

Overview and Commentary

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The California Health Benefits Review Program (CHBRP)—established in 2003 in response to new state legislation aimed at enhancing the evaluation of potential changes in health benefit packages—represents a unique marriage of academic analysis and real-time legislative decision making. CHBRP is based within the University of California (UC) Office of the President and provides analyses to the legislature within a 60-day timeframe on the potential consequences of specific benefit changes under consideration as part of legislative mandates. The consequences examined include current known medical effectiveness of the services for which coverage is to be mandated as well as potential costs and impact on public health considerations associated with the mandate. Teams throughout the University system specialize in analyzing medical effectiveness, costs, and public health impacts and work with a statewide faculty task force and a private actuarial firm to generate literature reviews and analyses in response to legislative requests. These teams work on multiple requests simultaneously, all within the constraints of the legislative calendar. In its first 2 years, CHBRP generated 22 such analyses.

The impetus to create the CHBRP began in 2002 when the California State Legislature took an important step to enhance the evaluation of bills related to health insurance benefits by passing Assembly Bill (AB) 1996 (Thomson, Statutes of 2002, Chapter 795). The intent of the legislation is highlighted in its preamble:

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 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 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.

After governor Gray Davis signed AB 1996 into law on September 22, 2002, the University of California was given the responsibility of providing the Legislature, within a 60-day timeframe, with unbiased, objective analysis of the medical effectiveness, cost impacts, and public health impacts of a mandate bill, i.e., of a bill under active consideration by either the California State Assembly or Senate that proposes a change to the mandated health benefits. To meet the provisions of the new law, UC established the CHBRP in 2003.

In an effort to be responsive to the provisions of AB 1996 and to establish and maintain clear analytic standards, CHBRP has established a faculty/professional analyst-based model that marries academic standards with the tight time pressures inherent in real-time legislative decision making. CHBRP has developed standardized analytic methods and review processes to facilitate transparency and minimize potential bias. These articles contained in this issue will serve to illustrate how this was done during the first 2 years of CHBRP's existence.

A brief description of CHBRP's infrastructure may be useful for context-setting. CHBRP is administered by UC at the systemwide Office of the President, and uses a small analytic staff to administer the program, support the faculty's analytic work, and liaison with the state legislature, agencies, and Governor's office. CHBRP's Faculty Task Force includes representatives from a wide range of disciplines to evaluate mandate bills as per the criteria laid out in AB 1996. These faculty are experts in health services research and health policy, public health, economics, political science, and clinical medicine. In addition, the Task Force was designed deliberately to include representatives from all the accredited schools of medicine within California—University of Southern California, Loma Linda University, and Stanford University—as well as all 10 of the University of California campuses. To organize the effort and responsibility for the three statutorily required components of each mandate evaluation (medical effectiveness, financial impact, and public-health impact analyses), there are three Vice Chairs, each of whom leads a team of faculty and staff. The Vice Chairs leading the three areas are researchers currently from the University of California at San Francisco (UCSF),

University of California at Los Angeles (UCLA), and University of California at Berkeley (UCB), respectively. Finally, a National Advisory Council made up of experts from outside the state of California and designed to provide balanced representation among groups with an interest in health insurance benefit mandates, reviews draft studies to assure their quality before they are transmitted to the Legislature. The State funds this work through a small annual assessment of health plans and insurers in California.

The CHBRP analytic process is designed to respond to criteria defined in AB 1996 (See Table 1). The criteria reflect the specific language of AB 1996 and may not include every analytic question one might want addressed in order to fully evaluate a potential mandate from all research perspectives. Furthermore, it is CHBRP's charge to collect and evaluate the evidence in specific categories, but it is up to the legislature to arrive at an overall decision. Thus, CHBRP reports do not make recommendations regarding passage of the mandate bill and are not intended to discuss the merits or drawbacks of specific bill provisions.

AN OVERVIEW OF THIS SPECIAL ISSUE

This special issue of *Health Services Research* describes and illustrates CHBRP's research methods and data sources; provides an overview of related activity in other states—e.g., trends in the proliferation of health insurance mandates and laws that establish mandate evaluation review programs—and finally, presents a preliminary assessment of CHBRP's impact in enhancing the evaluation of mandate bills in California.

