CALIFORNIA
HEALTH BENEFITS REVIEW PROGRAM

Analysis of Senate Bill 92: Health Care Reform

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

CHBRP 09-06

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

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

A Report to the 2009-2010 California State Legislature

Analysis of Senate Bill 92: Health Care Reform

April 13, 2009

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PREFACE

Senate Bill (SB) 92 is a legislative proposal with numerous provisions to reform the system of health care delivery in California. This report provides an analysis of the potential impacts of a subset of these provisions. The subset of provisions CHBRP analyzed would (1) allow a carrier domiciled in another state to offer, sell, or renew a health insurance policy in California that omits one or more currently mandated benefits if a contract holder or policyholder in the group or individual market waives the benefit; and (2) authorize in-state carriers to offer, market, and sell a health care service plan or health insurance policy that does not include all of the benefits mandated under California state law to individuals with incomes below 350% of the federal poverty level. In response to a request from the California Senate Committee on Health on February 12, 2009, the California Health Benefits Review Program (CHBRP) undertook this analysis pursuant to the provisions of Senate Bill 1704 (Chapter 684, Statutes of 2006) as chaptered in Section 127600, et seq. of the California Health and Safety Code.

Edward Yelin, PhD, Janet Coffman, MPP, PhD, and Wade Aubry, MD, all of the University of California, San Francisco, prepared the medical effectiveness analysis. Penny Coppernoll-Blach, MLIS, of the University of California, San Diego, conducted the literature search. Helen Halpin, ScM, PhD, Sara McMenamin, MPH, PhD, and Nicole Bellows, PhD, of the University of California, Berkeley, prepared the public health impact analysis. Gerald Kominski, PhD, of the University of California, Los Angeles, prepared the cost impact analysis. Robert Cosway, FSA, MAAA, of Milliman, provided actuarial analysis. H.E. Frech, III, PhD, of the University of California, Santa Barbara, provided technical assistance with the literature review and expert input on the analytic approach. Cynthia Robinson, MPP, of CHBRP staff prepared the background section and synthesized the individual sections into a single report. Sarah Ordódy provided editing services. A subcommittee of CHBRP's National Advisory Council (see final pages of this report) and a member of the CHBRP Faculty Task Force, Thomas MaCurdy, PhD, of Stanford University 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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EXECUTIVE SUMMARY

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

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

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

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

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

California has two regulatory agencies that provide oversight of health insurance products sold in California. The DMHC has as its primary focus the oversight of health maintenance organizations (HMOs) and some preferred provider organization (PPO) plans. The CDI has broad regulatory authority over all other health insurance products. Under current law, carriers may only sell health insurance policies to employers and individuals who reside or work in California if the carrier (or its subsidiary) holds a license from the DMHC or a certificate of authority from the CDI. SB 92 would relax this requirement by allowing a carrier domiciled (based) and licensed in another state to sell health insurance policies in California without

obtaining a license (or certificate of authority) from the DMHC or CDI, as long as the carrier complied with the regulations of the state where it was domiciled and licensed. Currently, about two-thirds of the private health insurance products sold in California are underwritten by in-state carriers—carriers domiciled and licensed in California.

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

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

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

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

Analytic Approach

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

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

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

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

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

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

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

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

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

Medical Effectiveness of Current Mandates: Summary of Evidence

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

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

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

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

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

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

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

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

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

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

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

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

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

Potential Cost Impacts

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

- Potential market responses include the following:

    - Carriers currently domiciled and licensed in California (in-state carriers) would be expected to continue to offer state-regulated health insurance products in the individual market. It would be likely that they would develop limited-mandate policies targeted to individuals with incomes less than 350% FPL. In-state carriers may move their base or "domicile" to another state if they considered it advantageous to compete with other carriers that offer products not subject to California regulations in the group market. It is not clear how quickly California's largest insurers, which are for-profit (with the exception of Kaiser Foundation Health Plan and Blue Shield of California), might establish out-of-state domiciles in order to offer limited-mandate policies in California. Blues Plans, for example, are not allowed to compete in the same market
    - Out-of-state carriers who hold a license from the DMHC or certificate of authority from the CDI would be able to sell their limited-mandate policies after the passage of SB 92. These carriers would likely choose to sell products in California that would be most competitive in the small employer group market and the individual market. Policies by out-of-state carriers would tend to be lower in cost than policies by in-state carriers because presumably carriers would elect to be domiciled in a state with minimal insurance requirements, regulatory review, or oversight. Out-of-state carriers that currently have a presence in California (i.e., currently have contracts with providers and already have a share of enrollment) would be well-positioned to develop, market, and sell out-of-state policies under SB 92.
    - Out-of-state carriers not currently licensed in California would be permitted to sell limited-mandate policies after the passage of SB 92. These carriers may not have the same market presence and ability to obtain advantageously priced contracts with providers in the same way carriers that already have a presence in California are able to, especially for managed care products, which tend to offer comprehensive benefits with defined provider networks. In-state carriers are able to negotiate

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

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

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

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

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

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

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

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

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

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

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

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

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

Source: California Health Benefits Review Program, 2009.
Notes: (a) This population includes privately insured (group and individual) and publicly insured (e.g., CalPERS, Medi-Cal, Healthy Families, AIM, MRMIP) individuals enrolled in health insurance products regulated by the DMHC or CDI. Population includes enrollees aged 0 to 64 years and enrollees 65 years or older covered by employment sponsored insurance. Beneficiaries of public insurance programs for the low-income and uninsured (e.g. MRMIB and Medi-Cal Managed Care) are assumed to be exempt from the SB 92 because the administering state agencies require participating contractors to follow the scope of benefits in the DMHC-regulated plans.
(b) Premium expenditures by individuals include employee contributions to employer-sponsored health insurance and member contributions to public insurance.
(c) Of the CalPERS employer expenditures, about 59% or $1.78 billion would be state expenditures for CalPERS members who are state employees.
Key: CalPERS = California Public Employees' Retirement System; AIM = Aid to Infants and Mothers; MRMIP = Major Risk Medical Insurance Plan.

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

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

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

Source: California Health Benefits Review Program, 2009.
Notes: (a) This population includes privately insured (group and individual) and publicly insured (e.g., CalPERS, Medi-Cal, Healthy Families, AIM, MRMIP) individuals enrolled in health insurance products regulated by the DMHC or CDI. Population includes enrollees aged 0 to 64 years and enrollees 65 years or older covered by employment-sponsored insurance. Beneficiaries of public insurance programs for the low-income and uninsured (e.g. MRMIB and Medi-Cal Managed Care) are assumed to be exempt from the SB 92 because the administering state agencies require participating contractors to follow the scope of benefits in the DMHC-regulated plans.
(b) Premium expenditures by individuals include employee contributions to employer-sponsored health insurance and member contributions to public insurance.
(c) Of the CalPERS employer expenditures, about 59%, or $1.865 billion, would be state expenditures for CalPERS members who are state employees; however, CHBRP estimates no impact of the mandate on CalPERS employer expenditures.
Key: CalPERS = California Public Employees' Retirement System; AIM = Aid to Infants and Mothers; MRMIP = Major Risk Medical Insurance Plan.

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

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

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

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

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

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

Source: California Health Benefits Review Program, 2009.

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

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

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

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

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

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

To assess the outcomes of allowing out-of-state carriers to sell policies in California without obtaining a license from the DMHC or CDI, CHBRP reviewed evidence on group purchasing pools because certain types of purchasing pools have, at one point, been exempt from state requirements or have been proposed as legislative solutions to reduce premiums and increase choice. The research on group purchasing arrangements is also relevant to SB 92 because this bill relaxes the requirements for associations to gain the same legal status as "small employers."[3]

[3] Existing law defines "small employer" to include a guaranteed association that purchases health care coverage for its members. Existing law defines "guaranteed association" to mean a nonprofit organization of individuals or employers that meets certain requirements, including having been in active existence and having included health coverage as a membership benefit for at least 5 years prior to January 1, 1992, and covering at least 1,000 persons in that regard. SB 92 would delete the requirements for a guaranteed association to have been in active existence and to have included health care coverage as a membership benefit for at least 5 years prior to January 1, 1992. The bill

Group purchasing arrangements bring different employers or individuals together for the purpose of purchasing health insurance or negotiating provider discounts on behalf of their members. Examples of group purchasing arrangements include purchasing cooperatives and alliances, multiple employer welfare arrangements (MEWAs), and association health plans (AHPs). Such arrangements need to be legally recognized by the state or federal government because, under state insurance regulation, multiple employers and individuals are prohibited from forming a group solely for the purpose of buying group insurance.

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

- Out-of-state carriers would be exempt from California-specific consumer protection and financial solvency requirements.
    - Enrollees in plans offered by such carriers would have to contact the insurance commissioner in the state of domicile to deal with denied claims or other disputes. Depending on the state, resource constraints such as time, number of employees, and budget may prevent regulators from providing assistance to out-of-state consumers and may prevent regulators from enforcing policies. In addition, some states' departments of insurance have taken the position that it is not in their jurisdiction to assist consumers who are out of state.
    - All states require insurance products to maintain adequate reserves to be financially solvent and be able to pay claims. However, these requirements and the capacity to monitor solvency of their carriers vary across states. In addition, funds that are set up to pay for claims if a carrier becomes insolvent may not cover out-of-state consumers or may not be adequate to pay for all eligible consumers (for example, if the carrier is domiciled in a small state with few insurers paying into the insolvency fund). Historically, less stringent solvency requirements have been associated with insolvency. Between 2001 and 2003, for example, four self-insured MEWAs became insolvent with 66,000 individuals and small businesses losing coverage and about $48 million in unpaid claims.
    - If a claim is denied by a carrier not licensed in California, consumers would need to deal with the out-of-state carrier per their arbitration rules, and potentially the out-of-state regulatory agency if there are applicable external grievance processes in place.
- Out-of-state carriers would be exempt from California-specific requirements related to cost and availability of insurance.
    - Federal proposals to introduce group purchasing arrangements (AHP plans that were exempt from various state-level requirements) increased coverage rates slightly. Nationally, an estimated 330,000 would become newly insured—because 4.6 million individuals would enroll in these new plans while enrollment in state-regulated plans

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would reduce the required number of persons covered by health coverage provided through the guaranteed association from 1,000 to 100. The bill would also define "small employer" to include an eligible association that purchases health care coverage for its members and would define an eligible association as a community or civic group or a charitable or religious organization.

would drop by 4.3 million. When examining the projected impacts of similar federal proposals on the California market, researchers found that there was virtually no increase in insurance coverage resulting from the introduction into the market of plans exempt from state requirements. They projected a less than 1% increase in new coverage or "virtually no net change in insurance coverage resulting from the availability of this alternative insurance product."

- California-specific and national analyses found that the introduction of AHPs in the market resulted in savings in premiums for those individuals who enrolled in the AHPs and an increase for those policyholders who stayed in the insured, state-regulated market. According to the California-specific study, the decrease in insurance premiums for AHP policyholders ranged from 13% to 14% and the increase for the policyholders in the insured, fully regulated market ranged from 2% to 5%. The savings in premiums for AHP policyholders is attributed to both exemption from state regulations as well as selection of better (low-cost) risk. Conversely, increased premiums in the state-regulated market are due to adverse selection of worse (high-cost) risk with fewer low-cost enrollees to spread the risk.
- Prior research evaluated a federal proposal that is similar to SB 92. The Health Care Choice Act of 2005 (H.R. 2355) would have allowed individuals buying health insurance in the individual market to do so from an entity licensed in another state. The Congressional Budget Office estimated about 1 million small-group enrollees would lose health insurance coverage as a result. However, low-risk individuals who were uninsured would obtain low-cost, out-of-state individual policies, offsetting those who lost insurance. Although the characteristics of the insured population could change, with low-risk individuals gaining insurance coverage and high-risk individuals losing coverage, the net effect with respect to the number of insured would be insubstantial.
- The development of AHPs and other proposals for the development and marketing of products exempt from state-specific requirement is projected to result in out-of-state policies attracting healthy, low-risk employees in the small-group and individual market. This selection of low-cost enrollees and risk segmentation could lead to a change in the composition of the market, leaving the high-risk individuals in the state-regulated market or uninsured.
- If fewer California-regulated products are offered in the commercial market as a result of SB 92, it is expected that over time, more large groups, and perhaps even mid-sized groups, might choose to self-insure rather than purchase an out-of-state policy. This would be likely to occur if the state-regulated products charged higher and higher premiums due to adverse selection. Out-of-state policies might not be an attractive alternative if they did not have the kind of generous benefit packages that large-groups tend to demand.
- Insurance requirements in the small-group market were intended to spread risk and ensure availability of coverage for otherwise uninsurable populations. AHPs and other arrangements exempt from state-specific requirement are likely to result in out-of-state carriers attracting healthy, low-risk employers and individuals. This favorable selection and risk segmentation could lead to change in the composition of the

market. For example, in the small-group market, those with younger and healthier employees may choose more affordable out-of-state products while other small groups may drop coverage altogether. Small groups may face dramatic variations in premiums when California-specific rate protections do not apply. The CDI calculated projected premium impacts if S. 1955 were to pass and found that small-group employees of the same firm could face premium differentials of 67% (versus 22% in current California law) based on less stringent rate band requirements.

INTRODUCTION

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

- Allow a carrier domiciled in another state to offer, sell, or renew a health care service plan contract or a health insurance policy in California without holding a license issued by the Department of Managed Health Care (DMHC) or a certificate of authority issued by the California Department of Insurance (CDI).[4] The bill would exempt the carrier's plan contract or policy from requirements otherwise applicable to plans and insurers providing health care coverage in California if the plan contract or policy complies with the domiciliary state's requirements, and the carrier is lawfully authorized to issue the plan contract or policy in that state and to transact business there.

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

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

California has two regulatory agencies that provide oversight of health insurance products sold in California. The DMHC has as its primary focus the oversight of health maintenance organizations (HMOs) and some preferred provider organization (PPO) plans. The CDI has broad regulatory authority over all other health insurance products. Under current law, carriers may only sell health insurance policies to employers and individuals who reside or work in California if the carrier (or its subsidiary) holds a license from the DMHC or a certificate of authority from the CDI. SB 92 would relax this requirement by allowing a carrier domiciled (based) and licensed in another state to sell health insurance policies in California without

[4] The term "health care service plans" is defined in the Knox-Keene Health Care Service Plan Act of 1975 (Health and Safety Code Section 1345). Since carriers domiciled in another state would not hold a Knox-Keene license from the DMHC, they would not be offering a health care service plan contract. Therefore, this report refers to all health insurance products by out-of-state carriers as health insurance policies.

obtaining a license (or certificate of authority) from the DMHC or CDI as long as the carrier complied with the regulations of the state where it was domiciled and licensed. Currently, about two-thirds of the private health insurance products sold in California are underwritten by in-state carriers—carriers domiciled and licensed in California.

According to the bill author, the subset of provisions analyzed in this report are intended to remedy the problem of costly state regulations, particularly legislatively imposed health insurance benefit mandates, that have reduced access to affordable health insurance by driving up the cost of premiums. The bill author maintains that the "state's idea of consumer protection does not match what is medically necessary or what consumers want."[5] According to the bill author, these provisions are also intended to help improve coverage for individuals close to poverty by providing access to private health insurance products with larger provider networks, which might otherwise be unavailable to them because of physicians' unwillingness to treat Medi-Cal beneficiaries due to low rates of reimbursement.[6]

In 2007, CHBRP conducted two previous analyses of legislation substantially similar to SB 92. One bill, Assembly Bill (AB) 1214 (Emmerson), would have allowed in-state carriers to issue plans or policies to groups and individuals that omitted one or more of the currently mandated health insurance benefits. The other bill, SB 365 (McClintock), would have allowed out-of-state carriers to offer health plans or insurance policies in California without obtaining a license or certificate of authority from the DMHC or CDI to offer health insurance products in California, as long as the carrier complied with the regulations of the state where it was "domiciled" and licensed. Neither bill passed out of the policy committee in their house of origin.

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

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

[5] Pat McConahay, *Republican Sen. Aanestad Puts Forward Market-Based Plan to Rework Health Care in California*, California Healthline Special Report, March 18, 2009. Available at www.californiahealthline.org/Special-Reports/2009/Republican-Sen-Aanestad-Puts-Forward-MarketBased-Vision-for-Health-Care-Reform.aspx. Accessed March 26, 2009.
[6] Personal communication with L. Halderman, MD, Office of Senator Aanestad, February 13, 2009.

Provisions of SB 92

A few important clarifications are warranted to understand the provisions of SB 92:

- **Effect on In-State Carriers.** Carriers currently domiciled and licensed in California (in-state carriers) would be allowed to offer limited-mandate policies to individuals with incomes less than 350% of the FPL. In-state carriers may move their base or "domicile" to another state if they considered it advantageous to compete with other carriers that offer products not subject to California regulations in all markets.

- **Effect on Out-of-State Carriers.** Carriers currently domiciled and licensed in another state (out-of-state carriers) would be allowed to offer, sell, or renew a health insurance policy in California without holding a license issued by the DMHC or without a certificate of authority issued by the CDI, as long as carriers followed the laws and regulations in the state where they were based (i.e., domiciled or licensed). This provision effectively exempts out-of-state carriers from California laws and regulations governing health insurance products.

  Because out-of-state carriers would only need to follow the laws and regulations in the state where they were domiciled, out-of-state carriers would be allowed to exclude any of the California benefit mandates from their insurance policies, including the minimum benefit package enacted by the Knox-Keene Health Care Service Act of 1975[7]. The Knox Keene Act benefits include a wide range of preventive and medically necessary diagnostic and treatment services provided in the inpatient, outpatient, physician offices, and post-acute care settings.[8] It is important to note that, under regulations promulgated and enforced by the DMHC, health plans are ultimately required to provide "medically necessary" services. Medical necessity is to be determined according to "the specific medical needs of the enrollee and any of the following: (1) peer-reviewed scientific and medical evidence regarding the effectiveness of the disputed service; (2) nationally recognized professional standards; (3) expert opinion; (4) generally accepted standards of medical practice; and (5) treatments that are likely to provide a benefit to a patient for conditions for which other treatments are not clinically efficacious."[9]

- **Limited-Mandate Policies.** For this report, limited-mandate policies refer to benefit packages that exclude a subset of the legislatively imposed mandates. Legislatively imposed mandates may mandate coverage of benefits or may mandate that coverage for the benefits be offered. "Mandates to cover" means that all health insurance products affected by the law must cover the benefit. "Mandate to offer" means all health insurance plans and insurers selling health insurance products affected by the mandate are required to offer the benefit for purchase. The plan or insurer may fulfill the mandate by including the benefit as standard in

[7] Health maintenance organizations in California are licensed under the Knox-Keene Health Care Services Plan Act, which is part of the California Health and Safety Code.
[8] "Basic Health Care Services" include 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 (7) Hospice Care. DMHC regulations to enact this statute elaborate on the range of necessary services [California Code of Regulations, Section 1300.67(f)(8)].
[9] Health and Safety Code §1370.4(c)(3)

affected products or may offer the benefit separately for an additional cost (e.g. a rider). Purchasers may then choose to buy the coverage or not. Benefit mandates or mandated offerings may only apply to the group market as opposed to the group *and* individual market. In these cases, the law specifically would state that individual plans and policies are exempt or that the law only applies to group policies. If the law is silent, it would apply to all markets.

Analytic Approach

This analysis and report is organized in two parts. Part I of the report describes the medical effectiveness and public health and cost impacts of allowing out-of-state limited-mandate plans to compete in the California market. Part II of the report describes the potential impacts of allowing out-of-state carriers to compete in the California health insurance market without being subject to the California laws and regulations imposed on in-state carriers.

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

- In the *Medical Effectiveness* section, CHBRP examines each of the benefits that may be excluded under SB 92 to determine whether the mandated benefit is considered to be medically effective based on existing evidence. Conclusions are drawn from the U.S. Preventive Services Task Force (USPSTF) recommendations, Centers for Disease Control (CDC) recommendations, National Institutes of Health (NIH) guidelines, and other authoritative sources. If a CHBRP analysis exists for a current benefit mandate, this report relies on that previous analysis. For example, the medical effectiveness analysis in the CHBRP report on AB 228 (2005) was used as evidence on the effectiveness of covering transplantation services for persons with HIV.
- The *Potential Cost Impacts s*ection addresses the issue of the added cost of California health insurance benefit mandates on the entire market by summarizing the existing literature and expert opinion on the premium savings associated with limited-mandate plans sold across state lines. This analysis draws upon a previous CHBRP report (AB 1214, 2007) that estimated the impact of allowing limited-mandate plans to be marketed in California. AB 1214 modeled the limited-mandate plans to reflect the insurance policies likely to be offered if in-state carriers were allowed to offer scaled-back benefit designs. Details on the designs used to model the cost impact scenarios are presented in Appendix F. Two possible scenarios are presented:

    - Scenario 1: Maximum Impact: This scenario assumes that limited-mandate policies would be purchased by all currently insured Californians in lieu of their current policies. All market segments (large group, small group, and individual) and all insurance products (high-deductible and low-deductible policies) would respond to the lower premiums offered by limited-mandate policies, and everyone would switch to those policies in response to a lower-cost alternative. This scenario assumes that all California insurance carriers would become domiciled in another state, such as Idaho, whose small number of mandates would allow carriers licensed there to offer the CHBRP prototype limited-mandate policies in all California market segments.

- Scenario 2: Low Impact: Because of evidence that employees in the group market prefer generous benefits (Marquis et al., 2006), this scenario assumes that limited-mandate policies would only have an impact on the individual market, which is also the most price-sensitive market segment. This scenario also assumes that all those currently insured in this market segment with incomes below 350% FPL currently own HDHP policies in the CDI-regulated segment of the market. This assumption is based on data from CHIS 2007 indicating that about 1/3 of those insured in the individual market have incomes below 350% FPL and CHBRP's estimates that about 1/3 of the total individual market consists of HDHP policies in the CDI-regulated segment of the market. Thus, CHBRP assumes in this scenario that everyone with incomes below 350% FPL has purchased a CDI-regulated HDHP, because they are the most price-sensitive purchasers in the individual market and HDHPs in the CDI-regulated market are the least expensive policies currently available.

- The *Potential Cost Impacts* section also estimates the short-term impacts on those currently uninsured in California under each of the scenarios described above.

- The *Public Health Impacts* section identifies the population that would be affected by a health condition related to a mandated benefit. The report offers general conclusions regarding the public health impact of waiving a particular benefit mandate based on the findings presented in the *Medical Effectiveness* section and the number of insured Californians that may be affected by the health condition.

PART I: THE IMPACT OF ALLOWING LIMITED-MANDATE PLANS TO COMPETE IN THE CALIFORNIA MARKET

Part I of this report focuses on the medical effectiveness and cost and public health impacts of allowing health insurance products that do not include legislatively imposed benefit mandates to be sold to Californians. Because this exemption would apply to products sold by carriers that are currently domiciled in California but obtain domicile elsewhere and those sold by carriers that are currently domiciled out-of-state, this part will refer to all limited-mandate policies as "out-of-state" limited-mandate policies.

Medical Effectiveness of Current Mandates: Summary of Evidence

SB 92 would permit the waiver of 46 health insurance mandates and mandated offering statutes that address numerous health care services used to screen for, diagnose, treat, and manage a wide range of diseases and conditions.

CHBRP reviewed evidence regarding the medical effectiveness of 31 of the 46 mandates and mandated offerings to which SB 92 would apply for its previous report on AB 1214, and summarized findings from CHBRP reports on two new mandates that were enacted since the AB 1214 report was published. Nine mandates were not analyzed because they do not require coverage for specific health care services or for specific diseases or conditions. Three mandates that address coverage for pharmaceuticals were not analyzed, because they apply to such a large number of diseases and conditions that the evidence cannot be summarized briefly. As indicated in Table 4, these mandates concern coverage for all drugs that are used off-label, not on health plans' formularies, or were previously prescribed to enrollees to treat any disease or condition. One mandate was not analyzed because it requires coverage for vaccination against a condition for which no vaccine is currently available (i.e., the AIDS virus).

Literature Review Methods

Studies of the medical effectiveness of the mandates and mandated offerings subject to SB 92 were identified through searches of databases that index peer-reviewed literature on the effectiveness of health care services. Web sites maintained by organizations that produce systematic reviews and evidence-based guidelines regarding health care services were also searched. In addition, previous CHBRP reports on pertinent topics were reviewed. *Appendix B* presents more detailed information about the literature search methods.

Once the literature search was completed, the most useful sources of evidence were selected for review. For this analysis, CHBRP relied primarily on meta-analyses, systematic reviews, and evidence-based practice guidelines, because these types of studies synthesize findings from multiple studies and, thus, provide the strongest evidence of effectiveness. Where multiple meta-analyses, systematic reviews, and evidence-based practice guidelines were available, CHBRP focused on the syntheses that were most thorough and which provided the most information about the research designs of the studies synthesized. Most syntheses were published within the past five years, although in a few cases the only syntheses available were published in the late 1980s or 1990s. Individual studies were reviewed only if meta-analyses, systematic reviews, or

evidence-based practice guidelines had not been published. If no studies had been published, CHBRP relied on clinical practice guidelines based on expert opinion.

Methodological Considerations

For this analysis, CHBRP took a broad view of the evidence of effectiveness for each mandate. The literature review focused on evidence about the effectiveness of major types of health care services used to screen, diagnose, treat, and manage the diseases and conditions addressed in the mandates and mandated offerings subject to SB 92. CHBRP chose this broad approach to the literature review because the rapid pace of advances in medical technology leads to frequent changes in state-of-the-art therapy for many conditions. Medications or procedures that are currently the most effective treatments for a disease or condition may soon be supplanted by new and improved alternatives.

This focused approach to the literature review may have led CHBRP staff to inadvertently omit important sources of evidence from the review. Most notably, relying on syntheses may have caused CHBRP to overlook studies published since the syntheses were completed. However, CHBRP believes this approach is appropriate given the large number of health care services for which evidence needed to be assessed in a short period of time. General conclusions about the effectiveness of treatments for which there is a large body of research probably would not change if the latest studies were added.

CHBRP discussed the relative merits of different tests and treatments for a disease or condition only where there was compelling evidence that certain tests or treatments were more effective than others. For example, CHBRP summarized findings regarding three different screening tests for breast cancer (i.e., mammography, clinical breast examination, and self-examination), because there is strong evidence that mammography is more effective than clinical breast examinations and self-examination. In contrast, CHBRP did not summarize findings from studies that have addressed the relative merits of different drugs used to treat osteoporosis because all of these drugs have been found to be more effective than placebos.

Outcomes Assessed

The outcomes that are most important for assessing effectiveness differ across the mandates and mandated offerings analyzed. Some of these mandates concern coverage for screening and diagnostic tests. In these cases, CHBRP examined evidence of a test's ability to accurately identify persons with a disease or condition, and evidence of whether the benefits of testing outweigh the harms. For two mandates that address coverage for immunizations, CHBRP examined evidence regarding the vaccines' ability to prevent illness and evidence that the benefits of vaccines outweigh their side effects. Other mandates concern coverage for treatment and management of illness. In these cases, the pertinent outcomes vary with the nature of the illness addressed. For example, control of blood glucose level is a critical outcome for studies of medication and services used to manage diabetes, because glucose control improves health outcomes for people with diabetes. Conversely, evaluation of breathing outcomes is important in studies of asthma management interventions, because asthma affects a person's ability to breathe and because better performance on pulmonary function tests and less frequent symptoms are associated with better health and less use of acute care services.

Study Findings

The amount and strength of evidence regarding the medical effectiveness of the services for which coverage is required under the mandates subject to SB 92 varies. For some mandates, CHBRP could draw upon multiple meta-analyses, systematic reviews, and evidence-based guidelines that synthesized findings from large, well-designed randomized controlled trials (RCTs). In other cases, the only evidence available comes from small, nonrandomized studies that have major methodological flaws. When examining the evidence for each mandate, CHBRP considered both the pattern of findings across studies and the methodological rigor of the studies.

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

Findings regarding the medical effectiveness of specific health care services addressed by the mandates and mandated offerings that could be excluded under SB 92 are described below. The mandates are grouped by major categories of diseases, conditions, populations, and types of services. The findings are summarized in Table 4 at the end of this section.

Cancer screening and treatment

Cancer screening tests

- There is *clear and convincing evidence*[10] that there are accurate screening tests for breast cancer, cervical cancer, and colorectal cancer and that the *benefits of routine screening of asymptomatic persons who are at risk for these cancers outweigh the harms*, because early diagnosis and treatment of these cancers reduces mortality (USPSTF, 2006).
- There is *insufficient evidence* to recommend for or against routine screening of asymptomatic persons for lung cancer, oral cancer, and skin cancer (USPSTF, 2006).
- There is a *preponderance of evidence*[11] that screening asymptomatic persons for bladder cancer, ovarian cancer, pancreatic cancer, and testicular cancer is *not effective* because screening tests pose some risks and because early detection and treatment does not improve health outcomes (USPSTF, 2006).
- Findings from two recently published RCTs suggest that using the prostate specific antigen (PSA) test to screen asymptomatic men for prostate cancer *may not be medically effective* (Andriole et al., 2009; Schröder et al., 2009). These are the first RCTs to assess the effectiveness of PSA screening. The benefits of PSA screening, seen only in the

[10] CHBRP characterizes evidence as "clear and convincing" where there are consistent findings from meta-analyses, systematic reviews, and evidence-based guidelines based on well-implemented RCTs or, if syntheses are not available, individual RCTs that are well-implemented. When assessing the strength of RCTs, CHBRP considers sample size, attrition, and equivalence between intervention and control groups. Blinding of health professionals and subjects to the assignment of subjects to the intervention and control groups is also taken into consideration in cases in which blinding is feasible.

[11] CHBRP characterizes the evidence as a "preponderance" if the majority of studies, but not an overwhelming majority, reach the same conclusion. This classification is also used when the evidence is drawn from RCTs with major methodological weaknesses and from nonrandomized studies. Even if the overwhelming majority of these studies report the similar findings, the evidence is not as strong as evidence obtained from well-implemented RCTs.

European trial, are relatively small, with over 1,000 men needing to be screened to prevent 1 cancer death over 10 years. In addition, 48 men diagnosed with prostate cancer would have to be treated to prevent 1 cancer death. This is balanced against the known long-term harms of prostate cancer treatment, which include incontinence and impotence. The U.S. study did not show a benefit, though the statistical analysis did demonstrate a small benefit, such as that seen in the European trial, is possible.

