the public health impact analysis. Shana Lavarreda, PhD, MPP, of the University of California, Los Angeles, prepared the cost impact analysis. Susan Pantely, FSA, MAAA, of Milliman, provided actuarial analysis. Content experts George Loewenstein, PhD, of Carnegie Mellon University, and Beth Ercolini, of ArlenGroup, provided technical assistance with the literature review and expert input on the analytic approach. John Lewis, MPA, and Nimit Ruparel, MPP, of CHBRP staff prepared the *Introduction* and synthesized the individual sections into a single report. A subcommittee of CHBRP's National Advisory Council (see final pages of this report) and a member of the CHBRP Faculty Task Force, Susan Ettner, PhD, of the University of California, Los Angeles, reviewed the analysis for its accuracy, completeness, clarity, and responsiveness to the Legislature's request.

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

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California Health Benefits Review Program Committees and Staff

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

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

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