The first four articles describe methods developed by CHBRP's Faculty Task Force and its contracting actuarial firm in response to the evaluation criteria specified in AB 1996. This issue's first article, "Evaluating Medical Effectiveness for the California Health Benefits Review Program" by Luft et al., describes the challenges inherent in (1) developing the medical effectiveness research question *specific to the mandate bill*; (2) developing a literature search strategy; (3) conducting a literature review; and (4) evaluating the literature for relevant outcomes—all within the first few weeks of the 60-day analysis period. Where possible, the Medical Effectiveness Team also summarizes quantifiable medical effectiveness outcomes in a format that can be used by the other research teams to estimate the cost and public health impacts. Luft and et al. illustrate the technique of weighing the evidence by the rigor of the studies' methodology—a technique that allows CHBRP to report

Table 1: Criteria for Evaluation as Specified in Assembly Bill 1996 (2002)

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 with 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

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

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 diseases 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
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findings of existing literature within the limited timeframe with reasonable confidence, but without conducting its own meta-analysis.

The second article, “The California Cost and Coverage Model: Analyses of the Financial Impacts of Benefit Mandates for the California Legislature,” presents the methods and data sources used by the Cost Team (made up of faculty and staff at UCLA and contracting actuaries from Milliman Inc.) to analyze the financial impacts of benefit mandates. While the Cost Team primarily relies on an actuarial model commonly used to project health insurance premiums in the privately insured market, the model’s underlying assumptions reflect current knowledge in the health services and health economics field such as provider practice patterns, expected utilization of the mandated service, substitution effects, and potential shifts in cost from the privately insured market to the public and/or the uninsured markets. The Cost Team also draws on the findings of the medical effectiveness analysis to adjust its assumptions, e.g., taking into account whether the implementation of a mandate is likely to increase the utilization of a specific device and directly decrease utilization of hospitalization.

CHBRP updates the cost model annually based on available data and feedback from legislative staff. In 2005, CHBRP undertook an extensive revision to our methods by updating the population estimates to model separately the impacts on the California Public Employees’ Retirement System, Medi-Cal, and Healthy Families (California’s S-CHIP program). While these changes were made after this paper was initially accepted for publication, Kominski and colleagues’ article still serves as a current reflection of CHBRP’s approach to analyzing impacts on the privately insured market.

In “Assessing the Public Health Impact of State Health Benefit Mandates,” McMenamín and et al. present the methods and data sources that CHBRP uses to project the impacts of a mandated benefit on the health of California’s insured population. These methods are unique in that they draw on the outcomes identified by the medical effectiveness analysis, and the coverage and utilization projections in the cost impact analysis, to project public health outcomes. Where possible, the public health analysis reports on sub-populations (e.g., children, women) that may be differentially impacted by the proposed mandate. McMenamín and et al. also discuss the challenges of public health impact analysis for mandates—especially those associated with limited population-based data sources.

To illustrate how these three analyses come together to build a complete report to the California Legislature, Halpin and et al. present “An Analysis of California Assembly Bill 2185: Mandating Coverage of Pediatric Asthma

Self-Management Training and Education.” The article adapts for publication a completed CHBRP analysis originally submitted to the California Legislature on April 14, 2004. This report was used by legislative staff in developing their analyses for members of the Assembly Committee on Health and the Senate Committee on Insurance during hearings in Spring 2004. AB 2185 became one of two bills analyzed by CHBRP that Governor Arnold Schwarzenegger signed into law. Table 2 provides a summary of actions related to all bills analyzed by CHBRP.

The next two articles provide contextual analysis of mandate benefit laws (Laugesen et al.), and of laws that established mandate benefit review programs (Bellows et al.). Laugesen and et al. in “A Comparative Analysis of Mandated Benefit Laws, 1949–2002” illustrate the willingness of state law makers to use mandate legislation as a tool to set limits on the managed care industry, which, during the 1990s, was increasing market penetration and developing sophisticated utilization control techniques. The authors provide context as to where California ranks among states in terms of the number of mandates; and presents analysis on the proliferation of specific types of mandates (e.g., for benefits or services, preventive versus treatment services, or access to specific types of providers). Finally, the authors offer a preliminary discussion on how the interaction among factors—available scientific evidence, perceived cost, and political consensus—surrounding a specific mandate bill affect its chances of becoming law.