Diagnosis and treatment of breast cancer

- There is *clear and convincing evidence* that there *are effective* diagnostic procedures and treatments for breast cancer. Major forms of treatment that have been found to be effective include surgery, radiation, chemotherapy, hormone therapy, and immunotherapy (ICSI, 2005; NCCN, 2007; USPSTF, 2006).[12]
- There is *insufficient evidence* to determine whether longer length of inpatient stay is associated with better outcomes for females who have a mastectomy or lymph node dissection (CHBRP, 2005a).

Chronic conditions

Diabetes[13]

- There is *clear and convincing evidence* that self-monitoring of blood glucose and comprehensive, ongoing education regarding diabetes self-management skills and nutrition therapy *improve* the management of Type 1, Type 2, and gestational diabetes.
- There is *clear and convincing evidence* that insulin is an *effective* treatment for persons with Type 1 diabetes and for some persons with Type 2 diabetes whose blood glucose levels are not well-controlled by other treatments.
- There is *clear and convincing evidence* that medications are *effective* treatments for Type 2 diabetes.
- There is a *preponderance of evidence* that insulin pump therapy is an *effective* alternative to multiple insulin injections for persons with diabetes who are unable to achieve glycemic control with multiple daily injections or for whom multiple injections are contraindicated (AACE, 2007; ACOG, 2001; ADA, 2006).

Osteoporosis

- There is *clear and convincing evidence* that measurement of bone mineral density with dual-energy X-ray absorptiometry (DEXA) is an *effective* diagnostic test for bone mineral loss or osteopenia.[14]

[12] Findings regarding the effects of performing breast reconstruction surgery in conjunction with mastectomy are discussed below under the heading "Reconstructive Surgery."
[13] Findings regarding the effects of therapeutic shoes on prevention and treatment of diabetic foot ulcers are discussed below under the heading "Special footwear (i.e., therapeutic shoes)."
[14] Osteoporosis is the most common type of osteopenia, but osteomalacia from vitamin D deficiency also causes bone mineral loss on DEXA testing.

- There is *clear and convincing evidence* that exercise, calcium, vitamin D, and medications are *effective* treatments for osteoporosis. Most studies of the effectiveness of medications have assessed effects on postmenopausal women (ICSI, 2006; SIGN, 2003).

Screening for human immunodeficiency virus (HIV)

- Although no studies have directly assessed whether testing asymptomatic persons for HIV decreases morbidity and mortality, there is substantial indirect evidence that screening for HIV is effective.
- There is a *preponderance of evidence* from multiple studies that tests for HIV are highly accurate (i.e., have high sensitivity and specificity).
- There is *clear and convincing evidence* from multiple controlled studies that highly active antiretroviral therapy (HAART), prophylaxis for opportunistic infection, and vaccination against hepatitis B and influenza reduce the risk of clinical progression, opportunistic infection, and death.
- There is a *preponderance of evidence* that delivering infants born to HIV-positive mothers by elective cesarean section and feeding them formula instead of breast milk further reduces the risk of HIV transmission from mother to infant above and beyond the reduction in risk achieved through use of HAART.
- There is also evidence from studies of self-reported behavior that persons who are aware that they are HIV-positive are less likely to engage in unprotected intercourse than persons who are not aware of their status (CHBRP, 2008).

Transplantation services for persons with HIV

- The available studies of organ transplantation in HIV-positive patients consist primarily of studies of kidney and liver transplantation, with only a few reports of heart transplantation, multiple organ transplantation, and autologous stem cell transplantation for lymphoma after high-dose chemotherapy.
- Evidence from case series and case reports suggests that patients with HIV undergoing kidney transplantation have survival rates *similar* to those of patients without HIV. Evidence from case series and case reports suggests that in persons who do not have hepatitis C, survival rates after liver transplantation are *similar* regardless of HIV status (CHBRP, 2005b).

Phenylketonuria (PKU)[15]

- The *preponderance of evidence* indicates that consuming phenylalanine-free medical formulas, low-protein medical foods, and foods that are naturally low in phenylalanine is *effective* in reducing the severity of mental and behavioral disorders associated with PKU (Fernandes et al., 2006; Nyhan et al., 2005).

[15] Phenylketonuria (PKU) is a metabolic disorder. Persons who have PKU cannot properly metabolize phenylalanine, an amino acid found in high concentrations in high-protein foods. Inability to metabolize phenylalanine causes accumulation of phenylalanine and phenylketones in the blood, which can lead to mental retardation, behavioral problems, and other disorders if not treated.

Mental illness and substance use disorders

Severe mental illnesses

- The *preponderance of evidence* indicates that medication, psychotherapy, and electroconvulsive therapy (ECT) are *effective* treatments for bipolar disorder, major depression, and schizophrenia.
- The *preponderance of evidence* indicates that treating persons who have bipolar disorder, schizophrenia, or severe or recurrent major depressive disorder with both medication and psychotherapy is more *effective* than treating them with either medication or psychotherapy alone (APA, 2000; APA, 2002; APA, 2004; NCCMH, 2003; NCCMH, 2004; NCCMH, 2006).

Alcoholism

- There is *clear and convincing evidence* that pharmaceuticals and certain forms of psychotherapy, including 12-step programs, are *effective* treatments for alcoholism (APA, 2006; Mann et al., 2004; Srisurapanont et al., 2005).

Illnesses and injuries due to intoxication or consumption of controlled substances

- There is *insufficient evidence* to determine whether prohibiting health insurers from excluding coverage for illnesses and injuries due to intoxication or use of controlled substances (other than those prescribed by a physician) increases the provision of screening and counseling for alcoholism and substance abuse disorders (CHBRP, 2007e).

Prostheses, orthoses, and special footwear

Prosthetic devices for amputations and limb deformities

- Use of prosthetic devices has been the standard of care for amputations and congenital limb deformities for so long that their benefits are widely accepted even though there are very few controlled studies of prosthetics versus no treatment.

Orthoses

- There is a *preponderance of evidence* that knee orthoses are *effective* treatments for osteoarthritis of the knee (Brouwer et al., 2005), that foot orthoses are *effective* treatments for rheumatoid arthritis of the foot (Clark et al., 2006; Egan et al., 2003), and that ankle orthoses are *effective* for prevention of ankle sprains (Handoll et al., 2001).
- There is *insufficient evidence* to assess the effectiveness of foot orthoses for treatment of Achilles tendonitis, plantar heel pain, soreness around the kneecap (Crawford and Thomson, 2003; D'Hondt et al., 2002; McLauchlan and Handoll, 2001); the effectiveness of knee orthoses for treatment of soreness around the knee; hand and wrist orthoses for treatment of rheumatoid arthritis of the hand and wrist; or the effectiveness of foot and knee orthoses for prevention of sprains, strains, and stress fractures (Rome et al., 2005; Yeung and Yeung, 2001).
- There is a *preponderance of evidence* that foot orthoses are *not effective* treatments for abnormal deviation of the big toe and bunions (Felson et al., 2000).

Prosthetic devices for persons who have had a laryngectomy

- Evidence from small nonrandomized studies of persons who have had a laryngectomy suggests that tracheoesophageal speech with a voice prosthesis *is more intelligible* than speech produced using esophageal speech and electrolaryngeal speech, and requires less cognitive effort on the part of listeners (Arias et al., 2000; Evitts and Searl, 2006; Globlek et al., 2004; Stajner-Katusic et al., 2006).[16]
- Evidence of the effect of tracheoesophageal speech with a voice prosthesis relative to esophageal speech and electrolaryngeal speech on self-reported ability to communicate in daily-life situations (e.g., talking on the telephone) is *ambiguous* (Carr et al., 2000; Farrand and Duncan, 2007; Tsai et al., 2003).
- The *preponderance of evidence* from two nonrandomized studies suggests that quality of life *does not differ* among persons with laryngectomies who use tracheoesophageal speech with a voice prosthesis, esophageal speech, or electrolaryngeal speech (Carr et al., 2000; Farrand and Duncan, 2007).

Special footwear (i.e., therapeutic shoes)

- A *preponderance of evidence* suggests that therapeutic shoes are *effective* in improving functioning and reducing pain and inflammation in persons with rheumatoid arthritis (Farrow et al., 2005).
- The evidence of the effectiveness of therapeutic footwear in preventing diabetic foot ulcers is *ambiguous* (Maciejewski et al., 2004; McIntosh et al., 2003).
- There is *insufficient evidence* to determine whether therapeutic footwear prevents amputation among persons with diabetes (Maciejewski et al., 2004; McIntosh et al., 2003).
- Evidence from two small RCTs suggests that therapeutic shoes are *less effective* than total contact casting in facilitating healing of diabetic foot ulcers (Maciejewski et al., 2004; McIntosh et al., 2003).

[16] Laryngectomies are usually performed to treat cancer of the larynx. They are occasionally performed on persons whose throats have been severely injured. Persons who have a laryngectomy lose the ability to speak normally. The three methods most frequently used to enable persons with largynectomies to speak are esophageal speech, electrolarygneal speech, and tracheosophageal speech with a voice prosthesis. Esophageal speech involves the use of the esophagus to produce sound in place of the larynx. Tracheoesophageal speech is generated through use of a one-way, prosthetic valve that is placed in an incision between the esophagus and the trachea. This prosthesis allows air from the lungs to flow into the esophagus to produce sound. Electrolaryngeal speech is produced by a battery-operated machine that is held against the neck or placed in a small tube in the corner of the mouth. Speech therapy is needed to successfully use any of these three methods.

Pain management

Acupuncture

- The *preponderance of evidence* suggests that needle acupuncture[17] is an *effective* treatment for some musculoskeletal conditions, chronic headache, and postoperative nausea and vomiting.
- The *preponderance of evidence* suggests that needle acupuncture is as *effective* as or *more effective* than other nonsurgical treatments for osteoarthritis of the knee, temporomandibular joint (TMJ) disorders, pelvic pain associated with pregnancy, chronic headache, and postoperative nausea and vomiting.
- The *preponderance of evidence* suggests that needle acupuncture is an *effective* adjuvant treatment for chronic low back pain, pelvic pain, stroke, and chemotherapy-induced vomiting (CHBRP, 2007b).

Pain management medication for persons with terminal illnesses

- Most of the research on pain management for persons with life-threatening illness has focused on cancer pain. Some of these studies include both persons whose cancers are terminal and persons who cancers are treatable.
- The *preponderance of evidence* indicates that medications *reduce* pain caused by cancer or cancer treatment (Goudas et al., 2001).

General anesthesia for dental procedures

- The use of general anesthesia and other forms of sedation for dental procedures is based primarily on consensus rather than scientific evidence.
- There is a consensus that general anesthesia is appropriate for persons who have physical or mental disabilities that make it difficult for them to cooperate during dental procedures, persons who cannot be given local anesthesia due to allergy or acute infection, and persons who need extensive dental care or dental surgery.
- There is a consensus that children undergoing dental procedures should receive general anesthesia only if they are unable or unwilling to undergo the procedure using local anesthesia or nitrous oxide (AAP and AAPD, 2006; AAPD, 2004; AAPD, 2006; ADA, 2005).

Pediatric health

Comprehensive preventive services for children and adolescents

- There is *a preponderance of evidence* that the following preventive services for children and adolescents are *effective*:

[17] Needle acupuncture refers to the use of needles to stimulate acupuncture pressure points. Evidence of the effectiveness of other treatments provided by acupuncturists, such cupping and moxibustion, was not reviewed.

- Immunizations recommended by the Centers for Disease Control Advisory Committee on Immunization Practices (CDC, 2005c; CDC, 2006; CDC ACIP, 2000; CHBRP, 2007a; USPSTF, 1996)[18]
- Counseling regarding nutrition and prevention of unintentional injuries (USPSTF, 1996)
- Screening newborns for metabolic disorders shortly after birth (e.g., thyroid, hemoglobinopathies, PKU, galactosemia) (USPSTF, 1996)
- Screening children younger than 5 years for visual impairment (USPSTF, 2006)
- Providing Pap smears to sexually active adolescent females (USPSTF, 2006)
- Screening for most sexually transmitted diseases among sexually active adolescents who are at *increased* risk for contracting these diseases (USPSTF, 2006)

- There is *insufficient evidence* to recommend for or against the following preventive services:
  - Screening newborns for hearing loss (USPSTF, 2006)
  - Screening asymptomatic children for iron deficiency anemia (USPSTF, 2006)
  - Screening asymptomatic adolescents for herpes simplex virus (USPSTF, 2006)
  - Violence prevention counseling (USPSTF, 2006)
- No meta-analyses, systematic reviews, or evidence-based guidelines could be located for some recommended preventive services for children and adolescents. In these cases, CHBRP relied on expert consensus or opinion. These services include:
  - Physical examinations (AAP, 2000)
  - Measurement of height, weight, head circumference, and blood pressure (Kuczmarski et al., 2000; USPSTF, 1996)
  - Developmental and behavioral assessments (AAP, 2000)
  - Screening children at high risk for iron deficiency (AAP, 2000)
  - Counseling regarding infant sleep position (AAP, 2000)
  - Preventive dental examinations (AAP, 2000)
  - Urinalysis screening of asymptomatic children under age 5 years and sexually active adolescents (AAP, 2000)
  - Pelvic examinations for sexually active adolescent females (AAP, 2000)
  - Tuberculin testing for children and adolescents at high risk for tuberculosis (AAP, 2000)
  - Cholesterol testing for children and adolescents at high risk for high cholesterol (AAP, 2000)

[18] These immunizations include vaccines against diphtheria, tetanus, pertussis, haemophilus influenza type b, hepatitis a, hepatitis b, human papillomavirus, polio, influenza, measles, mumps, rubella, meningococcal disease, pneumococcal infection, rotavirus, and chickenpox.

Management of pediatric asthma

- There is *clear and convincing evidence* that asthma self-management education helps children with asthma and their parents learn skills necessary for controlling asthma and improving their health.
- The *preponderance of evidence* suggests that peak flow monitoring is as *effective* as symptom monitoring and is especially useful for persons who have moderate or severe persistent asthma or a history of severe asthma exacerbations.
- The *preponderance of evidence* suggests that nebulizers and metered-dose inhalers (MDIs) are equally *effective* in improving health outcomes and that nebulizers should be used by persons who cannot use an MDI with a spacer or an MDI with both a spacer and face mask, such as infants.
- A *preponderance of evidence* suggests that use of spacers in conjunction with MDIs reduces the risk of local adverse effects, such as oral thrush;[19] they are most likely to benefit persons who are having a severe asthma exacerbation or who cannot use MDIs properly (e.g., young children) (Ahrens et al., 1995; CHBRP, 2004; CHBRP 2006a; Dolovich et al., 2005; Feddah et al., 2001; NHLBI, 2007).[20]

Screening for blood lead levels

- There is *insufficient evidence* to recommend for or against routine screening for elevated blood lead levels in asymptomatic children who are at *increased risk* for lead poisoning.
- There is a *preponderance of evidence* to recommend *against* routine screening for elevated blood lead levels in asymptomatic children who are at *average risk* for lead poisoning due to the significant potential harms of treatment (USPSTF, 2006).[21]

[19] Oral thrush is an oral yeast infection.

[20] Studies of the impact of using spacers with MDIs on inhalation of asthma medications are difficult to generalize, because their features vary and because they have been studied in conjunction with different medications. Findings from laboratory studies suggest that effectiveness varies across medications and across spacers with different features (e.g., integrated with MDI device, contains valved holding chamber, shape of chamber, rigid or flexible chamber). In addition, many studies have sample sizes that limit their ability to detect statistically significant differences in breathing outcomes. Finally, no studies have been published regarding the use of spacers with the new hydrofluoroalkane-propelled MDIs (HFA MDIs). Historically, MDIs have used chlorofluorocarbons (CFCs), a major cause of ozone depletion, to propel medication. The U.S. Food and Drug Administration (FDA) ordered the removal of CFC-based MDIs be removed from the market at the end of 2008. They have been replaced by HFA MDIs.

[21] There is good evidence that chelation treatment in asymptomatic children does not improve neurodevelopmental outcomes and is associated with a slight diminution in cognitive performance. Chelation therapy may result in transient renal, hepatic, and other toxicity, mild gastrointestinal symptoms, sensitivity reactions, and rare life-threatening reactions.

Contraceptive devices requiring a prescription[22]

- There is *clear and convincing evidence* that sexually active females who use prescription contraceptives are *much less likely* to become pregnant than sexually active females who do not use any type of contraception.
- There is a *preponderance of evidence* that prescription contraceptives are *more effective* than nonprescription contraceptives for preventing pregnancy.[23]
- There is *clear and convincing evidence* that hormone-based contraceptives and IUDs are *more effective* than barrier methods for preventing pregnancy (WHO, 2004).

Infertility

- There is a *preponderance of evidence* that there are *effective* tests for ascertaining whether female infertility is due to lack of ovulation, tubal occlusion, endometriosis, or chlamydia.
- There is a *preponderance of evidence* that medication and surgery are *effective* treatments for certain disorders that cause infertility in males and females, and that tubal flushing is an *effective* treatment for other causes of female infertility.
- There is *clear and convincing evidence* that intrauterine insemination *increases* the likelihood of pregnancy in couples with mild male factor fertility problems or unexplained fertility problems, or where a female partner has minimal to mild endometriosis (Attia et al, 2007; Luttjeboer et al., 2007; NCCWCH, 2004).

Prenatal diagnosis of genetic disorders

- There is a *preponderance of evidence* that there are *accurate* tests for identifying fetuses with certain genetic disorders, such as Down syndrome, spina bifida, and anencephaly (ACOG Committee on Practice Bulletins, 2007; Alfirevic et al., 2003).

Expanded alpha-fetoprotein screening

- There is a *preponderance of evidence* that expanded alpha-fetoprotein screening tests *accurately* detect likely cases of Down syndrome. Performing this test reduces the number of women with healthy fetuses who will undergo diagnostic tests that have a small risk of miscarriage (ACOG Committee on Practice Bulletins, 2007).

[22] Prescription contraceptives can be divided into three major categories. Barrier methods are devices inserted into the vagina that are used in conjunction with a spermicide and removed between episodes of intercourse. They include the cervical cap, the cervical shield, and the diaphragm. Intrauterine devices are small devices composed of copper wire wrapped around a plastic frame that are implanted in the uterus. Hormone-based contraceptives prevent ovulation and change the lining of the uterus and cervical mucus to prevent pregnancy. Multiple methods have been developed to deliver hormone-based contraceptives, including pills, injections, implants, skin patches, and vaginal rings.

[23] However, prescription contraceptives *do not* protect against HIV. Condoms are the only form of contraception that prevents transmission of HIV.

Surgical procedures

Jawbone and associated bone disorders

- TMJ disorders were the only disorder of the jawbone and associated bone joints for which evidence could be located.
- A *preponderance of evidence* suggests that surgical treatments for TMJ disorders reduce pain among persons who do not respond to nonsurgical treatments (Reston and Turkelson, 2003).

Reconstructive surgery

- Clubfoot, craniofacial abnormalities, and breast reconstruction following mastectomy are the only indications for reconstructive surgery for which evidence could be located.
- Evidence of the impact of breast reconstruction following mastectomy on psychosocial outcomes is *ambiguous* (Fung et al., 2001; Holly et al., 2003; Janz et al., 2005; Nano et al., 2005; Nissen et al., 2001; Pusic et al., 1999; Rowland et al., 2000; Rubino et al., 2007; Yurek et al., 2000).[24]
- There is *insufficient evidence* to ascertain the effects of reconstructive surgery on physical and psychosocial outcomes for persons with clubfoot or craniofacial abnormalities (Endriga and Kapp-Simon, 1999; Marcusson et al., 2001; Marcusson et al., 2002: Roye et al., 2001; Sarwer et al., 1999; Vitale et al., 2005).

Hospice and home health care

Hospice care[25]

- Studies of hospice care vary widely with regard to research design, study population, characteristics of the hospice intervention,[26] and outcomes assessed.
- Most studies of hospice care that have strong research designs were published in the 1980s. Pain control medication and standards of care for pain control may have changed since these studies were conducted.
- Most studies have evaluated the impact of hospice care on persons with terminal cancers.
- The *preponderance of evidence* suggests that hospice care *reduces* some symptoms associated with terminal illness, such as anxiety, diarrhea, and nausea.

[24] Women who have a mastectomy can elect to have breast reconstruction surgery or use a breast prosthesis. For most women with stage I or stage II breast cancer, mastectomy and breast conserving therapy (lumpectomy with levels I and II axillary node dissection, plus radiotherapy) are equally effective treatments. Mastectomy and chemotherapy and hormone treatment are the most effective treatments for stage III and stage IV cancers.

[25] Hospice care encompasses care and services provided to persons in the late stages of terminal illnesses to relieve pain and suffering and maximize quality of life prior to death, and services provided to families to help them cope with a loved one's illness and their own bereavement.

[26] Some studies have assessed the delivery of hospice care in patients' homes, and some have examined inpatient hospice units in hospitals. Others have evaluated interventions that combined home-based and inpatient hospice services.

- The evidence of the effects of hospice care on the duration, frequency, and severity of pain is *ambiguous*.
- The evidence of the effects of hospice care on hospital use and quality of life is *ambiguous* (Harding et al., 2005; Higginson et al., 2003; NICE, 2004).

Home care

- Studies of home care vary widely with regard to study populations, characteristics of home care interventions, comparison groups,[27] and outcomes assessed.
- Most studies have evaluated the impact of home care on elderly persons and many were conducted outside the United States.
- There is *clear and convincing evidence* that home care is associated with statistically significant *reductions* in days of hospitalization and nursing home use and with a nonsignificant decrease in mortality relative to usual care (Herick et al., 1989; Hughes et al., 1997; Parker et al., 2002).
- There is *clear and convincing evidence* that home-based rehabilitation is associated with *fewer* days of hospitalization than inpatient rehabilitation (Cunliffe et al., 2004; Shepperd and Iliffe, 2005).
- The *preponderance of evidence* suggests that persons with stroke or hip fracture who receive home-based rehabilitation have *better* physical functioning than persons who receive inpatient rehabilitation (Crotty et al., 2002; Early Supported Discharge Trialists, 2005; Giusti et al., 2006; Kuisma, 2002; Langhorne et al., 2007).
- The *preponderance of evidence* indicates that home-based rehabilitation and inpatient rehabilitation have *similar effects* on mortality, psychological functioning, quality of life, hospital readmission, and caregiver burden (Cunliffe et al., 2004; Early Supported Discharge Trialists, 2005; Langhorne et al., 2007; Shepperd and Iliffe, 2005).
- There is *insufficient evidence* to determine whether home care improves physical or mental health outcomes for children with very low birth weight, genetic disorders, or chronic conditions (Parker et al., 2002).

[27] Some studies compare persons receiving home care to persons who receive "usual care," an undefined set of services typically available to persons in the communities in which the studies are undertaken. Other studies compare persons who receive rehabilitative services (e.g., physical therapy) in their homes to persons who receive similar services in inpatient settings.

Table 4. Mandates Addressed in SB 92, by Strength of Evidence

Description	**Clear and Convincing Evidence that Test(s) and/or Treatment(s) *Are* Effective**	**Preponderance of Evidence that Test(s) and/or Treatment(s) *Are* Effective**	**Evidence of the Effectiveness of Test(s) and/or Treatment(s) Is Ambiguous**	**Insufficient Evidence to Determine whether Test(s) and/or Treatment(s) *Are* Effective**	**Preponderance of Evidence that Test(s) and/or Treatment(s) *Are Not* Effective**
Cancer Screening and Treatment					
Cancer screening tests	X – colorectal, breast, and cervical cancer screening			X – lung, oral, and skin cancer screening	X – bladder, ovarian, pancreatic, prostate, and testicular cancer screening
Prostate cancer screening and diagnosis					X
Cervical cancer screening	X				
Breast cancer screening, diagnosis and treatment	X				
Breast cancer screening with mammography	X				
Mastectomy and lymph node dissection – length of stay				X	
Chronic Conditions					
Diabetes management	X – except for special footwear				
Osteoporosis diagnosis, treatment, and management	X				
Human immunodeficiency virus screening	**X**				

Table 4. Mandates Addressed in SB 92, by Strength of Evidence (Cont'd)

Description	Clear and Convincing Evidence that Test(s) and/or Treatment(s) *Are* Effective	Preponderance of Evidence that Test(s) and/or Treatment(s) *Are* Effective	Evidence of the Effectiveness of Test(s) and/or Treatment(s) Is Ambiguous	Insufficient Evidence to Determine whether Test(s) and/or Treatment(s) *Are* Effective	Preponderance of Evidence that Test(s) and/or Treatment(s) *Are Not* Effective
Chronic Conditions (Cont'd)					
Transplantation services for persons with HIV		X[28]			
Phenylketonuria – medical formulas and medical foods		X			
Mental Illness and Substance Use Disorders					
Parity in coverage for severe mental illness	X[29]				
Coverage for mental and nervous disorders	X				
Alcoholism	X				
Prohibition on exclusion of coverage for illnesses or injuries associated with intoxication or consumption of controlled substances not prescribed by a physician				**X**	

[28] Most evidence regarding organ transplantation in persons with HIV comes from studies of persons receiving kidney or liver transplants. There is insufficient evidence to determine whether findings generalize to transplantation of other organs.

[29] Due to time constraints, the review of evidence regarding treatments for mental illness was limited to three severe mental illnesses: bipolar disorder, major depressive disorder, and schizophrenia.

Table 4. Mandates Addressed in SB 92, by Strength of Evidence (Cont'd)

Description	Clear and Convincing Evidence that Test(s) and/or Treatment(s) *Are* Effective	Preponderance of Evidence that Test(s) and/or Treatment(s) *Are* Effective	Evidence of the Effectiveness of Test(s) and/or Treatment(s) Is Ambiguous	Insufficient Evidence to Determine whether Test(s) and/or Treatment(s) *Are* Effective	Preponderance of Evidence that Test(s) and/or Treatment(s) *Are Not* Effective
Prostheses, Orthoses, and Footwear					
Orthotic and prosthetic devices		X – prostheses and some orthoses[30]		X – some orthoses[31]	X – foot orthoses for deviated big toe
Prosthetic devices for laryngectomy			X[32]		
Special footwear for persons with foot disfigurement		X – rheumatoid arthritis[33]	X – diabetes		
Pain Management					
Acupuncture		X[34]			
Pain management medication for persons with terminal illnesses		X – cancer [35]			
General anesthesia for				X[36]	

[30] There is a preponderance of evidence that knee orthoses are effective treatments for osteoarthritis of the knee and that foot orthoses are effective treatments for rheumatoid arthritis of the foot. There is also a preponderance of evidence that ankle orthoses are effective for prevention of ankle sprains.

[31] There is insufficient evidence to assess the effectiveness of foot orthoses for treatment of Achilles tendonitis, plantar heel pain, and soreness around the kneecap, and the effectiveness of knee orthoses for treatment of soreness around the kneecap. There is also insufficient evidence to determine the effectiveness of hand and wrist orthoses for treatment of rheumatoid arthritis, and the effectiveness of foot and knee orthoses for prevention of strains, sprains, and stress fractures.

[32] Findings from acoustical analyses differ from findings from studies of the self-reported ability to communicate in everyday situations.

[33] The only literature located on special footwear concerned special footwear for persons with diabetes or rheumatoid arthritis. Findings from these studies may not generalize to persons with foot disfigurement due to other diseases or conditions.

[34] Evidence of effectiveness varies across the many diseases and conditions that are treated with acupuncture. The literature review was limited to studies of the use of acupuncture needles to stimulate acupressure points; other services provided by acupuncturists, such as cupping and moxibustion, were not assessed.

[35] Most studies of the impact of pain management medication on persons with terminal illnesses have assessed persons with terminal cancers. Their findings may not generalize to persons in the terminal phases of other diseases or conditions.

[36] No studies of the effectiveness of general anesthesia for dental procedures were located. However, there is a consensus among experts that use of general anesthesia is appropriate for young children, children who are extremely anxious or fearful about dental procedures, persons with mental or physical disabilities that impede their ability to cooperate during dental procedures, persons for whom local anesthesia cannot be used due to allergy or acute infection, and persons who require extensive dental care or dental surgery.

Description	Clear and Convincing Evidence that Test(s) and/or Treatment(s) *Are* Effective	Preponderance of Evidence that Test(s) and/or Treatment(s) *Are* Effective	Evidence of the Effectiveness of Test(s) and/or Treatment(s) Is Ambiguous	Insufficient Evidence to Determine whether Test(s) and/or Treatment(s) *Are* Effective	Preponderance of Evidence that Test(s) and/or Treatment(s) *Are Not* Effective
dental procedures performed in hospitals					

Table 4. Mandates Addressed in SB 92, by Strength of Evidence (Cont'd)

Description	Clear and Convincing Evidence that Test(s) and/or Treatment(s) *Are* Effective	Preponderance of Evidence that Test(s) and/or Treatment(s) *Are* Effective	Evidence of the Effectiveness of Test(s) and/or Treatment(s) Is Ambiguous	Insufficient Evidence to Determine whether Test(s) and/or Treatment(s) *Are* Effective	Preponderance of Evidence that Test(s) and/or Treatment(s) *Are Not* Effective
Pediatric Health					
Comprehensive preventive services for children aged 16 years or younger		X – some recommended services[37]		X – some recommended services[38,39]	
Comprehensive preventive care for children aged 17 or 18 years		X – some recommended services		X – some recommended services	
Asthma management		X – peak flow	X – spacers		

[37] The mandates regarding comprehensive preventive services for children and adolescents require health plans to cover services recommended by the American Academy of Pediatrics (AAP) and the Recommended Childhood Immunization Schedule issued jointly by AAP, the American Academy of Family Physicians, and the Centers for Disease Control's Advisory Committee on Immunization Practices. Recommended services that *a preponderance of evidence indicates are effective* include immunizations, vision screening for children younger than five years, screening newborns for metabolic disorders, Pap smears for sexually active adolescent females, sexually transmitted disease screening for sexually active adolescents, and counseling parents and children about nutrition and prevention of unintentional injury.

[38] Recommended preventive services for children and adolescents for which *evidence of effectiveness is insufficient* include screening newborns for hearing loss, screening asymptomatic children for iron deficiency, screening asymptomatic adolescents for the herpes simplex virus, and violence prevention counseling.

[39] No meta-analyses, systematic reviews, or evidence-based guidelines could be located for some recommended preventive services for children and adolescents. For these services, the only evidence reviewed by CHBRP is based on expert consensus or opinion. These preventive services include physical examinations; measurement of height, weight, head circumference, and blood pressure; developmental and behavioral assessments; screening high risk children for iron deficiency; urinalysis screening of asymptomatic children under age 5 and sexually active adolescents; pelvic exams for sexually active adolescent females; tuberculin testing for children and adolescents at high risk for tuberculosis; cholesterol testing for children and adolescents at high risk for high cholesterol; counseling regarding infant sleep position; and preventive dental examinations.

Description	Clear and Convincing Evidence that Test(s) and/or Treatment(s) *Are* Effective	Preponderance of Evidence that Test(s) and/or Treatment(s) *Are* Effective	Evidence of the Effectiveness of Test(s) and/or Treatment(s) Is Ambiguous	Insufficient Evidence to Determine whether Test(s) and/or Treatment(s) *Are* Effective	Preponderance of Evidence that Test(s) and/or Treatment(s) *Are Not* Effective
		monitors, nebulizers, education			

Table 4. Mandates Addressed in SB 92, by Strength of Evidence (Cont'd)

Description	Clear and Convincing Evidence that Test(s) and/or Treatment(s) *Are* Effective	Preponderance of Evidence that Test(s) and/or Treatment(s) *Are* Effective	Evidence of the Effectiveness of Test(s) and/or Treatment(s) Is Ambiguous	Insufficient Evidence to Determine whether Test(s) and/or Treatment(s) *Are* Effective	Preponderance of Evidence that Test(s) and/or Treatment(s) *Are Not* Effective
Pediatric Health (cont'd)					
Screening children for blood lead levels				X – children at increased risk	X – children at average risk
Reproductive Health					
Contraceptive devices requiring a prescription	X				
Infertility – diagnosis and treatment	X				
Prenatal diagnosis of genetic disorders		X			
Expanded alpha-fetoprotein screening		X			
Surgical Procedures					
Jawbone and associated bone joints		X[40]			
Reconstructive surgery			X – mastectomy with breast	X – clubfoot and craniofacial abnormalities	

[40] TMJ disorders were the only indication for jaw surgery for which evidence of effectiveness could be located.

Description	Clear and Convincing Evidence that Test(s) and/or Treatment(s) *Are* Effective	Preponderance of Evidence that Test(s) and/or Treatment(s) *Are* Effective	Evidence of the Effectiveness of Test(s) and/or Treatment(s) Is Ambiguous	Insufficient Evidence to Determine whether Test(s) and/or Treatment(s) *Are* Effective	Preponderance of Evidence that Test(s) and/or Treatment(s) *Are Not* Effective
			reconstruction[41]		
Hospice and Home Health Care					
Hospice care			X		
Home health care	X – elderly and disabled adults			X – children	

[41] Evidence was located for only three indications for reconstructive surgery: breast reconstructive following mastectomy, clubfoot, and craniofacial abnormalities.

Potential Cost Impacts

SB 92 would allow in-state carriers to offer limited-mandate plans in the individual market to persons with incomes below 350% of the FPL, as well as allow out-of-state carriers to offer limited-mandate plans in both group and individual markets.

Because there are currently 46 health insurance benefit mandates under California law, the number of possible combinations of these 46 benefits that might be offered if they were no longer mandated is virtually limitless (more than 17 quadrillion). CHBRP employed simplifying assumptions regarding health insurance product design. These are as follows:

(1) Under Scenario 1, all currently insured would select a limited-mandate plan. Enrollees in a DMHC-group plan would choose a limited-mandate DMHC group plan, enrollees in a CDI-individual plan would choose a CDI individual limited-mandate plan, enrollees in a DMHC individual plan would choose a limited-mandate DMHC individual plan, and enrollees in a CDI-group plan would choose a limited-mandate CDI group plan.

(2) Under Scenario 2, in-state carriers would offer limited mandate plans to those currently in the individual market that are below 350% of the federal poverty line. Those currently enrolled in the individual market would move to a limited mandate HDHP. The complete description of the prototypes benefit plans appears in *Appendix F*.

This section first provides a brief summary of the existing literature on the cost of insurance mandates in order to put the possible effects of SB 92 on health care premiums into context. The section then presents further description of the assumptions used to model each scenario and their potential cost impacts.

Cost of Insurance Mandates: Summary of the Literature

The financial cost of mandated health insurance benefits can be defined either as the full cost of the service or as the marginal or additional cost of the mandate. The marginal cost equals the full cost of the service minus the cost of the services that would be covered in the absence of the legal requirement imposed by the mandates

Estimates for the cumulative cost of the mandated benefits vary. Recent studies estimate the cumulative cost range from 5% to 19% of premium. An evaluation of the federal legislative proposal to allow carriers to sell insurance across state lines found that in the small-group market, the elimination of benefit mandates that were not in effect in at least 45 states would lead to a premium reduction of 5% (CBO, 2006). For its 2007 analysis of SB 365, CHBRP estimated that allowing out-of-state carriers to compete in the California market without providing coverage for the 44 state-mandated benefits or the Knox-Keene Act benefits would produce a decrease of 10% in total health care expenditures, roughly proportional to a 10% decrease in premiums (CHBRP, 2007c). However, in preparing for the analysis of SB 92, CHBRP consulted with content experts who indicated that in-state carriers in California are able to obtain discounts of 10% to 15% and more from provider networks compared to out-of-state carriers because of such factors as the number of beneficiaries they may bring to the providers, their experience in negotiating with specific provider networks and vice versa, and economies of scale in

administraion of arrangements between health plans and provider networks. This cost advantage was not factored into CHBRP's previous analysis of SB 365. In analyzing a related piece of legislation (AB 1214), CHBRP estimated that eliminating all 44 of California's mandates for in-state carriers, while maintaining the Knox-Keene Act benefits, would reduce premiums by about 4.8% (CHBRP, 2007d).

The premiums savings for other states vary. The Texas Department of Insurance has been collecting mandated benefit cost and experience data from their largest carriers since 1992. For the most recent study period—October 2004 to September 2005 data—they estimate that for individual (nongroup) benefit plans, mandated benefit costs 3.10% of total premiums and 3.90% of total premiums for group plans. Their review of the data for each mandated benefit shows that each benefit accounted for less than 1% of total claim costs. Claims paid for diabetes education and supplies represented the highest percentage of claims at 0.74%. Reconstructive breast surgery following a mastectomy accounted for the next highest percentage of costs at 0.66% of total claims, followed by claims paid for serious mental illness (0.54%), colorectal cancer testing (0.47%), and hearing screening for children (0.44%). The least costly benefits were nutritional supplements for PKU (phynelketonuria) and other inheritable diseases (rare), and telemedicine services; both benefits had claims totaling less than 0.01% of total claims (TDI, 2005).

A Massachusetts study estimated total spending associated with the state's 26 mandated benefit laws was 12% of premiums for the study period: July 1, 2004 through June 30, 2005. Five mandates—maternity, mental health, home health, preventive care for children, and infertility services—accounted for 80% of the total cost of the mandated benefits, or 10% of premiums. This study estimated the marginal cost of the health insurance mandates ranged from 1.2% of the average premium to 6.4%, with an average between 3% and 4% of premium (Bachman et al., 2008).

A Maryland study (MHCC, 2008) that estimated the cost of their 42 mandates represents 15.4% of a typical group premium and 18.6% of premium for the individual market. The two most expensive mandates were for mental illness and substance abuse at roughly 5% of premium, and hospitalization benefits for childbirth and length of stay for mothers of newborns at 3% of premium when including the mandate on minimum length of stay.

The Maryland study estimated the marginal costs of all its mandates at 2.2% of premium. The two most expensive were for in vitro fertilization with a marginal cost equal to 0.6% of premium and mental illness and substance abuse with a marginal cost equal to 0.5% of premium. (MHCC, 2008)

Cost Impact of Allowing Limited-Mandate Policies to be Offered in the Group and Individual Markets

The impact of allowing out-of-state carriers to offer limited-mandate insurance products in California could result in lower premiums for Californians in all segments of the insurance market. In a previous analysis of AB 1214, which also would have allowed carriers to offer limited-mandate policies, CHBRP estimated that premium reductions of up to 4% or 5% could be achieved statewide. However, these estimates assumed that the carriers offering these limited-

mandate benefits were existing carriers in the California market. An analysis of the across-state-lines proposal that was the basis of Sen. McCain's proposal for health reform during his 2008 presidential campaign concluded that such a proposal would not necessarily lower premiums because of the large discounts available to large in-state insurers (Bertko et al., 2008). It is not clear how quickly California's largest insurers, which are for-profit (with the exception of Kaiser and Blue Shield of California), might establish out-of-state domiciles in order to offer limited-mandate policies in California. Or, whether other insurers from outside the state would be able to compete effectively with insurers currently licensed in California, which would be able to establish out-of-state domiciles to protect their market share. Because of this uncertainty, CHBRP's analysis of the potential cost impacts of SB 92 includes two scenarios, representing hypothetical maximum and low-impact estimates.

Potential market response by carriers to exemption from licensure in California

In-state carriers

Carriers currently domiciled and licensed in California (in-state carriers) would be allowed to offer limited-mandate policies to individuals with incomes les than 350% of the FPL. In-state carriers may move their base or "domicile" to another state if they considered it advantageous to compete with other carriers that offer products not subject to California regulations in all markets.

These carriers would not be expected to stop developing, marketing, or selling health insurance products subject to state regulation. Carriers licensed by DMHC would be expected to continue to offer Knox-Keene controlled managed care products, especially to large- or mid-sized groups that may demand a state-regulated product that comes with a comprehensive set of benefits and predictable provider network. Carriers who hold a certificate of authority from the CDI would continue to offer leaner policies since CDI projects are not subject to the mandate to cover maternity costs or hospitalization.

Out-of-state carriers currently licensed in California

Carriers currently domiciled and licensed in another state (out-of-state carriers) would be allowed to offer, sell, or renew a health insurance policy in California. These carriers would be likely to sell products in California that would be most competitive in the small employer group market and the individual market. These out-of-state policies would tend to be lower in cost than those sold by in-state carriers because the state of domicile allows for the development, marketing, and modification of products with minimal insurance requirements, regulatory review, or oversight. Out-of-state carriers that currently have a presence in California—meaning they currently have contracts with providers and already have a share of enrollment—would be well-positioned to develop, market, and sell out-of-state policies under SB 92.

Out-of-state carriers not currently licensed in California

Out-of-state carriers not currently licensed in California would be permitted to sell out-of-state policies in California. These carriers may not have the same market presence and ability

to obtain advantageously priced contracts with providers in the same way carriers that already have a presence in California are able to, especially for managed care products, which tend to offer comprehensive benefits with defined provider networks. Carriers currently licensed in California are able to negotiate substantial discounts with provider networks because of such factors as the number of beneficiaries they may bring to the providers, their experience in negotiating with specific provider networks and vice versa, and because of economies of scale in administration of arrangements between health plans and provider networks. In this analysis, Scenario 1 assumes that out-of-state carriers would have an immediate impact on all market segments, whereas Scenario 2 assumes that out-of-state carriers would have a more limited impact on the individual market only.

Market share, offer rates, scope of benefits offered, and take-up rates

The ultimate cost impact of SB 92 would depend on how large a market share the new limited-mandate plans capture, as well as the average premium savings that can be achieved by these plans. Because SB 92 is likely to increase the availability of health insurance products with lower premiums relative to the current market, economic theory and research evidence predict that some portion of the currently insured market would switch to these lower-cost plans (known as a substitution effect). Economic theory and evidence also indicate that some individuals who are currently uninsured would be able to purchase insurance because it is now more affordable (known as an income effect). In the group market, the impact of SB 92 would depend on the market share achieved by these limited-mandate plans, which in turn depends on the proportion of employers that offer these plans (i.e., the offer rate) and the proportion of employees who enroll in these plans when offered (i.e., the take-up rate). In the individual market, the impact of SB 92 on the market share of limited-mandate plans would depend solely on the take-up rate of individuals.

Evidence suggests that large-group employers who purchase health insurance also generally offer fairly generous benefit packages. For example, based on CHBRP's survey of the largest health insurers in California, 99.50% of covered lives in the large-group market have comprehensive benefit packages (i.e., those with deductibles lower than $1,100 per individual per year). In the small-group market (i.e., employers with 2 to 50 employees), the vast majority (77.67%) of employees have comprehensive benefit packages; although in the CDI-regulated small-group market, about 60% of employees have HDHPs.

HDHPs, which represent a less comprehensive benefit package because of the high deductibles and copayments, have a considerable market share in the individual market in California. About 45.03% of covered lives in the DMHC-regulated individual market and about 64.16% in the CDI-regulated individual market in California have HDHPs. The large market share of HDHPs in the individual market suggests that purchasers in this market segment are responsive to the lower premiums associated with HDHPs. This is not surprising, given the fact that these purchasers do not receive an employer contribution toward their premium.

Description of Scenario Analysis

In its analysis of SB 92, CHBRP does not attempt to predict the offer rates of employers or the take-up rates of individuals in the group market or individual market. Instead, the maximum-

impact hypothetical scenario (Scenario 1) and the low-impact hypothetical scenario (Scenario 2) make assumptions about the potential impact of SB 92 if limited-mandate plans replaced full-mandate plans in every segment of the insurance market with one exception. Beneficiaries of public insurance programs for the low-income and uninsured were assumed to be exempt from SB 92 because the administering state agencies require participating contractors to follow the scope of benefits in the DMHC-regulated plans. Specifically, in Scenario 1, CHBRP assumes that limited-mandate plans would replace full-mandate plans in each of the four major market segments (DMHC-regulated group, CDI-regulated group, DMHC-regulated individual, and CDI-regulated individual), and for both HDHP and non-HDHP policies within those market segments. This scenario is a high-impact estimate because it assumes a 100% offer rate of limited-mandate HDHP and non-HDHP policies developed by CHBRP and 100% take-up by all individuals in the group market and individual market. In other words, limited-mandate plans would completely displace full-mandate (comprehensive) plans in every market segment, but there would be no switching between HDHP and non-HDHP policies within market segment. This scenario assumes that current preferences for HDHP and non-HDHP remain constant, and that everyone switches to a limited-mandate version of their current policy in response to the lower premium. This scenario thus represents a maximum hypothetical impact of SB 92, because there is no reason to believe that every insured Californian would switch to a limited-mandate version of their current insurance policy.

Scenario 2 assumes that limited-mandate plans would only become widespread for HDHPs in the CDI-regulated individual insurance market. This hypothetical scenario assumes that in the group market, in-state insurers could prevent effective competition from out-of-state carriers because of the in-state discounts they have negotiated with provider networks, and thus would have no incentive to offer limited-mandate policies in the group market. Furthermore, the large group market currently has a very low penetration rate by HDHPs, so this market segment is assumed to be less price sensitive. While the small-group market is more likely to be price sensitive, this scenario focuses on the individual market because SB 92 allows in-state carriers to offer limited-mandate policies only to those with incomes <350% FPL in the individual market. As a result, in-state carriers would have an incentive to compete for market share with out-of-state carriers in this market segment. Furthermore, this scenario assumes that everyone with income <350% FPL in the individual market currently has a CDI-regulated HDHP policy. This assumption is reasonable based on analysis of income and insurance status information from CHIS 2007 and because CDI-regulated HDHP policies are currently the most affordable policies available in the individual market. This scenario is a low-impact estimate, because it assumes that only individuals who have demonstrated a willingness to purchase lower-cost, less comprehensive insurance plans would switch to even lower-cost, limited-mandate plans. Although Scenario 2 is limited to those who currently have HDHPs within the CDI-regulated individual market, it still is likely to overestimate the response within that market segment because it assumes 100% take-up by individuals with HDHPs in the CDI-regulated individual market.

These two scenarios were developed based on CHBRP analysis of the research literature, market trends, and lessons from other states that have attempted to make health insurance more affordable by allowing insurance policies that are exempt from benefit mandates. For example, the research literature and experts generally report that self-insured employers, who are exempt from state benefit mandates, typically offer generous benefit packages (CHCF, 2006b).

Therefore, CHBRP's analysis assumes that self-insured employers would remain self-insured under SB 92.

Price of Prototype Benefit Packages that Would Become Available in the DMHC- and CDI-Regulated Markets

Table 5 presents the estimated reduction in premiums associated with the prototype plans developed for Scenario 1. The second column shows the baseline premiums in each market segment. These are the baseline estimates CHBRP uses in all of its analyses. The third column shows the reduction in per member per month (PMPM) premium costs associated with the exclusion of currently mandated benefits. Finally, the fourth column shows the percent reduction in premiums that would result from the limited-mandate plans.

Table 5. Scenario 1: Comparison of Comprehensive-Mandate Plans and SB 92 Limited-Mandate Plans, by Market Segment

Market Segment	Premiums For Comprehensive Mandate Plans (Baseline) (1) (PMPM)	Reduction due to Limited-Mandate Plans (PMPM)	Reduction due to Limited-Mandate Plans (%)
Large Group Not HDHP, CDI	$441.93	$23.89	5.4%
Small Group Not HDHP, CDI	$409.62	$18.33	4.5%
Individual Not HDHP, CDI	$171.57	$12.75	7.4%
Large Group Not HDHP, DMHC	$349.91	$17.62	5.0%
Small Group Not HDHP, DMHC	$329.95	$14.76	4.5%
Individual Not HDHP, DMHC	$345.62	$13.57	3.9%
Large Group HDHP, CDI	$409.63	$22.27	5.4%
Small Group HDHP, CDI	$296.26	$13.22	4.5%
Individual HDHP, CDI	$168.00	$11.71	7.0%
Large Group HDHP, DMHC	$270.29	$11.53	4.3%
Small Group HDHP, DMHC	$212.38	$7.53	3.5%
Individual HDHP, DMHC	$312.92	$9.14	2.9%

Source: California Health Benefits Review Program, 2009.
Notes: Scenario 1 applies to all market segments in this table. In other words, it works from the assumption that the entire insured population would enroll in limited-mandate plans following enactment of SB 92. See Appendix F for more details regarding the prototype plans used in this analysis. This table strictly prices out the premium difference in the benefit packages. (1) Baseline benefit premiums are those included in CHBRP's 2009 Cost Model and include coverage of benefits typical of DMHC and CDI-regulated plans in the current market.

Estimated Impacts of SB 92: Using the Hypothetical Scenario Analysis

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

- Under this hypothetical scenario, total expenditures among the newly insured population would decline by $2,214 billion, a reduction of 2.63%. This overall reduction in expenditures includes a shift in costs from insurer to insured of $1.657 billion for benefits currently mandated that would no longer be covered. Note that if a health care service is no longer covered, CHBRP does not assume it would no longer be performed. Instead, CHBRP assumes that the utilization of newly uncovered services would drop by approximately 50%.

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

- The combined effect on overall health expenditures, therefore, of this scenario would be a reduction of $1.985 billion, or 2.12%.

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

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

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

- The combined effect on overall health expenditures of this scenario would be a reduction of $71.582 million, or 0.08%.

Table 6. .Scenario 1: Per Member Per Month Premium and Expenditures Before Enactment of SB 92, by Market Segment, California, 2009

	DMHC- Regulated							CDI- Regulated			Total Insured	Un-insured	Total Insured and Uninsured
	Large Group	Small Group	Indi-vidual	CalPERS (b) HMO	Medi-Cal (c) Managed Care 65 and Over	Medi-Cal (c) Managed Care Under 65	Healthy Families Managed Care	Large Group	Small Group	Indi-vidual	(Annual Cost)		(Annual Cost)
Total Population in Plans Subject to State Regulation (a)	11,100,000	2,844,000	966,000	820,000	159,000	2,366,000	715,000	400,000	932,000	1,038,000	21,340,000	4,847,000	26,187,000
Total Population in Plans Subject to SB 92	11,100,000	2,844,000	966,000	820,000	0	0	0	400,000	932,000	1,038,000	18,100,000	4,847,000	22,947,000
Average Portion of Premium Paid by Employer	$279.83	$246.48	$0.00	$321.26	$239.00	$128.09	$74.97	$341.25	$288.13	$0.00	$58,443,353,000	$0.00	$58,443,353,000
Average Portion of Premium Paid by Employee	$69.94	$71.52	$330.89	$56.69	$0.00	$0.71	$10.22	$97.61	$54.11	$169.28	$19,440,350,000	$0.00	$19,440,350,000
Total Premium	$349.77	$318.00	$330.89	$377.95	$239.00	$128.80	$85.19	$438.86	$342.24	$169.28	$77,883,703,000	$0.00	$77,883,703,000
Member expenses for covered benefits (Deductibles, copays, etc)	$18.90	$24.61	$54.10	$19.49	$0.00	$0.59	$2.32	$53.72	$124.95	$41.39	$6,384,077,000	$0.00	$6,384,077,000
Member expenses for benefits not covered	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0	$158.10	$9,195,770,000
Total Expenditures	$368.67	$342.62	$385.00	$397.44	$239.00	$129.39	$87.51	$492.58	$467.19	$210.66	$84,267,780,000	$158.10	$93,463,550,000

Source: California Health Benefits Review Program, 2009.

Notes: (a) The population includes individuals and dependents in California who have private insurance (group and individual) or are enrolled in CalPERS HMO. All population figures include enrollees aged 0 to 64 years and enrollees 65 years or older covered by employment-based coverage. (b) Of these CalPERS members, about 59% are state employees. (c) Medi-Cal state expenditures for members under 65 years of age include expenditures for the Major Risk Medical Insurance Program (MRMIP) and the Access for Infants and Mothers (AIM) program. Medi-Cal expenditures for members over 65 years of age include those with Medicare coverage. (d) Total expenditures by the uninsured are assumed to be equal to what the insured population expends for health care services **not** covered by insurance plus 50% of what the insured population expends for health care services that **are** covered by insurance. *Key*: DMHC = California Department of Managed Care, CDI = California Department of Insurance, CalPERS = California Public Employees' Retirement System; HMO = health maintenance organization and point of service plans.

Table 7. Scenario 1: Per Member Per Month Premium and Expenditures After Enactment of SB 92, by Market Segment, California, 2009

	DMHC- Regulated							CDI- Regulated			Uninsured Pre-Mandate	Total Insured	Uninsured	Total Insured and Uninsured
	Large Group	Small Group	Indi-vidual	CalPERS (b) HMO	Medi-Cal (c) Managed Care 65 and Over	Medi-Cal (c) Managed Care Under 65	Healthy Families Managed Care	Large Group	Small Group	Indi-vidual	Insured Post-Mandate	(Annual Cost)	Pre- and Post-Mandate	(Annual Cost)
Total Population in Plans Subject to State Regulation (a)	11,100,000	2,844,000	966,000	820,000	159,000	2,366,000	715,000	400,000	932,000	1,038,000	99,000	21,439,000	4,748,000	26,187,000
Total Population in Plans Subject to SB 92	11,100,000	2,844,000	966,000	820,000	0	0	0	400,000	932,000	1,038,000	99,000	18,199,000	4,748,000	22,947,000
Average Portion of Premium Paid by Employer	-$14.09	-$10.85	$0.00	-$16.18	$0.00	$0.00	$0.00	-$18.46	-$12.96	$0.00	$233.44	-$2,362,459,000	$0.00	-$2,362,459,000
Average Portion of Premium Paid by Employee	-$3.52	-$3.18	-$11.57	-$2.86	$0.00	$0.00	$0.00	-$5.28	-$2.44	-$12.08	$83.25	-$844,155,000	$0.00	-$844,155,000
Total Premium	-$17.61	-$14.03	-$11.57	-$19.03	$0.00	$0.00	$0.00	-$23.74	-$15.41	-$12.08	$316.69	-$3,206,614,000	$0.00	-$3,206,614,000
Member expenses for covered benefits (Deductibles, copays, etc)	-$0.95	-$1.06	-$1.73	-$0.98	$0.00	$0.00	$0.00	-$2.91	-$5.60	-$2.95	$27.03	-$273,774,000	$0.00	-$273,774,000
Member expenses for benefits not covered	$8.27	$6.19	$4.83	$8.58	$0.00	$0.00	$0.00	$11.53	$8.73	$5.51	-$150.35	$1,496,164,000	$0.00	$1,496,164,000
Total Expenditures	-$10.29	-$8.89	-$8.47	-$11.44	$0.00	$0.00	$0.00	-$15.11	-$12.28	-$9.53	$193.37	-$1,984,224,000	$0.00	-$1,984,224,000
Percentage Impact of Mandate														
Insured Premiums	-5.04%	-4.41%	-3.50%	-5.04%	0.00%	0.00%	0.00%	-5.41%	-4.50%	-7.14%	N/A	-4.12%	0.00%	-4.12%
Total Expenditures	-2.79%	-2.60%	-2.20%	-2.88%	0.00%	0.00%	0.00%	-3.07%	-2.63%	-4.52%	122.31%	-2.35%	0.00%	-2.12%

Source: California Health Benefits Review Program, 2009.
Notes:See notes to Table 6. .

Table 8. Scenario 2: Per Member Per Month Premium and Expenditures Before Enactment of SB 92, by Market Segment, California, 2009

	DMHC- Regulated							CDI- Regulated			Total Insured	Un-insured	Total Insured and Uninsured
	Large Group	Small Group	Indi-vidual	CalPERS (b) HMO	Medi-Cal (c) Managed Care 65 and Over	Medi-Cal (c) Managed Care Under 65	Healthy Families Managed Care	Large Group	Small Group	Indi-vidual	(Annual Cost)		(Annual Cost)
Total Population in Plans Subject to State Regulation (a)	11,100,000	2,844,000	966,000	820,000	159,000	2,366,000	715,000	400,000	932,000	1,038,000	21,340,000	4,847,000	26,187,000
Total Population in Plans Subject to SB 92	11,100,000	2,844,000	966,000	820,000	0	0	0	400,000	932,000	1,038,000	18,100,000	4,847,000	22,947,000
Average Portion of Premium Paid by Employer	$279.83	$246.48	$0.00	$321.26	$239.00	$128.09	$74.97	$341.25	$288.13	$0.00	$58,443,353,000	$0.00	$58,443,353,000
Average Portion of Premium Paid by Employee	$69.94	$71.52	$330.89	$56.69	$0.00	$0.71	$10.22	$97.61	$54.11	$169.28	$19,440,350,000	$0.00	$19,440,350,000
Total Premium	$349.77	$318.00	$330.89	$377.95	$239.00	$128.80	$85.19	$438.86	$342.24	$169.28	$77,883,703,000	$0.00	$77,883,703,000
Member expenses for covered benefits (Deductibles, copays, etc)	$18.90	$24.61	$54.10	$19.49	$0.00	$0.59	$2.32	$53.72	$124.95	$41.39	$6,384,077,000	$0.00	$6,384,077,000
Member expenses for benefits not covered	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0	$158.10	$9,195,770,000
Total Expenditures	$368.67	$342.62	$385.00	$397.44	$239.00	$129.39	$87.51	$492.58	$467.19	$210.66	$84,267,780,000	$158.10	$93,463,550,000

Source: California Health Benefits Review Program, 2009.

Notes: (a) The population includes individuals and dependents in California who have private insurance (group and individual) or are enrolled in CalPERS HMO. All population figures include enrollees aged 0 to 64 years and enrollees 65 years or older covered by employment-based coverage. (b) Of these CalPERS members, about 59% are state employees. (c) Medi-Cal state expenditures for members under 65 years of age include expenditures for the Major Risk Medical Insurance Program (MRMIP) and the Access for Infants and Mothers (AIM) program. Medi-Cal expenditures for members over 65 years of age include those with Medicare coverage. (d) Total expenditures by the uninsured are assumed to be equal to what the insured population expends for health care services **not** covered by insurance plus 50% of what the insured population expends for health care services that **are** covered by insurance.

Table 9. Scenario 2: Per Member Per Month Premium and Expenditures After Enactment of SB 92, by Market Segment, California, 2009

	DMHC- Regulated							CDI- Regulated			Uninsured Pre-Mandate	Total Insured	Un-insured	Total Insured and Uninsured
	Large Group	Small Group	Indi-vidual	CalPERS (b) HMO	Medi-Cal (c) Managed Care 65 and Over	Medi-Cal (c) Managed Care Under 65	Healthy Families Managed Care	Large Group	Small Group	Indi-vidual	Insured Post-Mandate	(Annual Cost)	Pre- and Post-Mandate	(Annual Cost)
Total Population in Plans Subject to State Regulation (a)	11,100,000	2,844,000	966,000	820,000	159,000	2,366,000	715,000	400,000	932,000	1,038,000	5,000	21,345,000	4,842,000	26,187,000
Total Population in Plans Subject to SB 92	11,100,000	2,844,000	966,000	820,000	0	0	0	400,000	932,000	1,038,000	5,000	18,105,000	4,842,000	22,947,000
Average Portion of Premium Paid by Employer	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0	$0.00	$0
Average Portion of Premium Paid by Employee	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	-$7.51	$156.29	-$84,213,000	$0.00	-$84,213,000
Total Premium	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	-$7.51	$156.29	-$84,213,000	$0.00	-$84,213,000
Member expenses for covered benefits (Deductibles, copays, etc)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	-$1.84	$38.17	-$20,568,000	$0.00	-$20,568,000
Member expenses for benefits not covered	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$3.40	-$152.81	$33,145,000	$0.00	$33,145,000
Total Expenditures	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	-$5.95	$41.65	-$71,635,000	$0.00	-$71,635,000
Percentage Impact of Mandate														
Insured Premiums	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-4.44%	N/A	-0.11%	0.00%	-0.11%
Total Expenditures	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-2.83%	26.35%	-0.09%	0.00%	-0.08%

Source: California Health Benefits Review Program, 2009.
Notes: See notes to Table 8.

Potential Public Health Impacts

SB 92 would likely result in both health benefits and harms to the California population. Using the scenario analyses presented in the previous section, the primary benefit could be an expansion of the insured population to an estimated 5,000 to 99,000 persons. Research has shown that having health insurance is associated with increased health care consumption and better health. 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 (Freeman et al., 2008; Hadley et al., 2003). 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 (Lave et al., 1998). 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.

While the benefits of having health insurance are clear, having less comprehensive or limited-mandate health insurance exposes individuals to the financial and health risks of becoming *underinsured* if insurers drop coverage for effective health services currently mandated in California. Researchers have found that being underinsured (having high out-of-pocket medical expenses even though one is insured) is associated with having unmet health care needs and not complying with recommended treatments (Schoen et al., 2008). Using the projections from the hypothetical scenarios, SB 92, could result in 666,000 to 18,100,000 previously insured persons moving from a plan with mandated benefits to one where coverage of mandated benefits is no longer required. With out-of-pocket expenditures potentially increasing for this population to between $42 million and $1.7 billion, these insured have an increased risk of foregoing treatment for services no longer covered under limited-mandate plans. Additionally, it is possible that persons moving to limited-mandate plans could develop a preexisting medical condition that would exclude them from moving back to a plan with increased benefits.