Bellows and et al. in “State-Mandated Benefit Review Laws” note the increasing trend in the number of mandates passed during the 1990s and illustrate a parallel desire on the part of legislatures around the country to have better information regarding the potential impacts of mandate bills, and the impacts of mandate laws already on the books. In addition, the authors outline the evaluation criteria laid out in the various state laws. Their findings illustrate how the California Legislature was among the few to place an emphasis on evaluating the medical effectiveness and public health impacts of a mandate *in addition to* the cost impacts.

Oliver and Singer pick up the contextual story and report on the specific climate in Sacramento that led to the passage of AB 1996 and how the responsibility fell to the University of California—the only mandate review program in the nation housed in an academic setting. Based on information provided through key informant interviews of CHBRP’s stakeholders, including legislative and agency staff, the authors place CHBRP in the larger political context, and discuss how the short-term limits of California Legislators may create additional pressures (and support) for a bill’s passage. They

Table 2: CHBRP Completed Analyses, 2004–2005

<i>Analyzed Legislation</i>	<i>Author</i>	<i>Topic</i>	<i>Completed Analyses</i>	<i>Outcome</i>
SB 576	Ortiz	Tobacco cessation services	8/22/05	Vetoed by Governor
AB 1185	Koretz	Chiropractic services	7/5/05	2 year bill
SB 913	Simitian	Medication therapies; Rheumatic diseases	4/16/05	2 year bill: Placed on Appropriations Suspense File*
SB 749	Speter	Pervasive developmental disorders/autism	4/16/05	2 year bill
SB 572	Perata	Mental health benefits	4/16/05	2 year bill
SB 415	Alquist	Prescription drugs; Alzheimer's disease	4/16/05	Amended so that the bill pertained to another subject matter (known as "guttled/amended")
SB 573	Romero	Elimination of intoxication exclusion	4/7/05	Vetoed by Governor
AB 228	Koretz	Transplantation services: human immunodeficiency virus	4/7/05	Enacted
AB 213	Liu	Lymphedema	4/7/05	2 year bill
AB 8	Cohn	Mastectomies and lymph node dissections	3/7/05	Guttled/amended

Continued

Table 2: *Continued*

2004				
<i>Analyzed Legislation</i>	<i>Author</i>	<i>Topic</i>	<i>Completed Analyses</i>	<i>Final Disposition of Legislation</i>
SB 1157	Romero	Elimination of intoxication exclusion	4/27/04	Vetoed by Governor
SB 1158	Scott	Hearing aids	4/19/04	Vetoed by Governor
AB 1927	Cohn	Vision services	4/16/04	Gutted/amended
AB 2185	Frommer	Asthma management	4/14/04	Enacted
SB 1555	Speier	Maternity services	4/1/04	Vetoed by Governor
SB 897	Speier	Maternity services	2/9/04	Reintroduced as SB 1555
SB 174	Scott, Koretz, and Wiggins	Hearing aids for children	2/9/04	Reintroduced as SB 1158
SB 101/1192	Chesbro	Substance disorder treatment	2/9/04	SB 101 was reintroduced as SB 1192. SB 1192 failed to be reported out of the Assembly
AB 1549	Frommer, Chan, and Laird	Childhood asthma	2/9/04	Health Committee Reintroduced as SB 2185
AB 1084	Maddox	Access to vision providers	2/9/04	Reintroduced as AB 1927
AB 547	Liu	Ovarian cancer screening	2/9/04	Gutted/amended
AB 438	Lieber	Osteoporosis screening	2/9/04	Died pursuant to Art. IV, Sec. 10(c) of the Constitution

*The Appropriations Committees place bills in a "Suspense File" when it would have a fiscal impact on the state government of \$150,000 or greater. The Committee assesses and prioritizes those bills separately and decides whether those bills will be passed out of committee to the Floor or are to remain with the committee indefinitely.

assess whether and how CHBRP products have been used, and by whom, during the first year and half of the program's existence. Using examples of legislative deliberations over specific bills, the authors examine how CHBRP analyses can serve as a source for objective information, especially when staff and members typically have access to only information provided by the bills' proponents and opponents.