In order to assess the public health impact if coverage for a particular benefit was dropped, three criteria were used. First, the medical effectiveness findings were used to determine if the benefit was effective. Benefits with "clear and convincing" evidence or a "preponderance" of evidence of their medical effectiveness were considered effective. For those benefits where there was evidence of "no impact," a conclusion of **no impact on public health** was drawn. For benefits where there was either "insufficient" or "ambiguous" medical effectiveness evidence or no prevalence data, a conclusion of **unknown** impact on public health was drawn.

The second criterion examined is the scope of the public health problem associated with the benefit. Public health scope was assessed using prevalence data and three categories are reported: **broad** public health scope for conditions affecting a large segment of the population (1 in 20 persons or more), **moderate** public health scope affecting between 1 in 2,000 and 1 in 20 persons, and **limited** public health scope affecting a more limited segment of the population (1 in 2,000 or less). The third criterion is the type of public health impact, defined in terms of **mortality** or **morbidity** impact. Mortality (rates of death within a population) and morbidity (rates of the incidence and prevalence of disease) are commonly used measures for health status in a community.

For each of the California mandates, *Appendix C* details the medical effectiveness conclusion, public health scope, morbidity/mortality health outcomes, relevant gender or racial/ethnic disparities, and conclusion about the potential public health impact if the mandated benefit would be dropped from insurance coverage. Table 10 details the current California mandates that have expected public health impacts if coverage was to be dropped from health insurance plans.

Table 10. Summary of Public Health Scope and Type of Impact for Current California Mandates

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

One mandate with evidence of **no impact on public health** if coverage is dropped is screening the blood lead levels of children at average risk for lead poisoning. Additionally, a number of mandates have an **unknown impact on public health** if coverage is dropped, including tests for screening and diagnosis of prostate cancer, transplantation services for persons with HIV, the

intoxication exclusion, prosthetic devices for persons who have had a laryngectomy, special footwear for persons with diabetes, reconstructive surgery for breast cancer, and reconstructive surgery for clubfoot and craniofacial abnormalities.

When reviewing the estimated public health impact of California's mandated benefits, another important issue to consider is the likelihood that health insurance products would drop coverage for a particular benefit if they are allowed to under SB 92. *Appendix F* details the expected limited-mandate plans that would be offered by insurance carriers if SB 92 were to be enacted. Comparing *Appendix F* to the mandates in Table 10, Table 11 details the medically effective benefits (based on medical effectiveness review) most likely to be dropped from coverage in health plans under SB 92. The mandated benefits likely to be dropped with the broadest public health impact related to mortality are alcoholism treatments and parity in coverage for severe mental illness/coverage for mental and nervous disorders. Other mandates related to mortality impacts include phenylketonuria (PKU) treatment with medical formula and foods and expanded alpha-fetoprotein screening (AFP). Prescription contraceptive devices have morbidity impacts of **broad public health scope**. Mandates with morbidity impacts of **moderate public health scope** include acupuncture, infertility treatments, jawbone or associated bone joint surgery, and orthotics and prosthetics, special footwear for persons with rheumatoid arthritis, and general anesthesia for dental procedures. The mandate for home care services for elderly and disabled adults has a morbidity impact of **limited public health scope**.

Table 11. Public Health Impact for Benefits Most Likely to be Dropped From Health Plans Under SB 92

Benefit	Medical Effectiveness Conclusion	Public Health Scope	Premature Death/ Mortality Outcomes	Potential Public Health Impact if Dropped
Alcoholism treatments	*Clear and convincing evidence* that pharmacological and psychosocial treatments are effective in treating alcohol dependence	7.8% of Californians report alcohol abuse or dependence in the past year	There are nearly 3,700 alcohol-induced deaths in California each year as well as 1,400 alcohol-related traffic fatalities	Mortality impact of broad public health scope
Parity in coverage for severe mental illness; Coverage for mental and nervous disorders	*Clear and convincing evidence* that medications and psychotherapy are effective in treating mental illness	6.35% of non-institutionalized population (over 2 million Californians)	There are an estimated 2,700 mental illness–related suicides each year in California	Mortality impact of broad public health scope
Phenylketonuria treatment with medical formula and foods	*Preponderance of evidence* that screening and treatment are effective in identifying children with PKU and reducing the severity of the associated mental and behavioral disorders	The prevalence of classic PKU is one in 27,000 births – this translates into 15-18 PKU births each year 450 children have been diagnosed since 1980	Women with PKU who become pregnant are at higher risk of spontaneous abortions if their PKU is not well managed	Mortality impact of limited public health scope
Expanded alpha-fetoprotein screening (AFP)	*Preponderance of evidence* that AFP tests detect likelihood of fetal Down syndrome at a rate of 70% to 80%	Down syndrome occurs at a rate of 1.51 per 1,000 births which translates into approximately 830 cases/year in California	10% of babies born with Down syndrome die before age 1	Mortality impact of limited public health scope

Table 11. Public Health Impact for Benefits Most Likely To Be Dropped From Health Plans Under SB 92 (Cont'd)

Benefit	Medical Effectiveness Conclusion	Public Health Scope	Premature Death/ Mortality Outcomes	Potential Public Health Impact if Dropped
Prescription contraceptive devices	*Clear and convincing evidence* that prescription contraceptives are more effective than nonprescription contraceptives for preventing pregnancy	Nearly 1 million insured females of reproductive age in California use prescription contraceptives	Contraceptives use does not lead to a reduction in premature death	Morbidity impact of broad public health scope
Acupuncture	*Preponderance of evidence* suggests that acupuncture is effective in reducing pain and functioning in persons with a variety of conditions	In California, it is estimated that 2.4% of insured adults have used acupuncture in the past year	Premature death is not an outcome typically associated with the conditions for which people get acupuncture	Morbidity impact of moderate public health scope
Infertility treatments	*Clear and convincing evidence* that diagnosis and treatment of male and female infertility are effective in improving pregnancy rates	15.1% of married females aged 15 to 44 years have impaired fecundity (i.e., ability to get pregnant or carry a baby to term), half of which (7.4%) are classified as infertile (not pregnant within 12 months)	Premature death is not an outcome associated with infertility treatments	Morbidity impact of moderate public health scope
Jawbone or associated bone joints – surgery	*Preponderance of evidence* suggests that surgical treatment for TMJ results in reduced pain	It is estimated that 1 million people in CA have TMJ disorders and 150,000 to 300,000 receive treatment annually	The reduction in premature death is not an outcome associated with jawbone or associated bone joint pain	Morbidity impact of moderate public health scope

Table 11. Public Health Impact for Benefits Most Likely To Be Dropped From Health Plans Under SB 92 (Cont'd)

Benefit	Medical Effectiveness Conclusion	Public Health Scope	Premature Death/ Mortality Outcomes	Potential Public Health Impact if Dropped
Orthotic and prosthetic devices and services	*Preponderance of evidence* that orthoses and prostheses are effective for some conditions	O&P devices were used by the insured population nationally in 2004, for a utilization rate of 40.4 procedures per 1,000 persons	Premature death is not an outcome typically associated with the utilization of O&P devices	Morbidity impact of moderate public health scope
Special footwear for persons suffering from foot disfigurement	*Preponderance of evidence* that special footwear is effective for persons with rheumatoid arthritis	Approximately 0.49% of the insured population under age 65 have been diagnosed with rheumatoid arthritis Special footwear is used by 30% to 60% of persons with this condition	The extent to which the utilization of special footwear for persons suffering from foot disfigurement reduces premature death is unknown	Morbidity impact of moderate public health scope for persons with rheumatoid arthritis
General anesthesia for dental procedures	Professional consensus that the use of general anesthesia is effective for young children, people with anxiety, or those with mental or physical limitations, and those needing extensive dental care	It is estimated that 2.8% of adults in the United States get general anesthesia for dental procedures	Gender or racial/ethnic disparities in the use of general anesthesia for dental procedures is unknown	Morbidity impact of moderate public health scope[42]

[42] There were no studies found on the effectiveness of general anesthesia for dental procedures. However, since the professional consensus is that it is effective for specific populations, we determined that there would be a public health impact if coverage was dropped, making an exception to the criteria requiring the level of evidence to be either "clear and convincing" or "a preponderance of evidence."

Table 11. Public Health Impact for Benefits Most Likely To Be Dropped From Health Plans Under SB 92 (Cont'd)

Benefit	Medical Effectiveness Conclusion	Public Health Scope	Premature Death/ Mortality Outcomes	Potential Public Health Impact if Dropped
Home health care	*Clear and convincing evidence* that home health care leads to better outcomes for elderly and disabled patients	The rate of current home health care use in the under 65 population across the U.S. is 16.4 per 100,000; this represents 29.5% of home health care patients	Overall, home health care resulted in a non-significant decrease in mortality relative to usual care	Morbidity impact of limited public health scope

Gender, Racial, and Ethnic Disparities

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

In California, racial disparities in health insurance coverage are also important where racial and ethnic minorities are more likely to be low income and more likely to be uninsured compared to whites (CHIS, 2007). As a result, among the 5,000 to 99,000 estimated newly insured, a larger proportion of minorities compared to whites could change from being uninsured to insured under SB 92. It is important to note, however, that coverage under SB 92 policies would likely attract low-risk enrollees rather than those uninsured with chronic or high-risk conditions.

PART II: POTENTIAL IMPACTS OF EXEMPTING OUT-OF-STATE CARRIERS FROM CALIFORNIA LAWS AND REGULATIONS

SB 92 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 DMHC or without a certificate of authority issued by the CDI. Under this proposal, an insurer would have to follow the laws and regulations in the state where it is based or "domiciled"—not the rules of California where the consumer or policyholder lives.

This section describes the potential impacts of exempting carriers from California health insurance rules, specifically those rules related to consumer protections (such as provider access standards, independent external reviews), financial solvency, and cost and availability (such as small group guaranteed issue and restrictions on medical underwriting).

Not only would the carriers' health insurance products be allowed to exclude legislatively imposed benefit mandates (as discussed in Part I of this report), but the carrier's themselves would be exempt from the laws and regulations imposed on "in-state carriers" codified in the statute or regulation.

The intent of SB 92 is to allow for the development, marketing, and purchasing of health insurance products licensed outside of California, thereby sparking innovation and competition among carriers, driving down the cost of available products, and expanding coverage to those who are currently uninsured—especially for those in the small-group or individual markets.

Proponents of similar bills at the federal level state that allowing for the development of plans exempt from state mandates would encourage the market to develop lower-priced products, giving employers and individuals more health plan choices, and forcing state-regulated plans to compete with lower-priced policies (Parente, 2008).

The bill seeks to meet these various policy objectives by effectively repealing all California-specific health insurance requirements, oversight, and regulatory authority of the DMHC and the CDI. The remainder of this report describes the impact of repealing these requirements on the health insurance market in California.

Background and Discussion on Carriers' Domicile

To be "domiciled" in a state means that the insurance company must be headquartered in that state. Currently about two-thirds of privately insured Californians have health insurance through a state-regulated health plans or insurance policies offered by an entity domiciled in California ("in-state carrier"). About one-third of California insured are covered by a carrier domiciled in another state ("out-of-state carrier"). Four of the seven major carriers are currently domiciled outside California. See Table 12 for a summary of where these carriers are currently domiciled and the corresponding share of the California market.

Table 12. California Market Share for Private Health Insurance by Insurer and State of Domicile

Insurer/CA Affiliate	Domicile (headquarters) of Insurer	States in which Insurer is Licensed	CA Market Share (CDI)	CA Market Share (DMHC)	Combined
Kaiser Permanente/Kaiser Foundation Health Plan, Inc.	Oakland, CA	9 states, including California and the District of Columbia	0%	40%	34%
Blue Shield of California/Blue Shield of California and Blue Shield of California Life & Health Insurance Company	San Francisco, CA	California	11%	19%	18%
Wellpoint, Inc./Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company	Indianapolis, IN	14 states, including California	41%	19%	23%
Heath Net, Inc./Health Net of California and Health Net Life Insurance Company	Woodland Hills, CA	Subsidiaries licensed in 50 states and the District of Columbia	10%	9%	9%
United HealthGroup, Inc./PacifiCare of California, PacifiCare Life and Health Insurance Company, and United HealthCare Insurance Company	Minnetonka, MN	Subsidiaries licensed in 50 states and the District of Columbia	9%	8%	8%
Aetna, Inc./Aetna Health of California and Aetna Life Insurance Company	Hartford, CT	Subsidiaries licensed in 50 states and the District of Columbia	11%	4%	4%
CIGNA Corporation/Cigna Healthcare of California	Philadelphia, PA	Subsidiaries licensed in 50 states and the District of Columbia	3%	1%	1%

Source: California Health Benefits Review Program analysis of data from Hoovers Inc. Available at www.hoovers.com. Accessed March 9, 2009; DMHC enrollment data as of 9/30/08; CDI Covered Lives Data Call for expense reimbursement Health Insurance products, 12/07.

DMHC and CDI Regulatory Authority

States are the primary regulators of health insurance companies and health insurance products. California has several laws in place that relate to availability of coverage, consumer protections, access to providers, financial solvency, and risk distribution. This section will summarize these requirements and qualitatively discuss the potential impacts of removing or relaxing these requirements, using the literature on group purchasing arrangements such as AHPs, MEWAs, and similar proposals at the federal level. This literature is instructive because these products or proposals are similar to SB 92 in that they allow for (1) the development of health insurance

products that can be sold across state lines, and (2) a certain level of exemptions from state-specific regulations. This section will also discuss the potential implications of removing health insurance oversight and enforcement authority from California to outside of the state.

During initial licensure and ongoing operations, California regulatory agencies monitor and take corrective action to ensure plans and insurers comply with their requirements related to consumer protections and financial solvency. Exempting insurers from requirements to obtain a Knox-Keene license from the DMHC or a certificate of authority from the CDI would limit the authority of the state in oversight of consumer protection and financial solvency.

The majority of California's health plans are regulated by either the DMHC or CDI. The DMHC regulates HMOs and certain preferred provider organizations (PPOs) (i.e., Anthem Blue Cross or Blue Shield of California) subject to the Knox-Keene Health Care Service Plan Act of 1975, as amended. Health plans apply for and obtain a Knox-Keene license prior to operating in California.

In applying for licensure, a DMHC-regulated health care service plan must submit for review and approval all of the types of plan contracts (policies) it will offer, standard provider contracts and payment methods, proposed advertising and marketing materials, audited financial statements, administrative structure, projections of financial viability, actuarial analyses, and specific proposed service areas.

The CDI regulates point-of-service health plans and certain PPO plans underwritten by disability insurers who sell health insurance products. Disability insurers obtain a certificate of authority from the CDI for the specific line(s) of business they intend to offer prior to conducting insurance business in this state.

The CDI certificate of authority review process involves a detailed operational and financial review. The application process includes review of the company's financial stability, available capital and assets, competency and integrity of ownership and management, claims payment procedures, actuarial certifications, and financial projections.[43]

Neither the DMHC nor the CDI regulate self-insured employer-sponsored plans, which represent about 30% of employer-based coverage in California. All employer-sponsored health plans fall under the jurisdiction of the Employee Retirement Income Security Act (ERISA). ERISA is a federal law that is enforced by the U.S. Department of Labor, Employee Benefits Security Administration (DOL-EBSA). Under ERISA, employer-sponsored plans are subject to minimum standards related to reporting and disclosure, claims processing, and fiduciary duty (Butler and Polzer, 2002). In addition, most states have further consumer protection requirements on employer-sponsored plans that are not self-insured, while self-insured employer-sponsored plans are exempt from most state requirements.[44]

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[43] Insurance Code § 717. CDI requirements to apply for certification of authority are available at www.insurance.ca.gov/0250-insurers/0300-insurers/0100-applications/certificate-of-authority/cert-of-authority-instructions/ca-specific-instruc.cfm.

[44] A self-insured plan is a health plan in which a group—usually a large employer, labor union, or group of employers—assumes financial responsibility for the health care expenses of its enrollees rather than purchasing

California's Consumer Protection Requirements

California currently has a number of patient and consumer protection requirements. Some of these requirements include disclosures, access to services, internal and external grievance review processes, quality assurance, benefit design requirements, and fair claims handling.

- **Consumer disclosure and marketing requirements:** Both the DMHC and the CDI require plans and carriers to disclose information regarding the benefits, services, and terms of the plan contract to provide enrollees with a full and fair disclosure of the provisions of the plan in readily understood language and a clearly organized manner.[45]
- **Access to services:** DMHC monitors and reviews specific guidelines for availability and accessibility of providers (e.g., one primary care physician for every 2,000 enrollees, primary care provider within 30 minutes or 15 miles of residence or work).[46] Plans are required to receive prior approval of networks in each geographic region. The CDI has accessibility regulations for exclusive provider organizations (EPOs).[47]
- **Coverage for categories of enrollees that could be discriminated against:** California has certain laws forbidding health insurers from denying coverage to certain types of enrollees. Plans and insurers cannot deny coverage to persons who are physically or mentally impaired. Additionally, DMHC-regulated plans cannot deny coverage for individuals who are blind or partially blind.
- **Internal grievance review processes:** DMHC-regulated plans are required to maintain an internal plan grievance system to respond to consumer complaints. The DMHC reviews a plan's internal grievance and complaint-handling procedures, including type, frequency, and resolution of complaints during on-site survey.[48] In addition, the DMHC operates the "HMO Help Center," a toll-free consumer complaint hotline, 24 hours a day, 7 days per week. An after-hours answering service can page DMHC health professionals. The CDI does not require insurers to maintain an internal grievance or complaint system. The CDI operates a consumer complaint line for all lines of insurance (e.g., life or auto) weekdays during business hours.
- **External grievance review processes:** Effective January 2001, both departments were legislatively mandated to administer an Independent Medical Review (IMR) program for external independent medical review of plan coverage decisions.[49] The IMR program allows enrollees to appeal denied claims and seek expedited review of denials for particular service (e.g., access to specialty care or a procedure). This process occurs after

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health insurance through an insurance company. However, such a group may contract with an insurance or other company (as a third-party administrator) for claims processing and other administrative services and may purchase stop-loss to limit its liability for medical claims (sometimes incorrectly called "reinsurance"). The DOL does not regulate self-insured health plans that are sponsored through school districts, other municipalities, and churches. The CDI does not regulate self-insured health plans. Consumers who are members of this type of plan may seek a legal remedy through a court of law. (The CDI's lack of jurisdiction over these products is described at www.insurance.ca.gov/0100-consumers/0060-information-guides/0050-health/health-insurance.cfm#hippa).

[45] Health and Safety Code §1363(a); Insurance Code §§10603 and 10604

[46] California Code of Regulations, Title 28, Section 1300.51

[47] Health and Safety Code § 1351(k) and 1367(e); Insurance Code § 10133.5. EPOs are similar to HMOs except they are regulated by the CDI. EPOs require use of their network providers for coverage of services.

[48] Health and Safety Code §§ 1351(I), 1368, 1370.2, 1380(F)

[49] Health and Safety Code §§ 1374.30; 1370.4; Insurance Code § 10145.3

any internal reviews within the plan have been exhausted. This legislation was motivated by people who felt that HMOs might be approving or denying treatment due to concerns about cost to insurers rather than based on medical appropriateness (IMQ, 2002).

- **Quality assurance:** The DMHC reviews internal procedures of plans to review quality of medical care and performance of providers. The DMHC also conducts onsite medical surveys at least once every three years. Both the DMHC and the CDI have standards for utilization review and disclosure requirements.[50]
- **Covered benefits and benefit design:** As discussed in the first part of this report, a number of benefits are mandated for DMHC- and CDI-regulated plans. The DMHC also reviews proposed cost-sharing arrangements under various product lines and may require changes to ensure contracts are "fair, reasonable and consistent with the objectives of the chapter." Benefits cannot be subject to "exclusion, exception, reduction, deductible, or copayment that renders the benefit illusory."[51] For example, for outpatient prescription drug benefits, the DMHC limits cost sharing to 20%. CDI-regulated plans have no such related requirements except that health insurers must cover benefits mandated under the Insurance Code.
- **Fair claims handling:** The DMHC monitors its plans for prompt payment of provider claims. The DMHC has also developed a definition of unfair payment patterns and a system of responding to them (AB 1455, Statutes of 2000). In January 2009, two additional consumer protections took effect. Under AB 1203, noncontracting hospitals are prohibited from billing patients for poststabilization care if the hospital fails to contact the patient's health plan for authorization or give the health plan an opportunity to transfer the patient. On January 8, the California Supreme Court released a unanimous ruling that bars emergency department physicians and hospitals from billing insured patients directly for charges that their health plans refuse to pay. In effect, the ruling bars so-called "balance billing," which typically occurs when insured people seek emergency care from out-of-network physicians and hospitals. Insurers reimburse out-of-network doctors and hospitals at a lower rate, and the health care provider's bill patients for the remainder of the charges in addition to copayments and deductibles. As for CDI-regulated products, the CDI has broad authority to enforce the Insurance Code.[52] As part of their market conduct examinations discussed below, CDI regulators can assess and address the market practices of insurers, including claims handling.[53]
- **Continuation of coverage:** As of January 2009, health plans and insurers are required to permit an individual who was covered under an individual plan contract or health benefit plan that was rescinded, other than the individual whose information led to the rescission, to transfer to any other individual plan contract or health benefit plan offered by that same entity that provides equal or lesser benefits within 60 days without medical underwriting (AB 2569, 2008).

[50] Health and Safety Code §§ 1370, 1380, 1380.1; Insurance Code §§ 101339(d) and 10123.1135
[51] § 1367 CCR Title 28 § 1300.67.4
[52] Insurance Code § 12919-12938
[53] The range of activities that the commissioner may initiate to assess and address the market practices of insurers include underwriting and rating, marketing and sales, complaint handling operations/management, advertising materials, licensing, policyholder services, claims handling, and policy forms and filing.

California's Financial Solvency Requirements

Regulatory agencies take a number of steps to protect consumers and health care providers from disruptions caused by insolvencies. The DMHC requires regular financial filings and conducts on-site financial reviews.[54] To ensure that business is conducted in an honest, open, and fair manner, the CDI conducts onsite review and regulatory examination of claims, financial records, and rating and underwriting practices of all licensed insurers. These are called market conduct examinations.[55]

To ensure that HMOs have sufficient levels of capital, the DMHC requires that each plan meet tangible net equity requirements. PPOs and POS plans licensed by the DMHC are subject to higher tangible net equity standards due to the increased risk of offering out-of-network services (Butler and Polzer, 2002).CDI-regulated insurers must maintain the greater of either risk-based capital standard or a minimum capital and surplus requirement (Butler and Polzer, 2002). Disability insurers are required to maintain reserve levels at the greater of either (1) a minimum of $5 million or (2) 200% of the Risk-Based Capital standards developed by the National Association of Insurance Commissioners (Roth and Kelch, 2001).

If a health plan becomes insolvent, the DMHC may allocate its enrollees to other plans in the area with sufficient capacity and financial resources. Plans must provide care for transferred members.[56] For carriers that present solvency problems, the CDI can take various options, including asking or ordering an insurer to reduce writing new business, reduce operating costs, seek financial support, or consider the use of reinsurance. As a last resort, the CDI will consider taking regulatory control of an insolvent insurer's operations (Butler and Polzer, 2002). In addition, the Insurance Code requires all life and disability insurers to participate in the Life and Health Insurance Guarantee Association, which will assess members to pay the losses (expenses) of people insured by the insolvent insurer.[57]

California has specific requirements prohibiting health plans from engaging in unfair payment practices to providers. Prohibited practices include the failure to process complete and accurate claims, reducing or denying complete and accurate claims, failing to make timely payments for claims, and failing to automatically include interest (AB 1455, SB 1177; 2000).[58] This legislation requires health plans to maintain a dispute resolution mechanism for resolving provider claims payment disputes. In 2003, the DMHC introduced regulations, known as the Claims Settlement Practice and Dispute Resolution Mechanism Regulations, to establish specific standards and safeguards for the timely and accurate payment of claims, and for the establishment of a fast, fair, and cost-effective dispute resolution process (DMHC, 2006).

[54] Health and Safety Code §§ 1376, 1381,1382
[55] www.insurance.ca.gov/0500-about-us/0100-cdi-introduction
[56] Health and Safety Code § 1394.7
[57] Insurance Code § 1067-1067.18
[58] Health and Safety Code §§ 1371.36-1371.39

Potential Impact of Exempting Out-of-State Policies from California's Consumer Protections and Financial Solvency Requirements

SB 92 would exempt out-of-state policies from California consumer protection requirements, and enrollees of such plans would have to contact the domicile state's insurance commissioner to deal with denied claims or other disputes. If disputes were to escalate, enrollees would have to seek resolution in an out-of-state court. Depending on the state, resource constraints—such as time, number of employees, and budget—may prevent regulators from providing assistance to out-of-state consumers and may prevent regulators from enforcing policies (Kofman et al., 2006). Given the size and population of California, its regulatory agencies' capacity is far greater than those of other states in terms of personnel, budget, and resources. For example, the Departments of Insurance in South Dakota and Wyoming have budgets of $1.7 million and $1.9 million, respectively, compared with the CDI's $244 million. In addition, the insurance departments in some states have taken the position that it is not in their jurisdiction to assist consumers who are out of state. Marketing practices are an example: out-of-state policies, depending on where they are domiciled, may be prohibited from solely marketing to a younger and healthier population, but again, enforcing such activities across state lines would be resource intensive.

SB 92 would exempt out-of-state policies from California-specific requirements regarding financial reporting and solvency. All states require insurance products to maintain adequate reserves to be financially solvent and able to pay claims. However, these requirements and the capacity to monitor solvency of their carriers vary across states. In addition, funds that are set up to pay for claims if a carrier becomes insolvent may not cover out-of-state consumers or may not be adequate to pay for all eligible consumers (for example if the carrier is domiciled in a small state with few insurers paying into the insolvency fund). If a claim is denied by an out-of-state carrier, the consumer would need to work with the out-of-state carrier, per their arbitration rules, and potentially the out-of-state regulatory agency if there are applicable external grievance processes in place.

SB 92 would exempt out-of-state policies from California-specific requirements prohibiting health plans from engaging in unfair payment practices to providers. Again, while all states require insurance products to pay claims in a timely fashion, it is unclear whether other states have protections similar to California's.

For products that are self-insured, the DOL is the regulatory agency with oversight authority and, under ERISA, there are no federal solvency rules. However, 28 states, including California under the CDI, also have licensing requirements for self-insured MEWAs. Under these state rules, MEWAs that self-insure are subject to lower levels of solvency requirements than for insured products, and depending on their size and risk pool, are at higher risk of becoming insolvent. From 2001 to 2003, four self-insured MEWAs became insolvent, with 66,000 individuals and small business losing coverage and about $48 million of unpaid claims (Kofman et al., 2006).

Past experience with MEWAs has shown that lack of clear regulatory oversight or inadequate oversight also creates incentives for the rise of fraudulent insurance products (GAO, 1992; GAO, 2004; Kofman et al., 2003). In the mid-1980s, the rise of such insurance scams led Congress to amend ERISA to clarify that states had the authority to regulate MEWAs that self-insure or purchase insured products (GAO, 1992). (As mentioned, 28 states have used the authority to

establish licensing requirements for self-insured products.) A national study found that about 144 fraudulent entities not authorized to sell insurance were mostly posing as plans exempt from state regulations under ERISA. All together, these entities included coverage for about 15,000 employers and 200,000 policyholders—leaving about $252 million in unpaid medical claims (GAO, 2004). As of January 2007, the DOL had 107 civil and 47 criminal cases, related to MEWA enforcement, open for investigation. The DOL states that often these group purchasing arrangements "are nothing more than shams to avoid state insurance regulations" (DOL, 2007). Under SB 92, the current California laws that require insurance policies to be licensed in state would no longer apply, thus potentially exposing consumers and groups—especially small groups—to greater risk of purchasing fraudulent polices that claim to be licensed out-of-state.

Cost and Availability of Health Insurance

SB 92 would allow out-of-state policies to be exempt from California-specific requirements related to the cost and availability of health insurance. These requirements have been designed to allow purchasers of health care to spread the risk of health insurance-related costs to allow access to health insurance for those who might otherwise face high and potentially unaffordable premiums. In the small-group market, these requirements were enacted in 1992 (AB 1672, Margolin, Chapter 1128, Statutes of 1992). When AB 1672 was first enacted, one of its goals was to curtail the insurance industry practice of segmenting risk—that is, providing lower rates to consumers and groups perceived as low-risk (low-cost, usually younger and healthier), while not covering, or charging higher rates to groups perceived as high-risk. This legislation changed insurance underwriting rules and encouraged greater price competition and more uniform benefits among insurers selling to groups of three to fifty persons. The strict underwriting and price limits were designed to provide affordable insurance to persons in high-risk occupations and to prevent "exorbitant" premium increases or termination of coverage due to serious illness (Oliver and Dowell, 1994). The key provisions included (1) limiting medical underwriting based on occupation, health status, or previous claims experience (allowing full reflection only for adjustments due to age, family size, and geographic area; (2) limiting denial of coverage for preexisting condition to one six-month period; (3) establishing narrow "rate bands" so that an insurer must offer to any group a premium that is within 20% of its average premium for that plan; and (4) requiring insurers to guarantee issuance and renewal of all plans (Oliver and Dowell, 1994).

Current Coverage and Availability Requirements

In the small-group market, requirements with respect to the cost and availability of health insurance include premium setting, guaranteed issue, guaranteed renewal, and limits on coverage based on preexisting conditions and continuation of coverage (Kelch, 2005). In the individual market, these requirements are related to guaranteed renewal and limiting coverage based on preexisting conditions (Roth, 2003). Under SB 92, out-of-state policies would remain subject to federal Health Insurance Portability and Accountability Act (HIPAA) requirements (discussed below) or those of their domiciled state if the state sets additional requirements beyond federal floors.

Premium setting

Premium setting requirements place limits on how much carriers may vary rates based on the health status of employees or any other risk factors. The intent of these requirements is to prevent carriers from imposing high, and potentially unaffordable, rates on higher-risk groups, thereby pricing them out of the market. Federal requirements under HIPAA prohibit group health plans (coverage sponsored by employers) from charging different premiums to workers and their dependents based on health-status related factors. Employers may have different premiums based on other factors such as location and employment status (i.e., full-time or part-time). These HIPAA standards, however, do not address the premium rates that insurers set for an employer group. Therefore, although employers cannot charge sick employees higher rates than healthy ones, insurers can charge the employer group with sicker workers a higher rate than an employer group with healthy workers. Most states have adopted premium restrictions, limiting the differences in rates that insurers charge small businesses (2 to 50 employees). Few states apply such restrictions in the individual markets.