CHBRP'S PRODUCTS AND FUTURE ROLE

The remaining portion of this overview briefly summarizes the work that CHBRP has produced and the processes in place to ensure objectivity of reports, and offers some thoughts about the future role of the program in informing legislative decisions on health benefit mandates in California.

CHBRP Products

By January 2006, CHBRP had issued 22 completed reports analyzing proposed benefit mandates, plus two analyses of amended bills, and four formal follow-up letters to the Legislature clarifying or providing further explanation of completed analysis or amended version of bills. All of the 22 analyses requested of CHBRP were completed within the 60-day timeframe or were designated specifically as 2-year bills for which an extended submission date was permitted by the Legislature.¹ Table 2 provides a complete list of these analyses and the outcomes of the bills analyzed. The four follow-up letters and two analyses of amended bills were completed within an abbreviated timeframe in order to provide useful information to the Legislature in time for hearings on the relevant bills. CHBRP's analytic staff also provided oral testimony at policy committee hearings to answer questions regarding their analyses. Before the hearings, CHBRP staff also provided assistance and clarifications as requested by legislators and legislative staff regarding CHBRP's analyses.

During the latter half of each calendar year, CHBRP staff and faculty do not usually undertake new analyses, instead providing ongoing consultation to legislative and state regulatory agency staff regarding analyses, and considering the potential implications of various amendments under legislative consideration. In addition, CHBRP works to improve its methods, the transparency of its processes, and its capacity to respond to the state legislature. CHBRP staff do this by (1) meeting with stakeholders such as health plans and advocates to allow for input on specific bills, and provide infor-

mation on analytic methods; (2) meeting with legislative and agency staff on ways to improve the readability, transparency, and usefulness of the reports; (3) conducting public forums where CHBRP faculty provide briefings on CHBRP's methods to the public, legislative and agency personnel, health advocates, and stakeholders; (4) obtaining input from CHBRP's National Advisory Council to improve the analyses and reports; (5) updating data sources and methods to reflect the most current available data and analytic approaches that can be feasibly implemented within a 60-day timeframe; and (6) conducting an internal review of operations at the administrative and campus level to ensure adequate capacity to respond to the workload and deadline pressures during the first quarter of each calendar year. Most of the above tasks are undertaken by full-time CHBRP staff. During this period, the faculty and staff of the three centers typically focus on updating methods and models and preparing products of some of the analyses for separate publication in academic venues, as well as other (non-CHBRP-related) academic activities.

Checks to Ensure Independent, Unbiased Reports

As mentioned, AB 1996 required nonpartisan and independent analysis of health insurance mandate bills. Thus, CHBRP developed processes to ensure that biases in its findings are minimized. These processes include systematically reviewing conflicts of interest of faculty, staff, and content experts; uniformly applying standardized methods for all analyses (in this issue: Luft et al., Kominski et al., and McMenamin et al.); and creating venues to obtain input from interested stakeholders and ensuring review of drafts by a subcommittee of CHBRP's National Advisory Council (see Oliver and Singer). The National Advisory Council review process and the CHBRP's standard analytic methods are discussed elsewhere in this issue. Following is a brief description of UC's extensive conflict of interest policy and procedures for CHBRP and the ways in which CHBRP obtains information from external stakeholders for a particular bill.

AB 1996 states:

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 (Health and Safety Code section 127663).

All who participate in the development of CHBRP's analyses are required to complete and submit a conflict-of-interest disclosure form and to update it annually or whenever compelled to do so 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 reviewed by UC Health Affairs staff, who monitor potential conflicts and, as appropriate, request recusal where actual or perceived conflicts of interest arise in relation to a given bill. Faculty Task Force 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 Task Force. Recusals are noted in CHBRP's bill analyses. In the last 2 years, various CHBRP faculty recused themselves from seven separate analyses, due to potential conflicts of interest. In these cases, other CHBRP researchers, including other faculty from the Task Force, have stepped in to conduct the relevant analyses.

As a major employer and provider of health care in California, UC may have inherent conflicts in terms of whether a mandate bill is passed into law. Thus, in establishing CHBRP, UC created "firewalls" to allow CHBRP to function independently. For example, officials responsible for negotiating the university system's health benefits and CHBRP staff are restricted from exchanging information regarding bill analyses or methods beyond what is publicly available.

Potential content experts who are selected as consultants during the early part of a particular bill analysis to provide guidance on key research are screened for conflicts of interest before they are selected. Examples of questions initially used to screen content experts are:

- Do you have any financial interest in the proposed mandated benefit? (Examples: investments or relations with pharmaceutical companies or medical device manufacturers; receipt of research funding.)
- Do you have any interest from an insurance perspective in the proposed mandated benefit? (Examples: acted as an expert witness for insurers or advocates of the mandate; testified or taken a public position on the mandate.)
- Could your existing research create a perception of bias as it pertains to the proposed mandate? (Example: authored research that included recommendations that are substantially similar to or directly oppose the proposed mandate.)

While conflict-of-interest screening is intended to help prevent bias from being introduced into a given report, CHBRP's process for obtaining information from interested parties helps ensure balance or, at least elicit the perspectives of key stakeholders involved in the policy debate. "Interested parties" are defined by CHBRP as any member of the public, including bill sponsors, disease-specific organizations, consumer advocate organizations, or health plans. CHBRP announces a new legislative request on its website and via its e-mail listserv, which any interested party may join. 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. CHBRP has received information through this public notification process on five completed analyses. Once CHBRP receives the information submitted by the interested party, the respective analytic teams (Medical Effectiveness, Cost, and Public Health Impact) review the information to determine whether the evidence submitted is relevant to the analysis and meets the standard of rigor for inclusion. All information that has been submitted is listed in an appendix in the relevant analysis.

CHBRP also works cooperatively with the bill author's staff to obtain any evidence or information submitted by bill's proponent. For example, at the request of Assembly member Koretz's office, CHBRP reviewed medical journal abstracts supplied by the California Chiropractic Association, proponents of AB 1185, a bill that would mandate coverage of chiropractic services. Assemblymember Liu's staff sent CHBRP information submitted by proponents of AB 213, a bill mandating coverage for the treatment of lymphedema.

CHBRP's Future Role

Since AB 1996 included a sunset clause, the program is set to end on January 1, 2007 and its future depends on whether the legislature wishes to extend the sunset date. CHBRP will continue to respond to requests that fall within the scope of its authority and provide policy-relevant analysis during 2006. The analyses CHBRP may conduct beyond 2006 will depend on whether the Legislature expands or contracts the scope and nature of legislation subject to CHBRP analysis.

Interesting issues have arisen around the foci of the bills analyzed to date, and the changing roles and functions of mandates. AB 1996 defines a “mandate” in the following terms:

- ... a ‘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.

To date, CHBRP has not received any requests to analyze a bill that mandates *offering* of a particular service or benefit. Virtually all of the bills reviewed have mandated *coverage* of a benefit or service. Three bills have focused on preventive services—screenings for osteoporosis and for ovarian cancer, and tobacco cessation treatment. Two bills that CHBRP has analyzed mandated health plans to allow access to specific provider types for services permitted within their scope of practice—optometrists and chiropractors.

PRESCRIPTION DRUGS

Sometimes, a mandate bill may not fit neatly into what is typically considered a “mandate.” Prescription drug mandates are an example of mandates that are highly specific. These mandates attempt to require coverage for specific drugs that may already be covered under the broader umbrella of “medical necessity” as defined under the Knox-Keene Act and the regulations currently being promulgated by the DMHC.² It is possible that the Legislature may be interested in bringing forth such legislative proposals in future years, because prescription drugs are the fastest-growing component of health care costs and because many drug manufacturers use direct-to-consumer advertising to stimulate demand for new and more expensive drug products. In response to rising costs, health plans have developed formularies or contracted out to pharmacy benefit management companies for formulary management. While such plans may cover the potentially mandated drugs if medically necessary, they may require evidence that less expensive alternatives are not effective for that specific patient; this process is often referred to as “step therapy.” Proposed mandate bills would potentially override such a requirement. In the

same way that state mandate benefits were in part a reaction to managed care, there may be an analogous increase in drug-specific mandate bills in reaction to increased pharmacy management.