Generally, there are two types of premium-setting requirements: community/adjusted community rating and rate bands. Community rating means that insurers must set prices for a policy based on the collective claims experience of everyone with such a policy in the state. In other words, regardless of one's age, gender, occupation, health needs (past and current), claims history, or employer group size, everyone pays the same rate. Insurers would not be allowed to vary rates based on the health status or prior claims experience of a business or individual. California does not require community rating. In the small-group market, for example, most states, including California, allow for rate bands with limits on how much premiums can range for sicker people compared to healthy ones buying that policy. These restrictions also include renewal rates (BCBSA, 2007; Kofman and Pollitz, 2006). California's rate bands are "tighter" than in other states, however. This means that the variation among sick and healthy is smaller in California than in states allowing insurers to vary rates based on health factors. In California, an insurer must offer a small group a premium that varies no more than 10% above or below the standard rate (Roth, 2003). In the individual market, there is no similar limit on premium variations. California law, however, requires that rate increases are not discriminatory and prohibits carriers from setting different rates based on race, religion, ancestry, genetic characteristics, or sexual orientation. CDI-regulated carriers are also required to apply rate increases consistently to individuals in a specific "class" of insured people, such as those sharing the same age, family size, geographic region, or health status (Kelch, 2005).

Guaranteed issue (and nondiscrimination)

Guaranteed issue is the right to buy coverage (regardless of industry, health status, age of employees, or any other risk factors). Guaranteed issue laws prohibit insurers from denying coverage to applicants based on health status related factors. For example, under guaranteed issue requirements health insurance carriers could not reject small groups applying for coverage because one employee has a costly, chronic medical condition.

Prior to HIPAA, most states required insurers to sell two products on a guaranteed issue basis. HIPAA expanded this to all small-group products. HIPAA's nondiscrimination protections apply to all size employers. These protections ensure that an employee or dependent is not denied

access to the group health plan on the basis of a health status related factor, such as claims or current medical needs. It also ensures that people within an employer group are not charged different rates on the basis of health status related factors. HIPAA also regulates insurers' ability to limit coverage for a condition predating plan enrollment (preexisting conditions).

For access to the individual market, HIPAA provides limited protections that apply only to people leaving job-based coverage and meeting specific qualifications. For people who do not qualify as HIPAA-eligible, federal law does not provide a right to purchase an individual health insurance policy.

California, like most states, does not have guaranteed issue requirements in the individual market for initial coverage—carriers may deny coverage based on an individual's health condition (past or present), health status, or any other risk factors. However, once a carrier offers to cover a person, that carrier is prohibited from excluding coverage for a preexisting condition[59] for more than 12 months. If the subscriber changes carriers, the new carrier is required to credit the time of that coverage toward any preexisting condition exclusion (Pollitz et al., 2006).

Guaranteed renewal

Guaranteed renewal is the right to renew coverage (regardless of changes in employee health status or use of services, or any other risk factors). Without such requirements, carriers could drop a group when one or more employees experience a high-cost medical condition. Guaranteed renewal laws prohibit insurers from canceling coverage on the basis of medical claims or diagnosis of an illness. HIPAA established rules that require all group and individual health insurance policies to be guaranteed renewable.

California law also requires health insurance plans marketing to individuals that stop selling coverage or stop enrolling new individuals in a particular product to either offer another product with comparable benefits, services, and terms with no additional underwriting or pool the risk for any discontinued products with other, similar products (Kelch, 2005). This requirement aims to protect individuals who cannot switch to other carriers or other products because of their risk profile. Without any legal protection, those enrolled in a "closed block" of business could end up being clustered in old or discontinued products at more expensive rates (American Academy of Actuaries, 2004; Kelch, 2005).[60]

Continuation of coverage laws

These laws are designed to protect individuals transitioning from group to individual coverage and gaps in coverage when they are changing jobs. Federal requirements under the Consolidated Omnibus Budget Reconciliation Act (COBRA) require groups with 20 or more employees to continue health insurance for employees and their dependents following death of a spouse, loss

[59] A preexisting condition is any illness or health condition for which an insured has received medical advice or treatment during the six months prior to obtaining health insurance (Insurance Code § 10198.7).

[60] It is a commonly observed practice of the current individual health insurance market that an insurer will periodically "close" a block of business (meaning they will no longer issue new business in that pool of policies). There can be many reasons for closing a block of business. Regardless of the reason, that block will typically experience claim costs rising more rapidly than would a block that was still open. More information on the closed block problem is available at www.actuary.org/pdf/health/rate_may04.pdf.

of a job, reduction in hours worked, or divorce. Under "Cal-COBRA," California expanded COBRA to include firms with 2 to 19 employees. California adopted HIPAA requirements for carriers to offer their two most popular products to individuals who are not eligible for COBRA or who have already exhausted their COBRA coverage. Under California law, people who exhaust their COBRA coverage or lose group coverage can purchase "conversion" coverage through the group's carrier. The group's carrier cannot refuse to cover these individuals because of health status or subject them to preexisting condition exclusions. California law also limits the premiums that can be charged for this type of coverage (Butler and Polzer, 2002).

Potential Impact of Exemption from California's Coverage and Availability Requirements

CHBRP reviewed evidence on group purchasing pools to gauge potential impact of SB 92 because certain types of purchasing pools have, at one point, been exempt from state requirements or have been proposed as legislative solutions to reduce premiums and increase choice. The research on group purchasing arrangements is also relevant to SB 92 because this bill relaxes the requirements for to associations to gain the same treatment as "small employers."[61]

Group purchasing arrangements bring different employers or individuals together for the purpose of purchasing health insurance or negotiating provider discounts on behalf of their members. Examples of group purchasing arrangements include purchasing cooperatives and alliances, MEWAs, and AHPs. Such arrangements need to be legally recognized by the state or federal government because, under traditional insurance regulation, multiple employers and individuals are prohibited from forming a group solely for the purpose of buying group insurance.

CHBRP relied on the input of content experts and the literature on group purchasing arrangements such as AHPs, MEWAs, and the development of similar products or proposals at the federal level to summarize the potential impacts of exempting out-of-state policies from California-specific requirements and regulatory oversight by the DMHC and the CDI

Impacts on coverage levels

With respect to products sold across state lines, there have been four quantitative models used for projecting the coverage impacts of AHPs: (1) developed by the analysts at the Congressional Budget Office (CBO); (2) developed by researchers at the Urban Institute, called the Health Insurance Reform Simulation Model (HIRSM); (3) developed by actuaries at Mercer Oliver Wyman; and (4) developed by consultants at The Lewin Group, called the Health Benefits Simulation Model.

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

The CBO model was used to examine the effects of the introduction of AHPs on the insurance market and specifically examined proposals that establish federally certified AHPs and HealthMarts that would not be subject to state insurance regulations (Baumgardner and Hagen, 2001).[62] Researchers found that the introduction of AHPs and HealthMarts would lead to a slight increase in health insurance coverage nationally. They estimated that an additional 330,000 would become newly insured as the net result of 4.6 million individuals who would enroll in those new plans would be partially offset by a decline in the enrollment in state-regulated plans of 4.3 million individuals.

Blumberg and Shen (2004) used the HIRSM model to estimate the impact of various AHP proposals on the California market. Characteristics of AHP provisions, such as those proposed under U.S. House of Representative bill H.R. 660 (2003) or under the U.S. Senate bill S. 545 (2003), were used in the analysis. These AHPs would have been certified by the DOL and, in general, would have been exempt from state benefit mandates or rules on availability of coverage (e.g., guaranteed renewal). Researchers found that there was a less than a 1% increase in new coverage or "virtually no net change in insurance coverage resulting from the availability of this alternative insurance product" (Blumberg and Shen, 2004).

The Mercer evaluation of the federal Health Insurance Marketplace Modernization and Affordability Act of 2006 (S. 1955), conducted for the National Small Business Association (NSBA), projected that the introduction of small business health plans (SBHPs) in the market would result in a net increase of 2 million insured in the small-group market. However, they assumed that specific state requirements and new federal standards would be in place.[63,64] A previous analysis conducted by Mercer of H.R. 660 and S. 545, also conducted for the NSBA, found that elimination of rate setting requirements under those AHP proposals would actually generate a net increase in the number of uninsured in the small-group market, since some groups would have to drop coverage as soon as an employee became sick (and considered high-risk) and their corresponding premiums increased (Fritchen and Bender, 2003).

The Lewin Group's analysis of S. 1955, conducted for the Coalition to Protect Access to Affordable Health Insurance, specifically analyzed the effects of the bill on states with community rating requirements. Since California does not have community rating requirement, the results are not relevant to this report (Lewin Group, 2006).

[62] Other CBO cost estimates on AHP, HealthMarts, and related proposals include CBO, 2000; CBO, 2003; and CBO, 2006. Baumgardner and Hagen (2001) article is summarized here because it includes the most detail regarding the CBO model and discussion on cost and coverage impacts.

[63] Specifically, Mercer assumed that (1) state regulations would remain in place since SBHPs were assumed to be fully insured plans, (2) all SBHPs would be subject to the same premium setting requirements as prescribed under S. 1955, and (3) state-regulated policies would be able to adopt the same federal premiums setting requirements that would apply to the SBHPs. Thus the Mercer evaluation essentially evaluated the effects of eliminating benefit mandates.

[64] Bender K, Fritchen B. Personal communication with Mr. Todd McCracken of the National Small Business Association regarding the Health Insurance Marketplace Modernization and Affordability Act of 2006, dated March 7, 2006.

Impacts on premiums and risk segmentation

The analyses using the CBO and HIRSM models found that the introduction of AHPs in the market resulted in savings in premiums for those individuals who entered the AHPs and an increase for those policyholders who stayed in the insured, fully regulated market. Blumberg and Shen (2004) found a decrease of 14% of insurance premiums for the AHP policyholders and an increase of 5% for the policyholders in the insured fully regulated market. Baumgardner and Hagen (2001) found a 2% increase for those remaining in the insured, fully regulated market, and a 13% difference between the premiums offered to AHP policyholders versus those in the insured market. The savings in premiums for AHP policyholders is attributed to both regulatory relief from state regulations as well as selection of better (low-cost) risk. Conversely, increased premiums in the state-regulated market are due to adverse selection of the worst (high-cost) risk with fewer low-cost enrollees to spread the risk. The Mercer evaluation of H.R. 660 and S. 545 concurred, finding that small-group AHPs would reap a 10% decrease in premiums but those decreases primarily resulted from risk selection. By contrast, small-group plans in the state-regulated market would face a 23% increase in premiums (Fritchen and Bender, 2003).

The Health Care Choice Act of 2005 (H.R. 2355) was a federal proposal similar to SB 92—it would have allowed individuals buying insurance in the individual market to do so from an entity licensed in another state. The out-of-state individual health policy would have been exempt from laws and regulations of the enrollee's residence state that are related to consumer protections, mandated benefits, and other requirements related to guaranteed issue, renewal, and limits on covering preexisting conditions.[65] CBO estimates showed that the price of individual policies in the resident state would increase as a result of H.R. 2355, since higher-risk individuals would not be offered insurance from out-of-state policies. CBO also projected that small-group markets in resident states would have incentives to stop offering coverage since more affordable out-of-state products would be available to their low-risk employees in the individual market and the remaining high-risk employees would be too costly to insure. This dynamic, the CBO estimated, would lead to about 1 million small-group enrollees losing health insurance coverage. However, low-risk individuals who were uninsured would obtain low-cost, out-of-state individual policies, offsetting those who lost insurance. Although the characteristics of the insured population could change, with low-risk individuals gaining insurance coverage and high-risk individuals losing coverage, the net effect with respect to the number of insured would be insubstantial (CBO, 2005). Kofman and Pollitz (2006) found that H.R. 2355 could leave carriers in the states with guaranteed issue requirements with only the sick enrollees who would need access to comprehensive coverage. Although California does not have guaranteed issue requirements in the individual market, state-regulated policies that are required to provide comprehensive health coverage under Knox-Keene requirements would face adverse selection, driving up the cost of coverage for those left in those individual policies.

Impacts on market stability

If SB 92 were to pass, large- and mid-sized employer groups would need to evaluate what products would provide them value for the premiums they expend. California is unusual in that a smaller proportion of private sector employer-sponsored health plans choose to self-insure. Instead, most employer-sponsored plans purchase insured plans that are subject to state

[65] H.R. 2355 would have required minimal capital and surplus levels to ensure solvency.

requirements (30% of employees in California are in self-insured plans versus 55% of employees nationally [KFF/HRET, 2008]). Employers choose to do so, in part, because managed care penetration in California had kept the cost of purchasing comprehensive health care coverage relatively low (Butler and Polzer, 2002). If fewer California-regulated products are offered in the commercial market, it is expected that over time, more large groups, and perhaps even mid-sized groups, might choose to self-insure rather than purchase an out-of-state policy. This would be likely to occur if the state-regulated purchased products charged higher and higher premiums, due to adverse selection. Out-of-state policies might not be an attractive alternative if they did not have the kind of generous benefit packages that large-groups tend to demand (Jensen and Morrisey, 1999a). It is likely that large, multi-state employers that already offer a self-insured product to employees of another state would do so for employees in California, rather than purchase an insured out-of-state product for California residents.

As previously discussed, insurance requirements in the small-group market were intended to spread risk and ensure availability of coverage for otherwise uninsurable populations. AHP and other proposals for the development and marketing of products exempt from state-specific requirement are likely to result in out-of-state policies attracting healthy, low-risk employers and individuals. This favorable selection and risk segmentation could lead to change in the composition of the market. For example, in the small-group market, those with younger and healthier employees may choose more affordable out-of-state products while other small groups may drop coverage altogether (Blumberg and Shen, 2004; Kofman and Pollitz, 2006; Kofman and Polzer, 2004). Small groups may face dramatic variations in premiums when California-specific rate protections do not apply. The CDI calculated projected premium impacts if S. 1955 were to pass and found that small-group employees of the same firm could face premium differentials of 67% (versus 22% in current California law) based on less stringent rate band requirements (CDI, 2006). Under SB 92, out-of-state policies licensed in the District of Columbia, Virginia, Pennsylvania, or Hawaii would have no rate band requirements. Thus, those premium differentials could be higher than estimated by the CDI (BCBSA, 2007; Kofman and Pollitz, 2006).

APPENDICES

Appendix A: Text of Relevant Bill Provisions Analyzed

INTRODUCED BY Senator Aanestad

JANUARY 21, 2009

An act to amend Section 2069 of the Business and Professions Code, to add Section 1815.5 to the Financial Code, to add Sections 22830.5, 22830.6, 22869.5, and 22917 to the Government Code, to amend Sections 1357, 1357.03, 1357.06, 1357.14, 1367.01, 1374.32, 1374.33, and 1374.58 of, to add Sections 1346.2, 1349.3, and 1367.38 to, and to add Article 12 (commencing with Section 1399.830) to Chapter 2.2 of Division 2 of, the Health and Safety Code, to amend Sections 10121.7, 10123.135, 10169.2, 10169.3, 10700, 10705, 10706, and 10708 of, to add Sections 699.6, 10123.56, and 12938.1 to, to add Chapter 9.7 (commencing with Section 10920) to Part 2 of Division 2 of, and to add Article 7 (commencing with Section 11885) to Chapter 4 of Part 3 of Division 2 of, the Insurance Code, to amend Sections 511 and 515 of, and to add Section 96.8 to, the Labor Code, to amend Sections 17072, 17215, and 19184 of, to add Sections 17053.91, 17053.102, 17053.103, 17138.5, 17138.6, and 17216 to, and to add and repeal Sections 17053.58, 17053.77, 17204, 23658, and 23677 of, the Revenue and Taxation Code, and to amend Sections 14043.26 and 14133 of, to add Sections 14026.7, 14029.7, 14079.7, 14132.104, 14132.105, and 14164.5 to, to add Article 2.94 (commencing with Section 14091.50) to Chapter 7 of Part 3 of Division 9 of, and to add Division 23 (commencing with Section 23000) to, the Welfare and Institutions Code, relating to health care, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

SB 92, as introduced, Aanestad. Health care reform.

(1) Existing law, the Knox-Keene Health Care Service Plan Act of 1975 (the Knox-Keene Act), provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the Knox-Keene Act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance.

The Knox-Keene Act requires, subject to specified exceptions, that a health care service plan be licensed by the department and provide basic health care services, as defined, among other benefits, unless exempted from that requirement by the director of the department. Existing law also requires, subject to specified exceptions, that an insurer obtain a certificate of authority from the Insurance Commissioner in order to transact business in this state and that the insurer operate in accordance with specified requirements.

This bill would allow a carrier domiciled in another state to offer, sell, or renew a health care service plan contract or a health insurance policy in this state without holding a license issued by the department or a certificate of authority issued by the 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.

The bill would also authorize health care service plans and health insurers to offer, market, and sell individual health care service plan contracts and individual health insurance policies that do not include all of the benefits mandated under state law to individuals with income below 350% of the federal poverty level if the individual waives those benefits, as specified, and the plan contract or insurance policy is approved by the Director of the Department of Managed Health Care or the Insurance Commissioner….

(3) Existing law imposes certain requirements on health care service plans and health insurers to enable small employers to access health care coverage. Existing law requires health care service plans and health insurers to sell to any small employer any of the benefit plan designs it offers to small employers and prohibits plans and insurers, among others, from encouraging or directing small employers to refrain from filing an application for coverage with the plan or insurer, and from encouraging or directing small employers
to seek coverage from another carrier, because of the health status, claims experience, industry, occupation, or geographic location within the carrier's approved service area of the small employer or the small employer's employees.

This bill would also prohibit a plan or insurer from taking either of those actions because of the employer's implementation of, or intent to implement, any form of claim support for covered employees, as specified.

Existing law defines "small employer" for these purposes to include a guaranteed association that purchases health care coverage for its members. Existing law defines "guaranteed association" to mean a nonprofit organization of individuals or employers that meets certain requirements, including having been in active existence and having included health coverage as a membership benefit for at least 5 years prior to January 1, 1992, and covering at least 1,000 persons in that regard.

This bill would delete the requirements for a guaranteed association to have been in active existence and to have included health care coverage as a membership benefit for at least 5 years prior to January 1, 1992. The bill would reduce the required number of persons covered by health coverage provided through the guaranteed association from 1,000 to 100. The bill would also define "small employer" to include an eligible association that purchases health care coverage for its members and would define an eligible association as a community or civic group or a charitable or religious organization….

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

SEC. 8. Section 1349.3 is added to the Health and Safety Code, to read:

1349.3. (a) Notwithstanding any other provision of law, a carrier domiciled in another state is exempt from Section 1349, if it meets the following criteria:

(1) It offers, sells, or renews a health care service plan contract in this state that complies with all of the requirements of the domiciliary state applicable to the plan contract.

(2) It is authorized to issue the plan contract in the state where it is domiciled and to transact business there.

(b) Notwithstanding any other provision of law, a health care service plan contract offered, sold, or renewed in this state by a carrier that satisfies the criteria of subdivision (a) is exempt from all other provisions of this chapter…

SEC. 18. Article 12 (commencing with Section 1399.830) is added to Chapter 2.2 of Division 2 of the Health and Safety Code, to read:

Article 12. Mandate-Free Individual Coverage

1399.830. (a) Notwithstanding any other provision of this chapter, on and after January 1, 2011, a health care service plan may offer, market, and sell an individual health care service plan contract that does not include all of the health benefits mandated under this chapter to an individual if all of the following requirements are met:

(1) The individual has an income below 350 percent of the federal poverty level.

(2) The individual waives the benefits pursuant to subdivision (c).

(3) The plan contract is approved by the director.

(b) The director, in consultation with the Insurance Commissioner, shall prepare a disclosure form prior to July 1, 2010, that is easily understood and that summarizes the benefits a health care service plan is required to include in its health care service plan contract under this chapter.

(c) Before a health care service plan contract described in subdivision (a) may be issued, the individual shall sign the disclosure form described in subdivision (b), specifying the benefits he or she is waiving and indicating that the plan has explained the contents of the disclosure and that he or she understands those contents…

SEC. 19. Section 699.6 is added to the Insurance Code, to read:

699.6. (a) Notwithstanding any other provision of law, a carrier domiciled in another state is exempt from Section 700, if it meets the following criteria:

(1) It offers, sells, or renews a health insurance policy in this state that complies with all of the requirements of the domiciliary state applicable to the policy.

(2) It is authorized to issue the policy in the state where it is domiciled and to transact business there.

(b) Notwithstanding any other provision of law, a health insurance policy offered, sold, or renewed in this state by a carrier that satisfies the criteria of subdivision (a) is exempt from all other provisions of this code…

SEC. 29. Chapter 9.7 (commencing with Section 10920) is added to Part 2 of Division 2 of the Insurance Code, to read:

CHAPTER 9.7. MANDATE-FREE INDIVIDUAL COVERAGE

10920. (a) Notwithstanding any other provision of this code, on and after January 1, 2011, a health insurer may offer, market, and sell an individual health insurance policy that does not

include all of the health benefits mandated under this code to an individual if all of the following requirements are met:

(1) The individual has an income below 350 percent of the federal poverty level.

(2) The individual waives the benefits pursuant to subdivision (c).

(3) The insurance policy is approved by the commissioner.

(b) The commissioner, in consultation with the Director of the Department of Managed Health Care, shall prepare a disclosure form prior to July 1, 2010, that is easily understood and that summarizes the benefits a health insurer is required to include in its health insurance policy under this code.

(c) Before a health insurance policy described in subdivision (a) may be issued, the individual shall sign the disclosure form described in subdivision (b), specifying the benefits he or she is waiving and indicating that the insurer has explained the contents of the disclosure and that he or she understands those contents…

Appendix B: Literature Review Methods

This literature review and summary relied on the published literature in peer-reviewed journals as well as reports found in the grey literature.

Grey literature is defined as "That which is produced on all levels of government, academics, business and industry in print and electronic formats, but which is not controlled by commercial publishers." (The New York Academy of Medicine, www.nyam.org/library/greywhat.shtml) Grey literature is, thus, valuable for its timeliness relative to scholarly publications and for its documentation of technical information.

CHBRP searched the grey literature and published peer reviewed journals using the following search terms:

- Association health plan
- Association-sponsored health plans or association-sponsored health insurance (and variations)
- Multiple-employer welfare association (MEWAs)
- Preemption or exemptions of state mandates or state insurance regulations (and variations)
- Cost of health insurance benefit mandates (and variations)
- Cost of government regulation of health insurance
- Financial responsibility/cost-sharing for health insurance in the individual market
- Medical debt
- Underinsurance in the individual market
- Consumer choice and information in the individual market
- Interstate shopping in the insurance marketplace
- Competition and American health care
- Underenrollment in public health insurance programs (e.g., Medicaid, SCHIP)
- Proportion of persons eligible for Medicaid and SCHIP who do not enroll
- Take-up rates for unsubsidized, individual insurance among low-income population (in this case, whether individuals below 350% of poverty choose to purchase private health insurance)
- Risk segmentation
- Consumer-driven health plans
- High-deductible health plans
- Out of pocket expenditures for health insurance benefits
- Health insurance benefit mandates and gender/racial disparities
- Health insurance benefit mandates and social impact (e.g., productivity)

The specific search engines and data bases that were systematically used are:

- PubMed (MEDLINE)
- Business Sources Complete
- EconLit

The specific websites that were searched are:

- American Health Insurance Plans (www.ahip.org)
- National Association of Health Underwriters (www.nahu.org)
- Employee Benefits Research Institute (www.ebri.org)
- Society of Actuaries (www.soa.org), American Academy of Actuaries (www.actuary.org)
- National Bureau of Economic Research (www.nber.org)
- Congressional Budget Office (www.cbo.gov)
- Congressional Hearings (www.gpoaccess.gov/chearings/index.html)
- General Accountability Office (www.gao.gov)
- Urban Institute (www.urbaninstitute.org)
- Commonwealth Fund (www.cmwf.org)
- RAND Health (www.rand.org/health)
- Robert Wood Johnson Foundation (www.rwjfo.org/main.html)
- Heritage Foundation (www.heritage.org)
- Cato Institute (www.cato.org)
- Pacific Research Institute (www.pacificresearch.org)
- Commonwealth Fund (www.commonwealthfund.org)
- Kaiser Family Foundation (www.kff.org)
- American Enterprise Institute (www.aei.org/)
- Center for Studying Health System Change (www.hschange.com)

CHBRP also relied on the input of health policy experts to help identify the relevant literature, provide input on research approach, and review the draft report. These individuals include:

Len Nichols, Ph.D of the New America Foundation

CHBRP also relied heavily on two previous reports: *Analysis of AB 1214: Waiver of Benefits*, which included input of Mila Kofman, Superintendent of Insurance for the State of Maine; and *Analysis of the Potential Impacts of Senate Bill 365: Out-of-State Carriers*,\ which included input from Melinda Beeuwkes Buntin, PhD, of RAND Inc.

Additionally a subcommittee of the CHBRP's National Advisory Council was selected to review and provide input on the draft report (see final pages of this report).

Appendix C: Public Health Impacts of Waiving Specific Benefit Mandates

Each of the current California mandates was assessed to determine the potential public health impact if coverage was to be dropped. Table C-1 details the three criteria used to assess the public health impact: medical effectiveness evidence, type of impact, and scope of the affected population.

Table C-1. Typology for Classifying Evidence of Negative Public Health Impact if Coverage for Benefit Were to Be Excluded[66]

Medical Effectiveness Evidence	Type of Impact	Scope of Affected Population	Potential Public Health Impact
Clear and convincing or preponderance of evidence	Mortality & Morbidity	1 in 20 persons affected	**Mortality** impact, **broad** scope
Clear and convincing or preponderance of evidence	Morbidity		**Morbidity** impact, **broad** scope
Clear and convincing or preponderance of evidence	Mortality & Morbidity	Between 1 in 20 and 1 in 2,000 persons affected	**Mortality** impact, **moderate** scope
Clear and convincing or preponderance of evidence	Morbidity		**Morbidity** impact, **moderate** scope
Clear and convincing or preponderance of evidence	Mortality & Morbidity	1 in 2,000 persons affected	**Mortality** impact, **limited** scope
Clear and convincing or preponderance of evidence	Morbidity		**Morbidity** impact, **limited** scope
Ambiguous, mixed, or insufficient evidence	N/A	N/A	**Unknown** impact
Evidence of no impact	N/A	N/A	**No** impact

For each mandate, this section of the report presents the public health scope of the condition or treatment, any gender or ethnic/racial disparities that are found in the literature, and the extent to which premature death is a relevant outcome.[67] Then an overall conclusion is drawn as to the potential public health impact if coverage for a particular mandated benefit were to be excluded by/for people for whom the coverage is relevant. In developing a typology for the classification of the public health impact, three factors were taken into consideration: (1) the conclusion of the medical effectiveness review, (2) the type of health impact of the condition, and (3) the scope of the affected population. Table 5 describes the factors and the overall characterization of the impact. See the tables in Appendix F for a summary of the public health impacts in tabular form and rationale for cases where exceptions were made to the typology presented.

[66] Previous research has relied on the use of disability-adjusted life years (DALYs) to compute the burden of specific diseases on a population (Lopez, 2005; McKenna et al., 2005). This approach was not used in this report because there were many conditions mandated for which DALYs were either not an appropriate measurement or had not been previously calculated by other researchers.

[67] To the extent that gender or racial/ethnic disparities are found in the literature, they will be presented in the report. However, this type of data is not collected for all conditions and the racial and ethnic categories reported on vary from condition to condition.

A. Mandates for Cancer Screening, Diagnosis, and Treatment

According to the California Cancer Registry, 142,815 new cases of cancer are expected in 2009, and nearly one out of every two Californians born today will develop cancer at some point over their lifetime (CCR, 2008). The most common cancer is breast cancer, accounting for 16% of new cases, followed by prostate cancer (13%), colorectal cancer (10%), and lung cancer (8%) (CCR, 2008). In addition, 1,480 cases of cervical cancer were expected in 2008 (1% of new cases) (CCR, 2008). As reported in the previous section, there is sufficient evidence to screen for colorectal cancer, cervical cancer, and breast cancer. There is either insufficient or equivocal evidence to screen for other cancers. It is estimated that 53% of insured males aged 50 to 64 years have had at least one prostate-specific antigen (PSA) test to screen for prostate cancer (CHIS, 2005). In addition, 80% of insured females aged 40 to 64 years have been screened for breast cancer using mammography in the last 2 years, while 91% of insured females aged 21 to 64 years have been screened for cervical cancer using a Pap smear in the past 3 years (CHIS, 2005). Among insured persons aged 40 to 64 years, 38% had been screened for colorectal cancer as recommended by screening guidelines (CHIS, 2005).

There are differences by gender and race/ethnicity in the rates of specific cancers and early diagnosis of these cancers. Overall, one in every two persons born today will develop cancer during the course of their lifetime (CCR, 2008). Prostate cancer only affects males while breast cancer predominantly (99.4% of cases) affects females and cervical cancer affects females exclusively. Among males, blacks have the highest overall cancer rates and among females, non-Hispanic whites have the highest overall cancer rates. Black males are more likely to develop prostate cancer compared to non-Hispanic white, Hispanic, and Asian/Pacific Islander males (CCR, 2007). In terms of cervical cancer, Hispanic females are twice as likely to develop cervical cancer compared to other racial/ethnic groups (CCR, 2007). Rates of early diagnosis for breast and cervical cancers vary significantly by race/ethnicity. Although overall, 69% of female breast cancers are found at an early stage (i.e., *in situ*/localized), non-Hispanic white females have the highest rates (71%), followed by Asian and Pacific Islanders (70%), Hispanic (63%), and black females (61%) (CCR, 2007). Rates of early diagnosis of cervical cancer also vary by race/ethnicity, with black females being diagnosed early at the highest rate (54%), followed by Hispanic (50%), non-Hispanic white (48%), and Asian/Pacific Islander females (45%).

Cancer accounts for 23% of deaths in California and is the second leading cause of death in the state (CCR, 2008). One in five Californians born today will die of cancer, and in 2009 it is estimated that 54,460 Californians will die as a result of cancer (CCR, 2008). Specifically, it is estimated that there were 5,140 deaths from colorectal cancer, 3,060 deaths from prostate cancer, 4,170 deaths from breast cancer, and 410 deaths from cervical cancer.

<u>Evidence of Public Health Impact if Coverage for Benefit Were to Be Excluded</u>

Mandate 1: Coverage for Cancer Screening Tests. There is clear and convincing evidence to screen for colorectal cancer, cervical cancer, and breast cancer. There is either insufficient or equivocal evidence to screen for other cancers. Cancers for which there are effective screening tests affect a large number of persons in California each year: colorectal cancer (14,250 cases), breast cancer (22,255 cases), and cervical cancer (1,480 cases). For each of these types of cancer, the associated mortality would increase significantly in the absence of screening tests. Therefore,

the analysis concluded that there is potential for a **mortality impact of broad public health scope** if coverage for this benefit were to be excluded.

Mandate 2: Prostate Cancer Screening and Diagnosis. Although there is sufficient evidence that prostate cancer screening can effectively detect prostate cancer in its early stages, there is insufficient evidence to determine whether prostate cancer screening improves health outcomes via early detection of prostate cancer. Therefore, the analysis concluded that there is an **unknown potential impact on public health** if coverage for this benefit were to be excluded.

Mandate 3: Cervical Cancer Screening. There is clear and convincing evidence that screening reduces incidence and mortality from cervical cancer. Nationally, it is estimated that over the last 50 years screening has lead to a 70% reduction in cervical cancer deaths (Saslow et al., 2002). Screening rates for cervical cancer are very high among the insured population in California (91% within last 3 years), which has lead to a reduction in the number of cervical cancer cases in the state. In the absence of screening, the mortality rates from cervical cancer increase dramatically. Therefore, the analysis concluded that there is potential for a **mortality impact of broad public health scope** if coverage for this benefit were to be excluded.

Mandate 4: Breast Cancer Benefits. There is clear and convincing evidence that screening and treatment significantly reduces mortality from breast cancer. Breast cancer is the most common cancer among females—affecting one in nine in California. Therefore, the analysis concluded that there is potential for a **mortality impact of broad public health scope** if coverage for this benefit were to be excluded.

Mandate 5: Breast Cancer Screening with Mammography. There is clear and convincing evidence to determine that mammography screening significantly reduces mortality from breast cancer. Breast cancer is the most common cancer among females—affecting one in nine in California. Therefore, the analysis concluded that there is potential for a **mortality impact of broad public health scope** if coverage for this benefit were to be excluded.

B. Mandates Relating to Chronic Conditions: Diabetes, Osteoporosis, HIV screening, Transplants for HIV Patients, and PKU

Diabetes

In 2005, 1.8 million adults in California were diagnosed with diabetes—representing 7% of the adult population (UCLA, 2007). Among diabetic adults in California, 83% report having type 2 diabetes, while 17% report having type 1 (UCLA, 2007). The complications of diabetes include blindness, kidney disease, cardiovascular disease, limb disease requiring amputation, and death (UCLA, 2007). Diabetic adults in California report receiving the recommended diabetes examinations such as annual foot examinations (71%), annual dilated eye exams (71%), and annual cholesterol tests (90%) (UCLA, 2007).

Diabetes prevalence differs by gender with males reporting higher prevalence rates compared to females (7.6% vs. 6.3%) (CHIS, 2005). In addition, the diabetes age-adjusted death rate for males was higher than for females (CHS, 2004). Diabetes prevalence also varies across race/ethnicity in California, with American Indians/Alaska Natives having the highest prevalence

rate (14.9%), followed by blacks (10.1%), and Hispanics (8.0%) (UCLA, 2007). The prevalence of diabetes among whites and Asians (6.0% and 6.5% respectively) did not vary significantly from the statewide average (7%) (UCLA, 2007). Blacks have the highest diabetes age-adjusted death rate compared to Hispanics, Asians, and whites (CHS, 2004). Overall, the diabetes crude death rate in California in 2002 was 18.9 deaths per 100,000 population (CHS, 2004). This translates into 6,783 deaths in 2002. Diabetes is also implicated in a range of other conditions that may be listed as the more proximate cause.

Osteoporosis[68]

In California, 32% of insured females aged 50 to 64 years have had a bone mass density test to test for osteoporosis (CHIS, 2001). Approximately one-third (34%) of these females have been diagnosed with a bone condition such as bone loss, osteopenia, or osteoporosis. This translates into an overall prevalence rate among insured females aged 50 to 64 years of 11%. In California in 2002, 2% of insured females aged 55 to 64 years who had been diagnosed with osteoporosis reported breaking a bone as a result of a fall in the last 12 months (CHIS, 2001).

An analysis by race/ethnicity shows that Hispanic (16%) and black females (17%) are significantly less likely to be screened for osteoporosis compared to other racial/ethnic groups, whereas white females are significantly more likely to be screened (38%) (CHIS, 2001). Of the females screened with a bone density test, there were no significant differences by race/ethnicity in the rates at which they were diagnosed with a bone condition.

People with osteoporosis and related diseases are more susceptible to fracturing bones as the result of a fall. This can lead to placement in a nursing home and eventually, death. There were 166 osteoporosis-related deaths in California in 2001 (Max et al., 2002). This included 140 deaths among females and 26 among males (CDC WONDER, 2001).

HIV Testing[69]

The prevalence of HIV in California is estimated to be 0.67% (Stopka et al., 2007). In 2004, almost 40% of persons who tested positive for HIV were unaware of their infections until shortly before they were diagnosed with AIDS (Branson et al., 2006). Treatment is less likely to be effective once a person has AIDS, because antiretroviral medications work primarily by slowing the progression of disease. Once a person has AIDS, the course of the disease is more difficult to reverse (Chou et al., 2005). It is estimated that just over half of the insured adult population in California has ever been tested for HIV, with approximately 3% of the insured getting tested each year (CHIS, 2007; Milliman, 2006).

Men are at markedly increased risk for HIV compared to women, and in California, men represent 90% of the cumulative HIV/AIDS cases (CDC, 2006b; Stopka et al., 2007). There are also marked ethnic differences in risk for HIV and progression to AIDS. For example, California's estimated AIDS incidence rates for blacks are almost four times greater than for

[68] This section relies on information originally presented in CHBRP's analysis of: Assembly Bill 438 Osteoporosis Screening, a report to the 2003-2004 California Legislature, February 9, 2004.
[69] This section relies on information originally presented in CHBRP's analysis of Assembly Bill 1894: HIV Testing, a Report to the 2007-2008 California Legislature, April 7, 2008.

Hispanic or whites and almost ten times greater than for Native Americans and Asian/Pacific Islanders (CDPH-OA, 2008).

Since the 1980s, the diagnosis and treatment of HIV infection have increased an HIV-positive person's average life expectancy from 4 years to 24.2 years from diagnosis (Shackman et al., 2006). With the introduction of pharmaceutical treatments, the mortality rate dropped by 50% in 1996 and by another 20% in 1998 (SFAF, 2005). Despite this progress, it is estimated that there are 1,300 deaths due to AIDS in California each year (CHS, 2006). It has been estimated that the average productivity loss per AIDS case is approximately $742,000 (Hutchinson et al., 2006).

Transplants for Patients with HIV[70]

An estimated 72,000 Californians are HIV-positive, and an additional 60,000 are living with AIDS (CHS, 2002; DHS OA, 2007). It is estimated that between 3.5% and 6.9% of persons with HIV have end-stage renal disease (ESRD), which would require a lifetime of kidney dialysis (Roland and Stock, 2003). Kidney dialysis may shorten the life expectancy of persons with HIV, thus creating a need for kidney transplants in this population. Coinfection with Hepatitis B virus (HBV) or Hepatitis C virus (HCV) can lead to the development of end-stage liver disease (ESLD) among HIV-positive patients. It is estimated that approximately 9% of HIV patients are coinfected with HBV and 23% to 33% of HIV patients are coinfected with HCV (Roland and Stock, 2003). The United Network for Organ Sharing (UNOS) maintains a national database of all persons on the waiting list for organ transplants, but their HIV status is not collected. Therefore, there is no way to determine how many HIV-positive Californians are currently on the waiting list for organ transplants.

Much of the literature on racial disparities within the HIV-positive population concerns the differences between blacks and whites. Blacks have substantially higher rates of HIV/AIDS. Rates for black males are seven times that for white males (CDC, 2004). For females, the difference is even more striking: the rates of HIV/AIDS among black females are 19 times higher than that of white females (CDC, 2004). Additionally, blacks suffer greater morbidity and mortality from HIV (CDC, 2005b; Fleishman and Hellinger, 2003; McGinnis et al., 2003). The extent of gender or racial/ethnic disparities among HIV-positive persons receiving organ transplants is unknown.

Due to advances in treatment, the prognosis for HIV-positive persons in developed countries has improved. Deaths within the HIV-positive population are due to organ failure (Neff et al., 2004; Roland and Havlir, 2003; Valdez et al., 2001), particularly liver and kidney failure (Calabrese et al., 2003; Puoti et al., 2000). The extent to which HIV-positive persons die of liver and kidney failure in California is unknown. In addition, the extent to which this mandate has increased the overall number of transplants among Californians is unknown.

[70] This section relies on information originally presented in CHBRP's analysis of Assembly Bill 228: Transplantation Services: Human Immunodeficiency Virus, a Report to the 2005-2006 California Legislature, April 7, 2005.

Phenylketonuria

Phenylketonuria (PKU) is a genetic disease in which the body is deficient in the enzyme needed to break down the amino acid phenylalanine. The result is a build up in blood and tissues of phenylalanine, which can lead to serious neurological problems. By following a medically supervised low phenylalanine diet, most of the symptoms of PKU can be avoided. In California, the prevalence of classic PKU is 1 in 27,000 births; this translates into 15 to 18 PKU births each year (CNSP, 2004). Since 1980, when a mandated screening program was instituted, 450 children have been diagnosed with PKU. PKU is found equally among males and females. Blacks have a lower incidence of PKU compared to whites and Asians (Medhelp, 2007). The complications from untreated PKU include mental retardation and brain damage, mental illness, seizures and tremors, and other cognitive problems. Women with PKU who become pregnant are at a higher risk for having a spontaneous abortion (Medhelp, 2007).

Evidence of Public Health Impact if Coverage for Benefit Were to Be Excluded

Mandate 1: Diabetes Management and Treatment. There is clear and convincing evidence that diabetes management and treatment improves health outcomes for persons with diabetes. Diabetes affects nearly 2 million persons in California. Therefore, the analysis concluded that there is potential for a **mortality impact of broad public health scope** if coverage for this benefit were to be excluded.

Mandate 2: Osteoporosis Diagnosis, Treatment, and Management. There is clear and convincing evidence that screening and treatment are effective in the diagnosis, treatment, and management of osteoporosis. Osteoporosis affects 11% of females aged 50 to 64 years, or 1 in 60 persons overall. Therefore, the analysis concluded that there is potential for a **mortality impact of moderate public health scope** if coverage for this benefit were to be excluded.

Mandate 3: HIV Testing. There is a preponderance of evidence that tests for HIV are highly accurate. There is also substantial indirect evidence that screening for HIV among asymptomatic persons is effective in reducing morbidity and mortality associated with AIDS. It is estimated that just over half of the insured adult population in California have ever been tested for HIV, with approximately 3% of the insured getting tested each year. Therefore, the analysis concluded that there is potential for a **mortality impact of moderate public health scope** if coverage for this benefit were to be excluded.

Mandate 4: Transplantation Services for Persons with HIV. There is a preponderance of evidence that suggests that patients with HIV undergoing liver or kidney transplant have similar survival rates as patients without HIV. It is unknown how many persons in need of a transplant are HIV-positive. In addition, the extent to which the mandate has increased the total number of transplants among all Californians is unknown. Therefore, the analysis concluded that there is an **unknown potential impact on public health** if coverage for this benefit were to be excluded.

Mandate 5: Phenylketonuria (PKU) testing and treatment. There is a preponderance of evidence that screening and treatment are effective in identifying children with PKU and reducing the severity of the associated mental and behavioral disorders. Between 15 and 18 babies with PKU are born every year in California. Therefore, the analysis concluded that there

is potential for a **mortality impact of limited public health scope** if coverage for this benefit were to be excluded.

C. Mandates Relating to Coverage for Mental Illness and Substance Abuse

Mental Illness

Mental health conditions covered under the current mandate include severe mental illness (SMI) of a person of any age, which includes schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorders or autism, anorexia nervosa, and bulimia. It also includes serious emotional disturbance (SED) of a child that results in behavior inappropriate to the child's age, according to expected developmental norms (DMHC, 2005). Based on 2000 Census data, the estimated prevalence of SED and SMI in California is 6.35 % of the non-institutionalized population (DMH, 2004). This breaks down into 7.46% of youth aged 0 to 17 years and 5.92% of adults aged 18 and older.

Among youth, there is no significant gender difference in the prevalence of SED and SMI. In contrast, among adults the prevalence was significantly different for males (4.54%) compared to females (7.23%) (DMH, 2004). The differences in rates of SED and SMI among children across race/ethnicity were not as dramatic, ranging from 6.83% for non-Hispanic white youth to 7.98% for Hispanic youth. Across the adult population there was more variation, ranging from 4.55% for non-Hispanic Native Americans to 6.81% for Hispanics.

The disease burden associated with mental illness includes suicide, and it is estimated that there are 2,700 mental illness–related suicides in California each year.[71] Males are four times more likely to die by suicide compared to females (NIMH, 2007). Non-Hispanic whites and American Indian/Alaska Natives have the highest suicide rates (12.9 per 100,000 and 12.4 per 100,000 respectively) (NIMH, 2007). Non-Hispanic blacks, Asian and Pacific Islanders, and Hispanics have the lowest rates of suicide (ranging from 5.3-5.9 per 100,000) (NIMH, 2007).

Alcoholism Treatment

It is estimated that 7.8% of Californians experienced alcohol dependence or abuse in the past year (SAMHSA, 2005). This breaks down into a rate of 6.1% among adolescents aged 12 to 17 years, 16.7% among adults aged 18 to 25 years, and 6.4% among adults aged 26 or older. In 2006 there were close to 40,000 alcohol-related admissions to substance abuse treatment facilities (SAMHSA, 2008). This broke down into 18,897 admissions for alcohol only, and 19,024 admissions for alcohol with secondary drug abuse. It is estimated that across the United States, there are 28.7 alcohol-related ED visits per 1,000 persons (McDonald et al., 2004). Applying this rate to California, it is estimated that there are approximately 1 million alcohol-related ED visits in California each year.

Compared to females, males were more likely to report binge alcohol use (33% vs. 16%) and heavy alcohol use (11% vs. 3%) (SAMHSA, 2008). Males were also more likely to be admitted

[71] Calculated as the product of the estimated annual number of suicides in California: 3,000 (Wilson, 1999) and the estimated proportion of suicides that are associated with mental health issues: 90% (Moscicki, 2001).

to a treatment facility for alcohol-related substance abuse treatment (SAMHSA, 2008). In addition, males are more likely to have an alcohol-related visit to the ED than females (7.9 vs. 2.9 per 1,000) (McDonald et al., 2004). In terms of alcohol abuse differences by race/ethnicity, the highest rates of binge alcohol use and heavy alcohol use were reported by persons of American Indian or Alaska Native descent (36.2% and 12.8%, respectively). The lowest rates of alcohol abuse were reported by Asians (SAMHSA, 2005).

There were 10.1 alcohol-induced deaths per 100,000 Californians in 2004—this translated into nearly 3,700 deaths (DHS OWH, 2006). Males had higher rates of alcohol-induced deaths compared to females (15.3 vs. 5.0 per 100,000). Persons of American Indian descent had the highest rates of alcohol-induced deaths (19.5 per 100,000). There are an additional 1,400 alcohol-related traffic fatalities each year in California (CHP, 2005).

Intoxication Exclusion Provision

Chronic inebriates and drug users often use emergency services, due to their substance abuse and the nature of their complicated medical needs—which are often exacerbated by acute intoxication, being high, or related illness or injury (Thornquist et al., 2002). In 2000, it was estimated that 7.8% of all ED visits were alcohol-related (McDonald et al., 2004), while overall, 1.3% of ED visits in the United States are attributable to drug use (SAMHSA, 2007).

Men are more likely to have an alcohol-related visit to the ED than women. In 2000, national data show that rates of alcohol-related visits among men were 7.9 per 1,000 population compared to a rate among women of 2.9 per 1,000 (McDonald et al., 2004). In addition, blacks are more likely to have an alcohol-related ED visit compared to whites, with rates of 8.8 and 4.6 per 1,000 population. respectively (McDonald et al., 2004). Amphetamine and methamphetamine-related ED visits are more likely to be for males (58%) compared to females (42%) (SAMHSA, 2004). Whites were more likely to have a methamphetamine-related ED visits compared to other racial/ethnic groups (Richards et al., 1999).

Although substance abuse does lead to premature death, there is no compelling evidence that the intoxication exclusion to exclude provision for coverage for illnesses and injuries due to intoxication or controlled substances has changed physician practice patterns in terms of screening and counseling for alcohol and substance abuse, or treatment for illness and injuries sustained in conjunction with alcohol or substance abuse. Therefore, there is no premature death directly related to the subject of this mandate.

Evidence of Public Health Impact if Coverage for Benefit Were to Be Excluded

Mandate 1: Parity in Coverage for Severe Mental Illness. There is clear and convincing evidence that indicates that medications and psychotherapy are effective in treating severe mental illness. Mental illness affects over 2 million persons in California. Therefore, the analysis concluded that there is potential for a **mortality impact of broad public health scope** if coverage for this benefit were to be excluded.

Mandate 2: Coverage for Mental and Nervous Disorders. There is clear and convincing evidence that indicates that medications and psychotherapy are effective in treating mental and nervous disorders. Mental illness affects over 2 million persons in California. Therefore, the

analysis concluded that there is potential for a **mortality impact of broad public health scope** if coverage for this benefit were to be excluded.

Mandate 3: Coverage for Alcoholism Treatment. There is clear and convincing evidence that pharmacological and psychosocial treatments are effective in treating alcohol dependence. Nearly 8% of Californians report alcohol abuse or dependence in the past year. Therefore, the analysis concluded that there is potential for a **mortality impact of broad public health scope** if coverage for this benefit were to be excluded.

Mandate 4: Intoxication Exclusion Provision. There is insufficient evidence to determine the effect of this mandate. Therefore, the analysis concluded that the impact on public health is unknown.

D. Mandates Relating to Orthotics and Prosthetics

Orthotic and Prosthetic Devices and Services[72]

A broad range of health conditions is associated with the use of orthotic and prosthetic (O&P) devices, from relatively rare diseases to more common conditions. According to Milliman analysis of national claims data, approximately 6.8 million O&P devices were used by the insured population nationally in 2004, for a utilization rate of 40.4 procedures per 1,000 persons. The 10 most common diagnoses associated with their use are: disorders of the muscle, ligament, and fascia (connective tissue); peripheral enthesopathies and allied syndromes (inflammation at site of attachment of ligament or tendon to bone); sprains and strains of the ankle and foot; other and unspecified disorders of the joint; mononeuritis of the upper limb and mononeuritis multiplex (painful nerve damage); traumatic amputation of leg(s); other disorders of the synovium (lining or membrane of the joints), tendon, and bursa (fluid sac between tendon and bone); sprains and strains of the knee and leg; malignant neoplasm of the female breast; and osteoarthritis and allied disorders.

No literature was identified that discussed gender or racial disparities with regard to overall utilization of O&P devices. There is some information, however, on disparities associated with the myriad of health conditions that necessitate the use of prostheses and orthoses. For example, males have been found to have higher rates of sprains and strains compared to females, and whites have higher rates compared to blacks (Collins, 1990). Research has also found that amputations and limb deficiency are more common in males than females (both adults and children) and more common in blacks compared to whites (CDC, 2001; Dillingham et al., 2002; Yigiter et al., 2005). According to the Milliman utilization database, males younger than 18 years appear to have a slightly higher utilization rate of O&P devices than females in the same age group (28.0 vs. 25.4 per 1,000 members). However, females aged 18 years and older have a substantially higher utilization rate (45.4 vs. 34.7 per 1,000 members) than their male counterparts. Utilization data by race and ethnicity are not available.

[72] This section relies on information originally presented in CHBRP's analysis of Assembly Bill 2012: Orthotic and Prosthetic Devices, a report to the 2006-2007 California Legislature, June 15, 2006.

Prosthetic Devices for Laryngectomy

A laryngectomy, or removal of the larynx, is typically performed in the course of treatment for laryngeal cancer. Occasionally a laryngectomy is performed due to a car accident or other trauma that results in severe damage of the larynx. Depending on the stage of progression of the cancer, either a partial or total laryngectomy may be performed. In California it is expected that there will be 885 new cases of laryngeal cancer in 2009 (CCR, 2008). Prosthetic devices can be used to help a patient who has undergone a laryngectomy to translate sounds into words.

In 2009, it is estimated that in California 720 cases of laryngeal cancer will be found among males, while only 170 cases will be found among females (CCR, 2008). This represents more than four times more cases of laryngeal cancer found in males compared to females. Nationally, blacks have the highest rates of laryngeal cancer (11.6 per 100,000 males and 2.0 per 100,000 females) while Asian/Pacific Islanders had the lowest rates (3.0 per 100,000 males and 0.3 per 100,000 females) (NCI, 2007).

Special Footwear for Persons Suffering from Foot Disfigurement

As defined in the mandate, foot disfigurement includes (but is not limited to) "disfigurement from cerebral palsy, arthritis, polio, spina bifida, diabetes, and foot disfigurement caused by accident or developmental disability." The two most common types of disfigurement are due to diabetes and rheumatoid arthritis. As reported in the *Medical Effectiveness* section, there is insufficient and ambiguous evidence on the effect of special footwear for persons with diabetes; there is a preponderance of evidence that special footwear is effective for persons with rheumatoid arthritis. Therefore, the remainder of this analysis will only discuss rheumatoid arthritis (RA). The consensus in the literature is that the prevalence of RA in the United States is approximately 1% across all age groups (Abdel-Nasser et al., 1997; Lawrence et al., 1998; Silman and Hochberg, 2001). California claims data provided by Milliman for persons under age 65 years suggests that the rate of RA among the insured population under 65 is 0.49%. This would translate into approximately 130,000 Californians with RA. Of patients with RA, it is estimated that 60% require special footwear, although only approximately 30% have received them (Vidigal et al., 1975).

In examining gender differences, the prevalence of RA is two to three times higher in females than in males (Abdel-Nasser et al., 1997; Lawrence et al., 1998; Rasch et al., 2003; Sangha, 2000; Voulgari et al., 2004). In addition, Native Americans have the highest prevalence of RA worldwide, and RA is at least twice as common in Native Americans compared with North American whites (Abdel-Nasser et al., 1997). The extent to which utilization rates of special footwear for RA differs across gender and race/ethnicity is unknown.

Evidence of Public Health Impact if Coverage for Benefit Were to Be Excluded

Mandate 1: Orthotic and Prosthetic Devices and Services. There is a preponderance of evidence that orthoses and prostheses are effective for some conditions. In California, it is estimated that among the insured population, 40.4 per 1,000 or 11,000 persons receive O&P devices each year. Therefore, the analysis concluded that there is potential for a **morbidity impact of moderate public health scope** if coverage for these benefits were to be excluded.

Mandate 2: Prosthetic Devices for Laryngectomy Patients. There is ambiguous evidence that prosthetic devices improve the quality of life for persons who have had a laryngectomy. Therefore, the analysis concluded that there is an **unknown potential impact on public health** if coverage for this benefit were to be excluded.

Mandate 3: Special Footwear for Persons Suffering from Foot Disfigurement. There is insufficient and ambiguous evidence on the effect of special footwear for persons with diabetes; there is a preponderance of evidence that special footwear is effective for persons with rheumatoid arthritis. Therefore, the analysis concluded that there is potential for a **morbidity impact of moderate public health scope** if coverage for this benefit were to be excluded.

E. Mandates Relating to Pain Management: Acupuncture, Pain Management Medication for Terminally Ill Patients, and General Anesthesia for Dental Procedures

Acupuncture[73]

Acupuncture therapies are used to treat a variety of health conditions. Based on Milliman's claims data (2005), within the categories of musculoskeletal and neurological disorders, three common conditions for which acupuncture is used include (1) lower back pain, (2) neck pain, and (3) migraine or severe headaches. The 3 month prevalence of these three health conditions among the insured adult population aged 18 to 64 years in the United States is 26.1% for lower back pain, 17.3% for migraine or severe headache, and 14.3% for neck pain (NHIS, 2002). The prevalence of any one of these three conditions is 37.3%. National estimates indicate that in 2002, 4.1% of the insured adult population had used acupuncture in their lifetime and 1.1% had used acupuncture in the past year (NHIS, 2002). In California, it is estimated that 2.4% of insured adults have used acupuncture in the past year (CHBRP, 2007b).

According to the National Health Interview Survey (NHIS) data, the self-reported prevalence of migraine or severe headache, in particular, is substantially higher in females at 23% compared to 10% of males. This finding is consistent with other studies on severe headaches and migraines, which indicate that migraines are two to three times more prevalent among females, possibly due to hormonal differences (Breslau and Rasmussen, 2001). In addition to high prevalence for these health conditions, females also reported using acupuncture at rates approximately twice as high compared to males (Goldstein et al., 2005; NHIS, 2002; Rafferty et al., 2002). After Asians, whites have the second highest utilization rate. Goldstein et al. (2005) found similar results among California respondents, with 5.9% of Asians using acupuncture in the past year compared to 3.1% of whites, 2.4% of blacks, and 1.3% of Hispanics.

Pain Management Medication for Terminally Ill Patients

Most of the research on pain management medication in the terminally ill has focused on patients dying of cancer. It was estimated that there would be 53,710 deaths in California from cancer in 2008 (CCR, 2007). Research has found that at the time of diagnosis, 30% to 40% of cancer patients indicate that they have moderate to severe pain, with 90% reporting significant pain sometime during the course of their disease (Whitecar et al., 2000; Zech et al., 1995; Zhukovsky

[73] This section relies on information originally presented in CHBRP's analysis of: Assembly Bill 54: Health Care Coverage: Acupuncture, a Report to the 2007-2008 California Legislature, June 22, 2007.

et al., 1995). Between 12% to 42% of cancer patients report that they inadequate pain management (Cleeland et al., 1994; Zech et al., 1995). Among patients in a palliative care program, good pain relief was reported by 76%, satisfactory efficacy by 12%, and inadequate efficacy by 12% (Zech et al., 1995).

Disparities in the provision of pain management medication to terminally ill patients by gender and race/ethnicity have been reported (Anderson et al., 2000; Cleeland et al., 1994; Cleeland et al., 1997). Overall, the results suggest that females and members of minority ethnic groups are not receiving sufficient pain management medication. Cleeland et al. (1997) found that blacks, Hispanics, and other non-whites were under-medicated at a significantly higher rate compared to whites (65% vs. 50%).

General Anesthesia for Dental Procedures

Across insured Californians aged 2 to 65 years, 76% visited the dentist within the past year, 19% reported visiting the dentist more than one year ago, and 5% report never having been to the dentist (CHIS, 2001). Of these visits, 21% were as a result of a dental problem requiring a dental procedure (CHIS, 2001). It is estimated that 2.8% of adults in the United States get general anesthesia for dental procedures (Dionne et al., 1998). This would translate into an estimated 120,000 procedures using general anesthesia in California annually.

Males and females reported visits to the dentist in the past year at similar rates. Among insured Californians aged 2 to 65 years, whites had a higher percentage of reporting a visit to the dentist in the past year (79%) compared to Hispanics (68%), blacks (76%), or Asians (77%) (CHIS, 2001). Gender or racial/ethnic disparities in the use of general anesthesia for dental procedures are unknown.

Evidence of Public Health Impact if Coverage for Benefit Were to Be Excluded

Mandate 1: Acupuncture. A preponderance of evidence suggests that acupuncture is effective in reducing pain and improving the functioning of persons with a variety of conditions. The utilization rate of acupuncture among the adult insured Californian population is 2.4%. Therefore, the analysis concluded that there is potential for a **morbidity impact of moderate public health scope** if coverage for this benefit were to be excluded.

Mandate 2: Pain Management for Terminally Ill Patients. There is a preponderance of evidence that suggests that pain medication is effective in reducing pain caused by cancer or cancer treatments. There were 53,710 deaths expected in 2008 in California from cancer, and it is estimated that pain medication is used in 84% of terminal cancer cases (Davis and Walsh, 2004). Therefore, the analysis concluded that there is potential for a **morbidity impact of moderate public health scope** if coverage for this benefit were to be excluded.

Mandate 3: General Anesthesia for Dental Procedures. Professional consensus suggests that the use of general anesthesia is effective for young children, persons who are extremely anxious, or those with mental or physical limitations, as well as those needing extensive dental care. The utilization rate of general anesthesia among adults in the United States is 2.8%. Therefore, the analysis concluded that there is potential for a **morbidity impact of moderate public health scope** if coverage for this benefit were to be excluded.

F. Mandates Relating to Pediatric Care

Comprehensive Preventive Care for Children

Recommended comprehensive preventive care for children includes routine physical examinations, health educations counseling, and immunizations. In California, the vast majority of insured children (aged 18 and under) have seen a doctor in the past year (89%) (CHIS, 2005). Among insured adolescents (aged 12 to 17 years), 80% reported that they went to a doctor for a routine physical exam or check-up within the past year, 13% reported a visit within 1 to 2 years, 5% reported a visit 2 or more years ago, and 3% reported no visits (CHIS, 2005). Health education counseling varied among insured adolescents with 76% reporting a discussion with their doctor regarding physical activity, while less than one-third reported discussing drug use (31%), smoking (29%), alcohol (28%), STDs (24%), or mental health (21%). In California it is estimated that 79% of children have coverage for all recommended vaccine series by 35 months of age (CDC, 2007).

Overall among California's insured children (aged 0 to 18 years), there were no differences in the rates at which males and females visited the doctor in the past year, but there were differences by race. Asian children reported having not visited the doctor in the past year at higher rates compared to white children (15% vs. 9%) (CHIS, 2005). There were no significant differences in the rates at which children were immunized by race or ethnicity in California (DHS OWH, 2006).

Comprehensive preventive care is associated with preventing a myriad of conditions that can lead to premature death. Immunizations protect against infectious diseases that can result in death; health education counseling can lead to a reduction in risky behaviors that can affect mortality rates; and routine health care check-ups are important to monitor blood pressure and weight, which can contribute to obesity, diabetes, and many other health problems.