In the 2005–2006 Legislative Session, CHBRP received two drug bills (SB 415 and SB 913) that mandated access to specific drugs. Discussions during the committee hearing revealed some uncertainty around the current benefit structure with respect to: the gatekeeper functions of health plans; the role of prior authorization, step therapy, formulary design; and contractual arrangements with drug manufacturers, which overlay the determination of medical necessity by a primary care physician. For future drug bills, CHBRP will need to provide a context for prescription drug benefit bills that reveals the layering of health care decisions and that provides legislators with sufficient information to determine whether their bills' language actually targets the issue they intend to address.

“CONSUMER-DRIVEN” PLANS

CHBRP recognizes the trend toward insurance product development with greater cost sharing by the enrollee or subscriber. High-deductible policies are becoming more common. In addition, there is an array of alternatives for individuals and employers that aims to increase cost sharing by individuals: health savings accounts, health reimbursement arrangements, and association health plans. Anticipating mandate bills in response to this trend, CHBRP has modified its carrier survey of the health plans with the highest enrollment in California to obtain baseline information on the number of individuals covered through these newer insurance vehicles. This will allow CHBRP to more accurately assess who bears the cost of proposed benefit mandates because a much higher proportion of certain types of services are likely to be within the deductible, and thus not affect the premium. This will help anticipate evaluation of any mandate bills that attempt to “level the paying field” among insurance products.

OTHER FUTURE PROPOSED LEGISLATION

In discussion with agency and legislative staff, it has been suggested that future proposed legislation may call for the repeal of existing mandates. Thus, CHBRP's future charge may include analyzing such proposals. Such an

undertaking would require its own set of analytic criteria. To analyze a repealed mandate, for example, the medical effectiveness analytic question would need to be defined. Would the question be, “what is the medical effectiveness of benefit or service that is to be repealed?” Or would it be a broader, more complex question such as, “in the absence of the mandate, what is the medical effectiveness of other substitutive services?” To model the cost impacts (presumably cost savings) after a repeal, CHBRP would need to determine the difference between what insurers would continue to provide (or what employers would purchase) versus what they would take away. To address this question adequately, CHBRP may need to alter its current bill-specific survey to insurers (designed to establish baseline coverage) to instead query insurers regarding their projected behavior. Insurers would in turn need to respond accurately by conducting some level of utilization and market analysis to determine whether halting the benefit coverage would lead to any adverse reaction from the market and whether any cost savings are worth the trade-off. Thus, CHBRP’s currently established research approach and methods would warrant revision or expansion based on the type of future legislation that may fall under CHBRP’s charge.

If the California legislature were to consider legislation permitting the development of “bare-bones” plans—insurance products usually offered in the individual and/or small group market covering basic benefits and are not subject to state mandate requirements—CHBRP may have a role in providing technical support to the state in setting benefit and plan structure. In recent years, states such as Florida and Washington have enacted legislation allowing carriers to develop or the state to offer bare-bones plans in the individual market in an effort to provide alternative coverage options for the uninsured.

CONCLUSION

The California State Legislature expressed a need for impartial, evidence-based analysis of health benefit mandate bills when it passed AB 1996. Since then, CHBRP, its associated faculty, and contracting actuaries have established transparent processes and standard methods to evaluate such bills within a narrow 60-day timeframe. The future direction of the program will depend on the extent to which the Legislature and the Governor’s office continues to use CHBRP products and technical support in deliberating policy decisions and whether they choose to expand or contract the scope and nature of legislation subject to CHBRP analysis beyond 2006.

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NOTES

1. This exception occurred in CHBRP's initial year of operation when the first analyses were requested before staff had been hired and analyses procedures were established.
2. See <http://wps0.dmhc.ca.gov/regulations/docs/regs/6/1105641312767.pdf> (accessed on December 14, 2005).