Asthma Management[74]

In California, 13.6% of the population have ever been diagnosed with asthma (CHIS, 2001). Approximately 9.4% of insured children in California have symptomatic asthma (i.e., asthma for which they experienced symptoms in the past year) (CHIS, 2003). It is estimated that 2.5% of insured children in California aged 1 to 17 years have high-risk asthma, which is defined having visited an emergency room in the past 12 months or reporting daily or weekly symptoms of asthma (2001). Adolescents (aged 12 to 17 years) in California with high-risk asthma missed an average of 1.4 days of school in the last four weeks and 79.3% of children (aged 1 to 11 years) with high-risk asthma experienced restricted physical activity due to their asthma (CHIS, 2001). More than 75% of children with high-risk asthma report they currently take medicine for their asthma (CHIS, 2001). In addition, 18% of children aged 1 to 17 years with high-risk asthma had an emergency room visit and 5% were hospitalized because of their disease in the past year.

[74] This section relies on information originally presented in CHBRP's analysis of AB 264: Pediatric Asthma Self-Management Training and Education Services for Children at High Risk, A Report to the 2006-2007 California Legislature, May 25, 2006.

Finally, 63.2% of adolescents with high-risk asthma report having ever received any information from their doctor on how to avoid the things that make their asthma worse (CHIS, 2001).

There are significant gender differences in high-risk asthma prevalence, with 2.9% of males aged 1 to 17 years reporting having high-risk asthma, compared with 2.1% of females in the same age group (CHIS, 2001). Black children have the highest rates of high-risk asthma (3.5%), followed by Hispanics (2.5%), whites (2.3%), and Asians (1.5%). In addition, black children with high-risk asthma reported the highest rate of restricted-activity days compared to white and Hispanic children.

Mortality among children with asthma is relatively rare. In 2002, the National Center for Health Statistics reported that there were 0.3 deaths due to asthma per 100,000 children. In California in 2002, 23 deaths due to asthma were reported among children 1 to 19 years and 458 deaths were reported among the entire population, including adults (CDC WONDER, 2002).

Screening Children for Elevated Blood Lead Levels

Elevated blood lead levels (BLLs) in children can lead to a variety of health problems including headaches, hearing problems, neurological impairment, seizures, and coma. The CDC definition of elevated BLLs is blood lead levels greater than or equal to 10 mcg/dL (micrograms of lead per deciliter of blood). Recent estimates of overall prevalence of elevated BLLs across the entire U.S. population is 0.7%, while prevalence for children aged 1 to 5 years and 6 to 19 years were 1.6% and 0.2%, respectively (CDC, 2005a).

Overall, males are at greater risk for elevated BLLs than females (1.1% vs. 0.3%), but restricting the population to children aged 1 to 19 years, the rates between males and females were not different (CDC, 2005a). Across all ages, non-Hispanic whites had the lowest rates of elevated BLLs (0.5%) compared to non-Hispanic blacks (1.4%) and Mexican Americans (1.5%) (CDC, 2005a). Among children, non-Hispanic white children had the lowest mean blood levels compared to non-Hispanic black and Mexican American children.

Mortality among children with elevated BLLs is very rare, but is possible if they are exposed to high enough levels of lead. No research was found that described any deaths in California from elevated BLLs.

Evidence of Public Health Impact if Coverage for Benefit Were to Be Excluded

Mandates 1, 2: Comprehensive preventive care for children aged 16 or younger and children aged 17-18. There is a preponderance of evidence that some recommended services are effective. There are more than 9.5 million children aged 0 to 18 years currently insured in California. Therefore, the analysis concluded that there is potential for a **mortality impact of broad public health scope** if coverage for this benefit were to be excluded.

Mandate 3: Asthma Management. There is a preponderance of evidence that asthma management is effective in reducing the negative side effects of asthma symptoms. In California, 13.6% of the entire population has been diagnosed with asthma. Therefore, the analysis concluded that there is potential for a **mortality impact of broad public health scope** if coverage for this benefit were to be excluded.

Mandate 4: Screening Children for Blood Lead Levels. There is a preponderance of evidence **against** routine screening in children of average risk, and there is insufficient evidence to determine if screening is effective in children at increased risk. Therefore, the analysis concluded that there is **no potential impact on public health** if coverage for this benefit were to be excluded.

G. Mandates Relating to Reproductive Services

Contraceptive Devices Requiring a Prescription

Unintended pregnancy is associated with many health and social consequences and costs the U.S. health care system an estimated $5 billion annually (DHS OWH, 2006; Trussell, 2007). In order to prevent unintended pregnancy, nearly 1 million insured females in California aged 18 to 44 report using some form of prescription contraceptives as their current form of birth control (DHS OWH, 2006). This represents 41% of the population of females currently using contraceptives and includes oral contraceptives (28%); long-acting methods such as Depo-Provera, contraceptive implant, and intrauterine contraceptives (11%); and the patch and the ring (2%). Other forms of nonprescription contraceptives used among females aged 18 to 44 years included condoms (25%), sterilization (both male and female, 29%), and other forms of contraceptives (5%).

Prescription contraceptive devices are only available for females. The contraceptive devices available to males (condoms and sterilization) do not require a prescription and thus would not be covered under this mandate. Among white females, the primary form of contraception most reported was the contraceptive pill (46%) (Weinbaum and Thorfinnson, 2006). In contrast, Hispanics and black females reported that condoms were their primary form of contraception (33% and 31%, respectively) (Weinbaum and Thorfinnson, 2006).

The use of prescription contraceptives overall is not associated with premature death, although persons with specific risk factors should take these risk factors into account when choosing which form of contraception to use. In general, the risks associated with taking oral contraceptives are lower than the risks associated with pregnancy and childbirth.

Infertility Treatments

Among married females aged 15 to 44 years in the United States, 15.1% have impaired fecundity (i.e., the physical ability for a woman or a couple to have a child)—half of whom (7.4%) are infertile (defined as a couple that had been married/cohabiting for more than 12 months, had not used contraception, and had not become pregnant) (Chandra et al., 2005). Overall, 11.9% of females in the United States aged 15 to 44 years reported that they had ever received any infertility services (Chandra, et al., 2005). This included 6.1% who had received fertility advice, 5.5% who had received medical help to prevent miscarriage, 4.8% who had tests performed on either the male or female, 3.8% who had received ovulation drugs, 1.1% who had received artificial insemination, 0.7% who received surgery or treatment of blocked tubes, and 0.3% who had assisted reproductive technology.

Across the United States, among married females aged 15 to 44 years, blacks report higher rates of infertility (11.5%) compared to Hispanics (7.7%) or non-Hispanic whites (7.0%) (Chandra et al., 2005). Among females aged 15 to 44 years (regardless of marital status), non-Hispanic whites have the highest rates of having ever received any infertility service (13.8%) compared to Hispanics (8.2%) or blacks (8.4%) (Chandra et al., 2005).

Prenatal Diagnosis of Genetic Disorders

Approximately 3% of babies born in California are born with a birth defect (CBDMP, n.d.). The most common birth defects include serious heart defects (2.25 cases per 1,000 births), chrosomosomal abnormalities (including Down syndrome, 1.87 cases per 1,000 births), oral cleft defects (1.27 cases per 1,000), and neural tube defects (0.68 cases per 1,000 births). Rates of birth defects vary by mother's race where black mothers have the highest rates of babies with birth defects (17.5 per 1,000 births), followed by whites (16.2 per 1,000 births), Hispanics (15.2 per 1,000 births), and Asians (12.9 per 1,000 births).

Nearly 1 in 10 babies with birth defects born in California will die before their first birthday (CBDMP, n.d.). The risk of infant death (i.e., before 1 year of age) among babies with birth defects is 92.5 per 1,000 births compared to 6.2 per 1,000 births for babies without birth defects (CBDMP, n.d.).

Expanded Alpha-Fetoprotein Screening

Alpha-fetoprotein screening (AFP) is used in California to calculate the risk of a pregnancy with a child with Down syndrome. Down syndrome occurs at a rate of 1.51 per 1,000 births which translates into approximately 830 cases/year in California (CBDMP, n.d.). Rates of Down syndrome increase by age for mothers aged 20 and older, with the highest rates in the >39 year old age category (9.99 per 1,000 births). More than half of children born with Down syndrome have heart defects or other associated birth defects. In California, approximately one quarter of pregnancies diagnosed with Down syndrome are terminated due to this diagnosis (Bishop et al., 1997). When looking specifically at Down syndrome by mother's race/ethnicity the highest rates are reported among births to Hispanic females (1.53 per 1000 births), followed by white females (1.15), black females (1.12), and Asian females (0.98) (CBDMP, n.d.). Due to heart defects and other birth defects, about 10% of babies born with Down syndrome die before age 1.

Evidence of Public Health Impact if Coverage for Benefit Were to Be Excluded

Mandate 1: Contraceptive Devices Requiring a Prescription. There is clear and convincing evidence that prescription contraceptives are more effective than nonprescription contraceptives for preventing pregnancy. Nearly one million insured females in California aged 18 to 44 years rely on prescription contraception for birth control. Therefore, the analysis concluded that there is potential for a **morbidity impact of broad public health scope** if coverage for this benefit were to be excluded.

Mandate 2: Infertility Treatments. There is clear and convincing of evidence that diagnosis and treatment of male and female infertility are effective in improving pregnancy rates. Among married females aged 15 to 44 years, 15.1% have impaired fecundity (i.e., ability to get pregnant or carry a baby to term). Therefore, the analysis concluded that there is potential for a **morbidity impact of moderate public health scope** if coverage for this benefit were to be excluded.

Mandate 3: Prenatal diagnosis of genetic disorders. The preponderance of evidence suggests that diagnostic procedures are effective in identifying genetic disorders of the fetus. In California, approximately 3% of babies are born with a birth defect. Therefore, the analysis concluded that there is potential for a **mortality impact of moderate public health scope** if coverage for this benefit were to be excluded.

Mandate 4: Expanded alpha-fetoprotein screening (AFP). There is a preponderance of evidence that AFP tests detect the likelihood of fetal Down syndrome at a rate of 70% to 80%. Down syndrome occurs at a rate of 1.51 per 1,000 births, which translates into approximately 830 cases/year in California. Therefore, the analysis concluded that there is potential for a **mortality impact of limited public health scope** if coverage for this benefit were to be excluded.

H. Mandates Relating to Surgery

Jawbone or Associated Bone Joints—Surgery

Conditions of the jaw and associated bone joints that require surgery include temporomandibular joint (TMJ) disorders, odontogenic tumors, and injury to the area from physical trauma. Of these, this report will focus on TMJ disorders because this is the condition where there is the most variability in coverage among health insurance plans. The cause of TMJ disorders is not clear, but physical trauma, grinding/clenching of teeth, presence of arthritis, and stress are all contributing factors. Across the United States, it is estimated that 10 million people currently have TMJ disorders and that 1.5 to 3 million people seek treatment annually (Marwick, 2005). This would translate into approximately 1 million Californians with TMJ disorders with 150,000 to 300,000 seeking treatment annually.

The literature suggests that the prevalence of TMJ disorders among females is 1.5 to 2 times higher than in males (Warren and Fried, 2001). The evidence is ambiguous in regards to different prevalence rates by race/ethnicity. While some research has found that rates of TMJ disorders do not differ by race/ethnicity (Keeling et al., 1994) others have found that blacks are more likely to have TMJ risk factors (Widmalm et al., 1995).

Reconstructive Surgery

Reconstructive surgery is most commonly done in California for females who have had a mastectomy to treat breast cancer. Breast cancer is the most common cancer among females in California, accounting for 43% of total current cancer in females (CCR, 2007). In 2008 was expected that 21,160 cases of breast cancer would be diagnosed in California (CCR, 2007). The Milliman database indicates that the mastectomy rates for females aged 0 to 64 years is 85 per 100,000 for partial mastectomy and 72 per 100,000 for full. Studies have reported that rates of breast reconstruction following mastectomy range between 12.5% and 17% of breast cancer patients (Alderman et al., 2003; Polednak, 2001; Rowland et al., 2000). Other conditions for which reconstructive surgery is performed include clubfoot or craniofacial abnormalities. Although clubfoot is a relatively common birth defect, occurring in 1 out of 1,000 live births, surgery is used only in extreme cases (NIH, 2007). Craniofacial abnormalities refer to a group of

deformities of the head or facial bones. The most common abnormality is oral clefts, with one in 790 babies born in California being diagnosed (CBDMP, n.d.). Oral clefts, such as cleft lip and cleft palate, require surgery to restore proper functioning.

The evidence regarding breast reconstructive rates following mammography by race and ethnicity is ambiguous. It has been reported that there is no difference in rates of reconstructive surgery post-mastectomy (Polednak, 2001), that blacks (compared to whites) have higher rates of surgery (Alderman et al., 2003), and that whites (compared to blacks) have higher rates of surgery (Rowland et al., 2000). Whites have the highest rates of cleft palate deformities and Asians had the lowest (CBDMP, n.d.).

Evidence of Public Health Impact if Coverage for Benefit Were to Be Excluded

Mandate 1: Jawbone or Associated Bone Joints—Surgery. A preponderance of evidence suggests that surgical treatments for TMJ disorders results in reduced pain. TMJ disorders affect approximately 1 million persons in California. Therefore, the analysis concluded that there is potential for a **morbidity impact of moderate public health scope** if coverage for this benefit were to be excluded.

Mandate 2: Reconstructive Surgery. The evidence on the impact of reconstructive surgery for breast reconstruction, club foot, or craniofacial abnormalities is ambiguous or insufficient. Therefore, the analysis concluded that there is an **unknown potential impact on public health** if coverage for this benefit were to be excluded.

I. Mandates Relating to Hospice and Home Health Care

Hospice Care

Hospice care provides physical, psychological, social, and spiritual care to dying persons and their families. Hospice care can be provided in either inpatient or at home on a part-time, full-time, or round-the-clock basis. The rate of current hospice care in the under 65 population across the United States is 8.0 per 100,000 (NHHCS, 2004a). The under 65 population represents 18.6% of total hospice patients. The rate of hospice care discharges in 2000 (including death) was 52.1 per 100,000 persons (NHHCS, 2004a). In the under 65 population, the mean length of hospice care service lasts for 163 days while the median length of service is 89 days (NHHCS, 2004a). This discrepancy in rates takes into account the fact that there are many episodes of care that are short in duration.

Across the United States, the rate of hospice care varies in the under 65 population by both gender and race. Looking at gender, females report higher rates of current hospice use (8.6 per 100,000) compared to males (7.5 per 100,000) (NHHCS, 2004a). In addition, blacks report much higher rates of current hospice use (14.4 per 100,000) compared to whites (6.8 per 100,000) (NHHCS, 2004a).

Home Health Care

Home health care is used to help patients who are recovering from an illness or injury to continue to receive medical care on a regular basis without having to leave their home. The most common primary diagnoses of current home health care patients are: diseases of the circulatory system (including heart disease), injury and poisoning, diseases of the musculoskeletal system and connective tissue (such as arthritis), diabetes, diseases of the nervous system, diseases of the respiratory system, and cancer (NHHCS, 2004b). The rate of current home health care use in the under 65 population across the United States is 16.4 per 100,000 (NHHCS, 2004b). This represents 29.5% of total patients. In the under 65 population, the mean length of home health care service lasts for 51 days while the median length of service is 17 days (NHHCS, 2004a).

Across the United States, the rate of home health care use varies in the under 65 population by both gender and race. Looking at gender, females report higher rates of home health care use (17.2 per 100,000) compared to males (15.6 per 100,000) (NHHCS, 2004b). In addition, blacks report higher rates of current home health care use (17.8 per 100,000) compared to whites (14.1 per 100,000) (NHHCS, 2004b).

Evidence of Public Health Impact if Coverage for Benefit Were to Be Excluded

Mandate 1: Hospice Care. The evidence of the effects of hospice care on the duration, frequency, severity of pain, and quality of life is ambiguous. However, the preponderance of evidence suggests that hospice care reduces other symptoms associated with terminal illness (e.g., anxiety, diarrhea, nausea). Hospice is currently used by approximately 8.0 per 100,000 persons. Therefore, the analysis concluded that there is potential for a **morbidity impact of limited public health scope** if coverage for this benefit were to be excluded

Mandate 2: Home Health Care. There is clear and convincing evidence that home health care leads to better outcomes for elderly and disabled adult patients. Home health care is currently used by approximately 16.4 per 100,000 persons aged 0 to 64 years. Therefore, the analysis concluded that there is potential for a **morbidity impact of limited public health scope** if coverage for this benefit were to be excluded.

Table C-2. Summary of Public Health Impacts

Part A. Cancer Screening & Treatment

Topic (Statute)	Medical Effectiveness Conclusion	Public Health Scope	Gender or Racial/Ethnic Disparities	Premature Death	Potential Public Health Impact if Dropped
Cancer Screening Tests	*Clear and convincing evidence* to screen for colorectal cancer, cervical cancer, and breast cancer, but not for other cancers	140,815 new cases of cancer expected in 2009 in California, including 14,250 cases of colorectal cancer, 1,480 cases of cervical cancer, and 22,255 cases of breast cancer	52% of cancer occurs in males; 48% in females; among men, blacks have the highest rates and among women, non-Hispanic whites have the highest rates	54,460 deaths expected in 2009 in California from cancer, including 5,140 due to colorectal cancer, 410 due to cervical cancer, and 4,170 from breast cancer	Mortality impact of broad public health scope for colorectal, cervical, and breast cancer Unknown impact on public health for other cancers
Prostate Cancer Screening and Diagnosis	*Insufficient evidence* to determine whether prostate cancer screening reduces mortality	17,890 new cases expected in 2009 in California Probability of male being diagnosed over lifetime 1 in 7	Affects males only African American males are 50% more likely to develop compared to non-Hispanic white, 70% more likely to develop compared to Hispanic males, and 6 times more likely than API males	3,060 deaths expected in 2008 in California There is a 94% 5-years survival rate	Unknown impact on public health

Part A. Cancer Screening & Treatment

Topic (Statute)	Medical Effectiveness Conclusion	Public Health Scope	Gender or Racial/Ethnic Disparities	Premature Death	Potential Public Health Impact if Dropped
Cervical Cancer Screening	*Clear and convincing evidence* that screening reduces incidence and mortality from cervical cancer	There are 1,480 new cases expected in 2009 in California 91% of females received recommended screening in past 3 years	Affects females only Hispanic females have the highest risk of developing cervical cancer, about twice as high as non-Hispanic white females, black and Asian/Pacific Islander females	410 deaths expected in 2009 in California. There is a 72% 5-year survival rate	Mortality impact of broad public health scope[75]
Breast cancer screening, diagnosis, and treatment Breast Cancer Screening with Mammography Breast cancer benefits	*Clear and convincing evidence* that screening and treatment significantly reduce mortality from breast cancer	22,255 new cases expected in 2009 in California The probability of female being diagnosed over lifetime is 1 in 9	Affects females predominantly (99.4% of new cases) Hispanics were less likely to ever have a mammography screening compared to non-Hispanic white and black females	4,170 deaths expected in 2009 in California There is an 88% 5-year survival rate for females	Mortality impact of broad public health scope

[75] Although the number of cases of cervical cancer in California is not large enough to be classified as "broad scope" (i.e., 5% of population or greater) – current screening practices have reduced cervical cancer deaths by 70%. Currently 91% of females in California are screened for cervical cancer at the recommended rate. These factors led CHBRP to classify the impact of dropping coverage for cervical cancer screening as "broad scope."

Part B. Chronic Conditions

Topic (Statute)	Medical Effectiveness Conclusion	Public Health Scope	Gender or Racial/Ethnic Disparities	Premature Death	Potential Public Health Impact if Dropped
Diabetes Management	*Clear and convincing evidence* that diabetes management and treatment is effective in improving health outcomes for persons with diabetes	Prevalence of diabetes among adults in CA in 2005 was 7% – which translates into nearly 2 million people	Diabetes is more prevalent among males than among females AIAN (14.9%), blacks (10.1%), and Hispanics (8.0%) have higher prevalence compared to whites (6.0%) or Asians (6.5%)	The crude death rate in CA in 2002 was 18.9 per 100,000 people – which translates into 6,800 deaths	Mortality impact of broad public health scope
Osteoporosis Diagnosis, Treatment, and Management	*Clear and convincing evidence* that screening and treatment for osteoporosis are effective	11% of insured females aged 50 to 64 years have been diagnosed with a bone condition such as bone loss, osteopenia, or osteoporosis	Osteoporosis affects females predominantly No differences by race/ethnicity in rates of bone conditions	166 osteoporosis-related deaths in California in 2001	Mortality impact of moderate public health scope
HIV Testing	*Preponderance of evidence* that tests for HIV are highly accurate; *Substantial indirect evidence* that screening for HIV among asymptomatic persons is effective in improving health outcomes.	Prevalence of HIV in California is estimated to be 0.67% of people ages 15-49; 3% of the insured get tested each year.	Men and blacks are at markedly increased risk for HIV disease.	1,300 HIV disease related deaths	Mortality impact of moderate public health scope

Part B. Chronic Conditions (Cont'd)

Topic (Statute)	Medical Effectiveness Conclusion	Public Health Scope	Gender or Racial/Ethnic Disparities	Premature Death	Potential Public Health Impact if Dropped
Transplantation Services for Persons with HIV	*Preponderance of evidence* that patients with HIV undergoing liver or kidney transplant have similar survival rates of patients without HIV	It is unknown how many persons in need of a transplant are HIV-positive	It is unknown to the extent that there are gender or racial/ethnic disparities among HIV-positive persons receiving organ transplants	The extent to which HIV-positive persons die of liver and kidney failure in California is unknown	Unknown impact on public health
Phenylketonuria testing and treatment	*Preponderance of evidence* that screening and treatment are effective in identifying children with PKU and reducing the severity of the associated mental and behavioral disorders	The prevalence of classic PKU is one in 27,000 births – this translates into 15-18 PKU births each year 450 children have been diagnosed since 1980	There is no difference in rates of PKU among males and females, but blacks are much less likely to have PKU compared to whites and Asians	Women with PKU who become pregnant are at higher risk of spontaneous abortions if their PKU is not well managed	Mortality impact of limited public health scope

Part C. Mental Illness and Substance Abuse

Topic (Statute)	Medical Effectiveness Conclusion	Public Health Scope	Gender or Racial/Ethnic Disparities	Premature Death	Potential Public Health Impact if Dropped
Parity in coverage for severe mental illness; Coverage for mental and nervous disorders	*Clear and convincing evidence* that medications and psychotherapy are effective in treating mental illness	6.35% of non-institutionalized population (over 2 million Californians)	Higher rates among adult females and Hispanics	There are an estimated 2,700 mental illness–related suicides each year in California	Mortality impact of broad public health scope
Alcoholism treatment	*Clear and convincing evidence* that pharmacological and psychosocial treatments are effective in treating alcohol dependence	7.8% of Californians report alcohol abuse or dependence in the past year	Males and people of AIAN descent report higher rates of abuse	There are nearly 3,700 alcohol-induced deaths in California each year as well as 1,400 alcohol-related traffic fatalities	Mortality impact of broad public health scope
Intoxication Exclusion Provision	*Insufficient evidence* to determine impact	7.8% of all ED visits are alcohol-related while 1.3% of ED visits are attributable to drug use.	Higher rates of alcohol-related ED visits among men and blacks and higher rates of methamphetamine-related ED visits among men and whites.	No deaths expected as a direct result of the UPPL Exclusion	Unknown impact on public health

Part D. Orthotics and Prosthetics

Topic (Statute)	Medical Effectiveness Conclusion	Public Health Scope	Gender or Racial/Ethnic Disparities	Premature Death	Potential Public Health Impact if Dropped
Orthotic and prosthetic devices and services	*Preponderance of evidence* that orthoses and prostheses are effective for some conditions	O&P devices were used by the insured population nationally in 2004, for a utilization rate of 40.4 procedures per 1,000 persons	Adult females had higher utilization rates compared to males in 2004 (45.4 per 1,000 compared to 34.7) Utilization data by race/ethnicity is not available	Premature death is not an outcome typically associated with the utilization of O&P devices	Morbidity impact of moderate public health scope
Prosthetic devices for laryngectomy	*Ambiguous evidence* of the effect voice prosthesis has on quality of life	885 new cases of laryngeal cancer are expected in California in 2009	Four times as many males get laryngeal cancer compared to females Blacks have much higher rates of laryngeal cancer compared to other racial/ethnic groups	Premature death is not an outcome associated with prosthetic devices for laryngectomy	Unknown impact on public health
Special footwear for persons suffering from foot disfigurement	*Ambiguous /insufficient evidence* on the effect of special footwear for persons with diabetes; *preponderance of evidence* that special footwear is effective for persons with rheumatoid arthritis	Approximately 0.49% of the insured population under age 65 have been diagnosed with rheumatoid arthritis Special footwear is used by 30% to 60% of persons with this condition	The extent to which utilization rates of special footwear for rheumatoid arthritis differs across gender and race/ethnicity is unknown	The extent to which the utilization of special footwear for persons suffering from foot disfigurement reduces premature death is unknown	Morbidity impact of moderate public health scope for persons with rheumatoid arthritis Unknown impact on public health for persons with diabetes

Part E. Pain Management

Topic (Statute)	Medical Effectiveness Conclusion	Public Health Scope	Gender or Racial/Ethnic Disparities	Premature Death	Potential Public Health Impact if Dropped
Acupuncture	*Preponderance of evidence* suggests that acupuncture is effective in reducing pain and functioning in persons with a variety of conditions	In California, it is estimated that 2.4% of insured adults have used acupuncture in the past year	Females report higher prevalence of lower back pain, neck pain, and migraines or severe headache Females and Asians report higher utilization of acupuncture	Premature death is not an outcome typically associated with the conditions for which people get acupuncture	Morbidity impact of moderate public health scope
Pain management medication for terminally ill patients	*Preponderance of evidence* suggests that pain medication is effective in reducing pain caused by cancer or cancer treatment	53,710 deaths in California from cancer – estimated that pain medication is used in 84% of terminal cancer cases	Females, blacks, and Hispanics are not receiving sufficient pain management medication	Pain medication does not reduce premature death for terminally ill patients	Morbidity impact of moderate public health scope
General anesthesia for dental procedures	Professional consensus that the use of general anesthesia is effective for young children, people with anxiety, or those with mental or physical limitations, and those needing extensive dental care	It is estimated that 2.8% of adults in the United States get general anesthesia for dental procedures	Gender or racial/ethnic disparities in the use of general anesthesia for dental procedures is unknown	None associated	Morbidity impact of moderate public health scope (1)

Note: (1) There were no studies found on the effectiveness of general anesthesia for dental procedures. However, since the professional consensus is that it is effective for specific populations, we determined that there would be a public health impact if coverage was dropped, making an exception to the criteria requiring the level of evidence to be either "clear and convincing" or "a preponderance of evidence."

Part F. Pediatric Health

Topic (Statute)	Medical Effectiveness Conclusion	Public Health Scope	Gender or Racial/Ethnic Disparities	Premature Death	Potential Public Health Impact if Dropped
Comprehensive preventive care for children aged 16 years or younger Comprehensive preventive care for children aged 17 or 18 years	*Preponderance of evidence* for some recommended services such as physical exams, counseling regarding health risks, and immunizations	89% of children aged 0 to 18 years visited a doctor in the past year; 79% of children have received the recommended vaccine series by 35 months	Asians were less likely to have a doctor visit in the past year compared to whites No racial/ethnic differences were found in immunization rates	Comprehensive preventive care is effective in preventing premature death through immunizations, health education counseling, and monitoring of health status indicators	Mortality impact of broad public health scope
Asthma management	*Preponderance of evidence* that asthma management is effective in reducing the negative side effects of asthma symptoms	13.6% of the population in California have been diagnosed with asthma; 2.5% of insured children have high risk asthma	Males have higher rates of asthma compared to females Blacks have higher rates of asthma compared to whites and Hispanics	In California in 2002, 23 deaths due to asthma were reported among children aged 1 to 19 years old	Mortality impact of broad public health scope
Screening children for blood lead levels	*Preponderance of evidence* against routine screening in children of average risk Insufficient evidence to determine if screening is effective in children at increased risk	1.6% of children in the U.S. aged 1 to 5 years had elevated blood lead levels (BLL) Among children aged 6 to 19 years, 0.2% had elevated BLL	Non-Hispanic whites are less likely to have elevated BLLs compared to non-Hispanic black and Mexican American children	Mortality among children with elevated BLLs is very rare, but is possible if they are exposed to high enough levels of lead	No impact on public health

Part G. Reproductive

Topic (Statute)	Medical Effectiveness Conclusion	Public Health Scope	Gender or Racial/Ethnic Disparities	Premature Death	Potential Public Health Impact if Dropped
Contraceptive devices requiring a prescription	*Clear and convincing evidence* that prescription contraceptives are more effective than nonprescription contraceptives for preventing pregnancy	Nearly 1 million insured females of reproductive age in California use prescription contraceptives	Contraceptive devices are only prescribed for females White females are more likely to use oral contraceptives while Hispanic and black females are more likely to use condoms	Contraceptives use does not lead to a reduction in premature death	Morbidity impact of broad public health scope[76]
Infertility treatments	*Clear and convincing evidence* that diagnosis and treatment of male and female infertility are effective in improving pregnancy rates	15.1% of married females aged 15 to 44 years have impaired fecundity (i.e., ability to get pregnant or carry a baby to term), half of which (7.4%) are classified as infertile (not pregnant within 12 months)	Blacks report higher rates of infertility compared to non-Hispanic whites and Hispanics; non-Hispanic whites report higher rates of ever having used infertility services	Premature death is not an outcome associated with infertility treatments	Morbidity impact of moderate public health scope
Prenatal diagnosis of genetic disorders	*Preponderance of evidence* that diagnostic procedures identify genetic disorders of the fetus	3% of babies born in California have a birth defect	Birth defects were highest for babies born to black mothers and lowest for babies born to Asian mothers	Nearly one in ten babies born in California with birth defects will die before their first birthday	Mortality impact of moderate public health scope

[76] This mandate was categorized as "broad scope" assuming that the health impacts (including psychological) of contraceptive use extends to partners of women using contraceptives. This would translate into nearly 2 million men and women using contraceptive devices requiring a prescription.

Part G. Reproductive (Cont'd)

Topic (Statute)	Medical Effectiveness Conclusion	Public Health Scope	Gender or Racial/Ethnic Disparities	Premature Death	Potential Public Health Impact if Dropped
Expanded alpha-fetoprotein screening (AFP)	*Preponderance of evidence* that AFP tests detect likelihood of fetal Down syndrome at a rate of 70% to 80%	Down syndrome occurs at a rate of 1.51 per 1,000 births which translates into approximately 830 cases/year in California	Rates by race/ethnicity vary from 0.98 per 1,000 births to Asian females to 1.53 per 1,000 births to Hispanic females	10% of babies born with Down syndrome die before age 1	Mortality impact of limited public health scope

Part H. Surgical

Topic (Statute)	Medical Effectiveness Conclusion	Public Health Scope	Gender or Racial/Ethnic Disparities	Premature Death	Potential Public Health Impact if Dropped
Jawbone or associated bone joints – surgery	*Preponderance of evidence* suggests that surgical treatment for TMJ results in reduced pain	It is estimated that 1 million people in CA have TMJ disorders and 150,000 to 300,000 receive treatment annually	Women have higher rates of TMJ disorders compared to men. The evidence is ambiguous in regards to different prevalence rates by race/ethnicity	The reduction in premature death is not an outcome associated with jawbone or associated bone joint pain	Morbidity impact of moderate public health scope
Reconstructive surgery	*Ambiguous/insufficient evidence* on the impact of reconstructive surgery for breast reconstruction, for club foot, or craniofacial abnormalities	Reconstructive surgery is most commonly preformed post-mastectomy (12.5%-17% of breast cancer patients), to correct craniofacial defects, and to correct club foot	Unknown gender or racial/ethnic disparities in rates of reconstructive surgery	Not an associated outcome	Unknown impact on public health

Part I. Hospice and Home Health Care

Topic (Statute)	Medical Effectiveness Conclusion	Public Health Scope	Gender or Racial/Ethnic Disparities	Premature Death	Potential Public Health Impact if Dropped
Hospice care	The evidence of the effects of hospice care on the duration, frequency, severity of pain, and quality of life is *ambiguous* However, the *preponderance of evidence* suggests that hospice care reduces other symptoms associated with terminal illness	The rate of current hospice care in the under 65 population across the U.S. is 8.0 per 100,000	Females and blacks have higher rates of hospice use	The reduction in premature death is not an outcome associated with the use of hospice care	Morbidity impact of limited public health scope
Home health care	*Clear and convincing evidence* that home health care leads to better outcomes for elderly and disabled patients	The rate of current home health care use in the under 65 population across the U.S. is 16.4 per 100,000; this represents 29.5% of home health care patients	Females and blacks have higher rates of home health care use	Overall, home health care resulted in a non-significant decrease in mortality relative to usual care	Morbidity impact of limited public health scope

Source: California Health Benefits Review Program, 2009.
Notes: API = Asian/Pacific Islander; AIAN = American Indian/Alaska Native

Appendix D: Cost Impact Analysis: Data Sources, Caveats, and Assumptions

This appendix describes data sources, as well as general and bill-specific caveats and assumptions used in conducting the cost impact scenario analysis. For additional information on the cost model and underlying methodology, please refer to the CHBRP Web site at http://www.chbrp.org/analysis_methodology/cost_impact_analysis.php. Please also refer to Appendix F for further information regarding the plan prototypes that were used in the Scenario Analysis.

The cost analysis in this report was prepared by the Cost Team, which consists of CHBRP task force members and staff, specifically from the University of California, Los Angeles, and Milliman Inc. (Milliman). Milliman is an actuarial firm that provides data and analyses per the provisions of CHBRP's authorizing legislation.

Data Sources

In preparing cost estimates, the Cost Team relies on a variety of data sources as described below.

Private Health Insurance

1. The latest (2007) California Health Interview Survey (CHIS), which is used to estimate insurance coverage for California's population and distribution by payer (i.e., employment-based, privately purchased, or publicly financed). The biannual CHIS is the largest state health survey conducted in the United States, collecting information from over approximately 53,000 households. More information on CHIS is available at www.chis.ucla.edu.

2. The latest (2008) California Employer Health Benefits Survey is used to estimate:

- size of firm,
- percentage of firms that are purchased/underwritten (versus self-insured),
- premiums for plans regulated by the Department of Managed Health Care (DMHC) (primarily health maintenance organizations [HMOs] and Point of Service Plans [POS]),
- premiums for policies regulated by the California Department of Insurance (CDI) (primarily preferred provider organizations [PPOs] and fee-for-service plans [FFS]), and
- premiums for high-deductible health plans (HDHPs) for the California population covered under employment-based health insurance.

  This annual survey is currently released by the California Health Care Foundation/National Opinion Research Center (CHCF/NORC) and is similar to the national employer survey released annually by the Kaiser Family Foundation and the Health Research and Educational Trust. Information on the CHCF/NORC data is available at www.chcf.org/topics/healthinsurance/index.cfm?itemID=133543.

3. Milliman data sources are relied on to estimate the premium impact of mandates. Milliman's projections derive from the Milliman Health Cost Guidelines (HCGs). The HCGs are a health care pricing tool used by many of the major health plans in the United

States. See www.milliman.com/expertise/healthcare/products-tools/milliman-care-guidelines/index.php. Most of the data sources underlying the HCGs are claims databases from commercial health insurance plans. The data are supplied by health insurance companies, Blues plans, HMOs, self-funded employers, and private data vendors. The data are mostly from loosely managed health care plans, generally those characterized as preferred provider plans or PPOs. The HCGs currently include claims drawn from plans covering 4.6 million members. In addition to the Milliman HCGs, CHBRP's utilization and cost estimates draw on other data, including the following:

- The MarketScan Database, which includes demographic information and claim detail data for approximately 13 million members of self-insured and insured group health plans.
- An annual survey of HMO and PPO pricing and claim experience. The most recent survey (2008 Group Health Insurance Survey) contains data from seven major California health plans regarding their 2007 experience.
- Ingenix MDR Charge Payment System, which includes information about professional fees paid for health care services, based upon approximately 800 million claims from commercial insurance companies, HMOs, and self-insured health plans.

These data are reviewed for applicability by an extended group of experts within Milliman but are not audited externally.

4. An annual survey by CHBRP of the seven largest providers of health insurance in California (Aetna, Anthem Blue Cross of California, Blue Shield of California, CIGNA, Health Net, Kaiser Foundation Health Plan, and PacifiCare) to obtain estimates of baseline enrollment by purchaser (i.e., large and small group and individual), type of plan (i.e., DMHC- or CDI-regulated), cost-sharing arrangements with enrollees, and average premiums. Enrollment in these seven firms represents 96.0% of the privately insured market: 98.0% of privately insured enrollees in full-service health plans regulated by the DMHC and 82% of lives privately insured health insurance products regulated by the CDI.

Public Insurance

5. Premiums and enrollment in DMHC- and CDI-regulated plans by self-insured status and firm size are obtained annually from CalPERS 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—comprising about 75% of CalPERS total enrollment. CalPERS self-funded plans—approximately 25% of enrollment—are not subject to state mandates. In addition, CHBRP obtains information on current scope of benefits from health plans' evidence of coverage (EOCs) publicly available at www.calpers.ca.gov.

6. Enrollment in Medi-Cal Managed Care (Knox-Keene licensed plans regulated by the DMHC) is estimated based on CHIS and data maintained by the Department of Health Care Services (DHCS). DHCS supplies CHBRP with the statewide average premiums negotiated for the Two-Plan Model, as well as generic contracts that summarize the

current scope of benefits. CHBRP assesses enrollment information online at www.dhcs.ca.gov/dataandstats/statistics/Pages/BeneficiaryDataFiles.aspx.

7. Enrollment data for other public programs — Healthy Families, Access for Infants and Mothers (AIM), and the Major Risk Medical Insurance Program (MRMIP) — are estimated based on CHIS and data maintained by the Managed Risk Medical Insurance Board (MRMIB). The basic minimum scope of benefits offered by participating plans under these programs must comply with all requirements of the Knox-Keene Act, and thus these plans are affected by changes in coverage for Knox-Keene licensed plans. CHBRP does not include enrollment in the Post-MRMIP Guaranteed-Issue Coverage Products as these individuals are already included in the enrollment for individual health insurance products offered by private carriers. Enrollment figures for AIM and MRMIP are included with enrollment for Medi-Cal in presentation of premium impacts. Enrollment information is obtained online at www.mrmib.ca.gov/. Average statewide premium information is provided to CHBRP by MRMIB staff.

General Caveats and Assumptions

The projected cost estimates are estimates of the costs that would result if a certain set of assumptions were exactly realized. Actual costs will differ from these estimates for a wide variety of reasons, including:

- Prevalence of mandated benefits before and after the mandate may be different from CHBRP assumptions.
- Utilization of mandated services before and after the mandate may be different from CHBRP assumptions.
- Random fluctuations in the utilization and cost of health care services may occur.

Additional assumptions that underlie the cost estimates presented in this report are:

- Cost impacts are shown only for products subject to state-mandated health insurance benefits.
- Cost impacts are only for the first year after enactment of the proposed mandate
- Employers and employees will share proportionately (on a percentage basis) in premium rate increases resulting from the mandate. In other words, the distribution of premium paid by the subscriber (or employee) and the employer will be unaffected by the mandate.
- For state-sponsored programs for the uninsured, the state share would continue to be equal to the absolute dollar amount of funds dedicated to the program.
- When cost savings are estimated, they reflect savings realized for one year. Potential long-term cost savings or impacts are estimated if existing data and literature sources are available and provide adequate detail for estimating long-term impacts. For more information on CHBRP's criteria for estimating long-term impacts please see http://www.chbrp.org/analysis_methodology/cost_impact_analysis.php.

- Several recent studies have examined the effect of private insurance premium increases on the number of uninsured (Chernew, et al., 2005; Hadley 2006; Glied and Jack 2003). Chernew et al. estimate that a 10% increase in private premiums results in a 0.74 to 0.92 percentage point decrease in the number of insured, while Hadley (2006) and Glied and Jack (2003) estimate that a 10% increase in private premiums produces a 0.88 and 0.84 percentage point decrease in the number of insured, respectively. The price elasticity of demand for insurance can be calculated from these studies in the following way. First, take the average percentage point decrease in the number of insured reported in these studies in response to a 1% increase in premiums (about -0.088), divided by the average percentage of insured individuals (about 80%), multiplied by 100%, i.e., ({[-0.088/80] x 100} = -0.11). This elasticity converts the *percentage point* decrease in the number of insured into a *percentage* decrease in the number of insured for every 1% increase in premiums. Because each of these studies reported results for the large-group, small-group, and individual insurance markets combined, CHBRP employs the simplifying assumption that the elasticity is the same across different types of markets. For more information on CHBRP's criteria for estimating impacts on the uninsured please see http://www.chbrp.org/analysis_methodology/cost_impact_analysis.php.

There are other variables that may affect costs, but which CHBRP did not consider in the cost projections presented in this report. Such variables include, but are not limited to:

- Population shifts by type of health insurance coverage: If a mandate increases health insurance costs, then some employer groups and individuals may elect to drop their coverage. Employers may also switch to self-funding to avoid having to comply with the mandate.
- Changes in benefit plans: To help offset the premium increase resulting from a mandate, health plan members may elect to increase their overall plan deductibles or copayments. Such changes would have a direct impact on the distribution of costs between the health plan and the insured person, and may also result in utilization reductions (i.e., high levels of patient cost sharing result in lower utilization of health care services). CHBRP did not include the effects of such potential benefit changes in its analysis.
- Adverse selection: Theoretically, individuals or employer groups who had previously foregone insurance may now elect to enroll in an insurance plan post-mandate because they perceive that it is to their economic benefit to do so.
- Health plans may react to the mandate by tightening their medical management of the mandated benefit. This would tend to dampen the CHBRP cost estimates. The dampening would be more pronounced on the plan types that previously had the least effective medical management (i.e., PPO plans).
- Variation in existing utilization and costs, and in the impact of the mandate, by geographic area and delivery system models: Even within the plan types CHBRP modeled (HMO—including HMO and point of service (POS) plans—and non-HMO—including PPO and fee for service (FFS) policies), there are likely variations in utilization and costs by these plan types. Utilization also differs within California due to differences in the health status of the local commercial population, provider practice patterns, and the level of managed care available in each community. The average cost per service would

also vary due to different underlying cost levels experienced by providers throughout California and the market dynamic in negotiations between health plans and providers. Both the baseline costs prior to the mandate and the estimated cost impact of the mandate could vary within the state due to geographic and delivery system differences. For purposes of this analysis, however, CHBRP has estimated the impact on a statewide level

Caveats and Assumptions

CHBRP's analysis of SB 92 is based on several key assumptions, some of which apply to both scenarios presented in this report, and others that are unique to each of the scenarios. These assumptions are:

Key assumptions common to scenarios 1 (high impact) and 2 (low impact):

- Because it is impossible to determine exactly which combinations of current mandated benefits would be offered under SB 92, CHBRP developed three prototype limited-mandate insurance policies that would be likely to be offered under SB 92 in each of the four major market segments (DMHC-regulated group, CDI-regulated group, DMHC-regulated individual, and CDI-regulated individual). These prototype limited-mandate insurance policies were based on: (1) review of grey literature; (2) review of plans offered in other states with laws that allowed for the development of limited-mandate plans (or plans not subject to state mandates); (3) review of low-premium plans currently offered in California; and (4) discussion with CHBRP's content expert for the AB 1214 report, Melinda Buntin, PhD, health economist at the RAND Corporation.
- The uninsurance rate among adults aged 18 to 64 years and children aged 0 to 17 years who are not eligible for public programs would decline by 1.1% for every 10% drop in premiums in each market segment. The overall price change estimated by CHBRP for all limited-mandate plans would be applied to the estimated 4.847 million uninsured adults and children not eligible for public programs. The number of uninsured was obtained from CHIS 2007. CHBRP was not able to stratify the uninsured who are employed by size of firm. There is some evidence in the research literature that reducing the number of mandated benefits does have a positive impact on the number of insured individuals (Sloan and Conover, 1998; Jensen and Morrisey, 1999).
- The newly insured would be distributed according to the same proportions as in the baseline period. The cost of the uninsured in the baseline period would be about 50% of spending in the post-SB 92 period for the newly insured, based on estimates from the RAND Health Insurance Experiment data about the impact on expenditures of moving from high-deductible coverage to comprehensive coverage with limited cost sharing (Newhouse, 1993).
- The administrative expenses and profit margins are assumed to be the same for comprehensive, full benefit plans as they are for limited-mandate plans, HDHPs and limited-mandate HDHP plans.

Key assumptions under scenario 1 (high impact):

- This scenario assumes all insurers would offer limited-mandate plans in every market, and all currently insured Californians would purchase the limited-mandate plans instead of their current health insurance products. The purpose of this scenario is to illustrate the maximum savings possible from removing the requirement for mandated benefits in the short term.
- Because premiums for all segments of the market (large-group, small-group, and individual sectors, and DMHC-regulated vs. CDI-regulated) would be lower, CHBRP assumes that the market share of low- and zero-deductible plans relative to HDHPs remains the same within each market segment, even though the price reductions are not exactly the same in each market. This simplifying assumption is supported by evidence from Marquis et al. (2006) that overall demand for insurance is not sensitive to changes in the benefits offered.

Key assumptions under scenario 2 (low impact):

- This scenario assumes that only those who currently have the lowest-premium plans (i.e., HDHPs in the CDI-regulated individual market) would be interested in purchasing health insurance products with limited mandates, and that everyone currently with an HDHP in the CDI-regulated individual market would purchase a less-expensive HDHP with limited mandates.
- The reduction in the number of uninsured will be estimated in the same way as above under scenario 1, but all newly insured will be concentrated in HDHPs in the CDI-regulated individual market only.

Both scenarios overstate the impact of SB 92, because not everyone would switch from their current plans to limited-mandate plans. Therefore, these scenarios should be thought of as hypothetical maximum and low-impact scenarios in the short term rather than actual estimates of how the market might respond to SB 92. They are useful because they show **at most** the short-term savings that might be possible if there was broad acceptance of these policies.

Appendix E: Information Submitted by Outside Parties

In accordance with CHBRP policy to analyze information submitted by outside parties during the first two weeks of the CHBRP review, the following parties chose to submit information.

No information was submitted directly by interested parties for this analysis.

For information on the processes for submitting information to CHBRP for review and consideration please visit http://www.chbrp.org/recent_requests/index.php.

Appendix F: Limited-Mandate Plan Designs Used to Model Cost Impact Scenarios

This appendix presents the prototypes for the limited-mandate plans that are used to model the hypothetical cost impact scenarios presented in this report. For more information regarding the underlying assumption of which benefit *mandates* are included or excluded, please refer to Table F-4. Treatment of Mandates in Current Law for Each of the CDI Limited-Mandate Plan Prototypes, and Table F-5. Treatment of Mandates in Current Law for Each of the DMHC Limited-Mandate Plan Prototype.

The limited-mandate plans designs, and underlying assumptions as to which benefit mandates are included, were based on a review of "summary of benefits" documents or disclosure forms for carriers that offered limited-mandate or limited-benefit plans in other states that have laws permitting the development of these plans. Typically these limited-mandate plans may waive or be exempt from all or a subset of benefit mandates in law in those particular states. In addition to these publicly available marketing sources, the grey literature was also consulted. Note that these prototypes do not include cost-sharing information such as the deductible, copayments, and out-of-pocket maximums. This is not specified because this cost impact analysis assumes that cost sharing would not change as a result of SB 92 since the bill does not affect related requirements.

Group CDI-Regulated Limited-Mandate Policies

The proposed design for a large-group CDI limited-mandate plan could be one that a carrier can present as a lower-premium option to large-group purchasers. Large-group purchasers who offer this policy to their employees would do so in conjunction with another, more comprehensive HMO or PPO policy. The policy is designed to provide large-group employees the option of purchasing a bare bones policy at the lowest cost. The design for a small-group CDI limited-mandate plan is identical to that of the large-group market. It is also designed for small-group purchasers who would want to make available a bare bones policy at the lowest cost. This could be also be used by some small groups to attract better risk. If there is enough premium savings associated with this plan, smaller groups who do not currently offer health insurance may offer this policy. This plan design could also be appropriate for groups that would not offer coverage for dependants.

Table F-1. Large-Group and Small-Group CDI Limited-Mandate Plan

BENEFIT	INCLUDED/ EXCLUDED
Professional Services (Doctor office visits)	
Primary and specialty care visits (includes routine and Urgent Care appointments)	Included
Preventive screening	Included
Well-child preventive care visits (0-23 months)	Included
Family planning visits	Excluded
Scheduled prenatal care and first postpartum visit	Included
Eye exams	Excluded
Hearing tests	Excluded
Physical, occupational, and speech therapy visits	Included
Outpatient Services	
Outpatient surgery	Included
Vaccines (immunizations)	Included
X-rays and lab tests	Included
Health education	Excluded
Hospitalization Services	
Room and board, surgery, anesthesia, X-rays, lab tests, and drugs	Included
Labor & Delivery	Included
Emergency Department visits	Included
Ambulance Services	Included
Prescription Drug Coverage	
Generic	Included
Brand name	Excluded
Contraception drugs and devices	Excluded
Durable Medical Equipment	Excluded
Prosthetics and Orthotics	Excluded
Mental Health Services	
Inpatient psychiatric care	Excluded
Outpatient visits	Excluded
Chemical Dependency Services	
Inpatient detoxification	Excluded
Outpatient visits	Excluded
Home Health Services	Excluded
Non-custodial skilled nursing facility care	Included
Hospice care	Excluded
Infertility services	Excluded
Acupuncture	Excluded
Chiropractic	Excluded
Other (dental procedures, TMJ, experimental or investigational treatment, cosmetic surgery, food and dietary supplements, hearing aid, over-the-counter drugs or devices, weight reduction, sexual reassignment surgery)	Excluded

Individual CDI-Regulated Limited-Mandate Plan

This plan is designed for young, healthy adults who cannot necessarily afford a comprehensive HMO or PPO option. It would provide catastrophic coverage and provide only those preventive services recommended for adults. It is not designed to carry children as dependants. Note that the main difference between this individual plan design and the plan design for CDI large and small groups is its lack of maternity coverage.

Table F-2. Individual CDI Limited-Mandate Plan

BENEFIT	INCLUDED/ EXCLUDED
Professional Services (Doctor office visits)	
Primary and specialty care visits (includes routine and Urgent Care appointments)	Included
Preventive screening	Included
Well-child preventive care visits (0-23 months)	Excluded
Family planning visits	Excluded
Scheduled prenatal care and first postpartum visit	Excluded
Eye exams	Excluded
Hearing tests	Excluded
Physical, occupational, and speech therapy visits	Included
Outpatient Services	
Outpatient surgery	Included
Vaccines (immunizations)	Included
X-rays and lab tests	Included
Health education	Excluded
Hospitalization Services	
Room and board, surgery, anesthesia, X-rays, lab tests, and drugs	Included
Labor & Delivery	Excluded
Emergency Department visits	Included
Ambulance Services	Included
Prescription Drug Coverage	
Generic	Included
Brand name	Excluded
Contraception drugs and devices	Excluded
Durable Medical Equipment	Excluded
Prosthetics and Orthotics	Excluded
Mental Health Services	
Inpatient psychiatric care	Excluded
Outpatient visits	Excluded
Chemical Dependency Services	
Inpatient detoxification	Excluded
Outpatient visits	Excluded
Home Health Services	Excluded
Non-custodial skilled nursing facility care	Included
Hospice care	Excluded
Infertility services	Excluded
Acupuncture	Excluded
Chiropractic	Excluded
Other (dental procedures, TMJ, experimental or investigational treatment, cosmetic surgery, food and dietary supplements, hearing aid, over-the-counter drugs or devices, weight reduction, sexual reassignment surgery)	Excluded

DMHC Limited-Mandate Plan

This plan is designed to provide large- and small-group employees and individuals the option of purchasing a bare bones policy at the lowest cost and for those groups who may otherwise not offer coverage for dependants. This could be attractive to those who would prefer an HMO option.

Table F-3. Group and Individual DMHC Limited-Mandate Plan

BENEFIT	INCLUDED/ EXCLUDED
Professional Services (Doctor office visits)	
Primary and specialty care visits (includes routine and Urgent Care appointments)	Included
Preventive screening	Included
Well-child preventive care visits (0-23 months)	Included
Family planning visits	Excluded
Scheduled prenatal care and first postpartum visit	Included
Eye exams	Excluded
Hearing tests	Excluded
Physical, occupational, and speech therapy visits	Included
Outpatient Services	
Outpatient surgery	Included
Vaccines (immunizations)	Included
X-rays and lab tests	Included
Health education	Excluded
Hospitalization Services	
Room and board, surgery, anesthesia, X-rays, lab tests, and drugs	Included
Labor & Delivery	Included
Emergency Department visits	Included
Ambulance Services	Included
Prescription Drug Coverage	
Generic	Included
Brand name	Included
Contraception drugs and devices	Excluded
Durable Medical Equipment	Excluded
Prosthetics and Orthotics	Excluded
Mental Health Services	
Inpatient psychiatric care	Included
Outpatient visits	Included
Chemical Dependency Services	
Inpatient detoxification	Excluded
Outpatient visits	Excluded
Home Health Services	Included
Non-custodial skilled nursing facility care	Included
Hospice care	Included
Infertility services	Excluded
Acupuncture	Excluded
Chiropractic	Excluded
Other (dental procedures, TMJ, experimental or investigational treatment, cosmetic surgery, food and dietary supplements, hearing aid, over-the-counter drugs or devices, weight reduction, sexual reassignment surgery)	Excluded

Table F-4. Treatment of Mandates in Current Law for Each of the CDI-Regulated Limited-Mandate Plan Prototypes

Part A. Cancer Screening & Treatment

Description of Benefit	**Health & Safety Code Section**	**California Insurance Code Section**	**Type of Requirement Mandate or Mandated Offering**	**Markets Affected**	**CDI Individual** N/A=mandate doesn't apply	**CDI Group** N/A=mandate doesn't apply
Cancer screening tests	1367.665	10123.2	Mandate	Individual and group	Included as part of preventive services	Included as part of preventive services
Prostate cancer screening and diagnosis	1367.64	10123.83	Mandate	Individual and group	Included as part of preventive services	Included as part of preventive services
Cervical cancer screening	1367.66	10123.18	Mandate	Individual and group	Included as part of preventive services	Included as part of preventive services
Breast cancer screening, diagnosis, and treatment	1367.6	10123.8	Mandate	No mention	Included	Included
Breast cancer screening with Mammography	1367.65	10123.81	Mandate	No mention	Included as part of preventive services	Included as part of preventive services
Mastectomy and lymph node dissection – length of stay	1367.635	10123.86	Mandate	Individual and group	Included under ambulatory care or inpatient services	Included under ambulatory or inpatient services
Patient care related to clinical trials for cancer	1370.6	N/A	Mandate	No mention	N/A	N/A

Part B. Chronic Conditions

Description of Benefit	**Health & Safety Code Section**	**California Insurance Code Section**	**Type of Requirement Mandate or Mandated Offering**	**Markets Affected**	**CDI Individual** N/A=mandate doesn't apply	**CDI Group** N/A=mandate doesn't apply
Diabetes management and treatment	1367.51	10176.61	Mandate	No mention	Included	Included
Osteoporosis diagnosis, treatment and management	1367.67	10123.185	Mandate	No mention	Included	Included

Part B. Chronic Conditions (Cont'd)

Description of Benefit	**Health & Safety Code Section**	**California Insurance Code Section**	**Type of Requirement Mandate or Mandated Offering**	**Markets Affected**	**CDI Individual** N/A=mandate doesn't apply	**CDI Group** N/A=mandate doesn't apply
Transplantation services for persons with HIV	1374.17	10123.21	Mandate	No mention	Included under inpatient services	Included under inpatient services
AIDS vaccine	1367.45	10145.2	Mandate	Individual and group	Excluded	Excluded
HIV/AIDS, HIV Testing	1367.46	10123.91	Mandate	Individual and group	Excluded	Included
Phenylketonuria	1374.56	10123.89	Mandate	No mention	Excluded as part of maternity services	Included as part of maternity services

Part C. Mental Illness

Description of Benefit	**Health & Safety Code Section**	**California Insurance Code Section**	**Type of Requirement Mandate or Mandated Offering**	**Markets Affected**	**CDI Individual** N/A=mandate doesn't apply	**CDI Group** N/A=mandate doesn't apply
Coverage for mental and nervous disorders	N/A	10125	Mandated offering	Group	N/A	Excluded
Coverage and premiums for persons with physical or mental impairment	1367.8	10122.1	Mandate	Individual and group	Excluded under mental health services	Excluded under mental health services
Parity in coverage for severe mental illness	1374.72	10123.15 (10144.5)	Mandate	Group	N/A	Excluded under mental health services
Alcoholism treatment	1367.2	10123.6	Mandated offering	Group	N/A	Excluded under chemical dependency services
Alcohol and drug exclusion	N/A	10369.12	Mandate	Group	N/A	Excluded

Part D. Orthotics and Prosthetics

Description of Benefit	**Health & Safety Code Section**	**California Insurance Code Section**	**Type of Requirement Mandate or Mandated Offering**	**Markets Affected**	**CDI Individual** N/A=mandate doesn't apply	**CDI Group** N/A=mandate doesn't apply
Orthotic and prosthetic devices and services	1367.18	10123.7	Mandated offering	Group	N/A	Excluded
Prosthetic devices for laryngectomy	1367.61	10123.82	Mandate	No mention	Excluded	Excluded
Special footwear for persons suffering from foot disfigurement	1367.19	10123.141	Mandated offering	No mention	Excluded as orthotic and prosthetic items and devices	Excluded as orthotic and prosthetic items and devices

Part E. Pain Management

Description of Benefit	**Health & Safety Code Section**	**California Insurance Code Section**	**Type of Requirement Mandate or Mandated Offering**	**Markets Affected**	**CDI Individual** N/A=mandate doesn't apply	**CDI Group** N/A=mandate doesn't apply
Acupuncture	N/A	10127.3	Mandated offering	Group	N/A	Excluded
Pain management medication for terminally ill	1367.215	N/A	Mandate	No mention	N/A	N/A
General anesthesia for dental procedures	1367.71	10119.9	Mandate	No mention	Excluded	Excluded

Part F. Pediatric Health

Description of Benefit	**Health & Safety Code Section**	**California Insurance Code Section**	**Type of Requirement Mandate or Mandated Offering**	**Markets Affected**	**CDI Individual** N/A=mandate doesn't apply	**CDI Group** N/A=mandate doesn't apply
Comprehensive preventive care for children aged 16 years or younger	1367.3	10123.55	Mandated offering	Group	N/A (excluded under preventive services)	Included as part of preventive services
Comprehensive preventive care for children aged 17 or 18 years	1367.3	10123.55	Mandated offering	Group	N/A (excluded under preventive services)	Included as part of preventive services
Asthma management	1367.06	N/A	Mandate	No mention	N/A	N/A
Screening children for blood lead levels	1367.3 (b)(2)(D)	10119.8	Mandate	Individual and group	Excluded under preventive services	Included as part of preventive services

Table F-5. Treatment of Mandates in Current Law for the DMHC Limited-Mandate Plan Prototype

Part A. Cancer Screening & Treatment

Description of Benefit	**Health & Safety Code Section**	**California Insurance Code Section**	**Type of Requirement Mandate or Mandated Offering**	**Markets Affected**	**DMHC Individual** N/A=mandate doesn't apply	**DMHC Small and Large Group** N/A=mandate doesn't apply
Cancer screening tests	1367.665	10123.2	Mandate	Individual and group	Included as part of preventive services	Included as part of preventive services
Prostate cancer screening and diagnosis	1367.64	10123.83	Mandate	Individual and group	Included as part of preventive services	Included as part of preventive services
Cervical cancer screening	1367.66	10123.18	Mandate	Individual and group	Included as part of preventive services	Included as part of preventive services
Breast cancer screening, diagnosis, and treatment	1367.6	10123.8	Mandate	No mention	Included	Included
Breast cancer screening with Mammography	1367.65	10123.81	Mandate	No mention	Included as part of preventive services	Included as part of preventive services
Mastectomy and lymph node dissection – length of stay	1367.635	10123.86	Mandate	Individual and group	Included under ambulatory care or inpatient services	Included under ambulatory or inpatient services
Patient care related to clinical trials for cancer	1370.6	N/A	Mandate	No mention	Excluded	Excluded

Part B. Chronic Conditions

Description of Benefit	**Health & Safety Code Section**	**California Insurance Code Section**	**Type of Requirement Mandate or Mandated Offering**	**Markets Affected**	**DMHC Individual** N/A=mandate doesn't apply	**DMHC Small and Large Group** N/A=mandate doesn't apply
Diabetes management and treatment	1367.51	10176.61	Mandate	No mention	Included	Included
Osteoporosis diagnosis treatment and management	1367.67	10123.185	Mandate	No mention	Included	Included
Transplantation services for persons with HIV	1374.17	10123.21	Mandate	No mention	Included under inpatient services	Included under inpatient services
AIDS vaccine	1367.45	10145.2	Mandate	Individual and group	Excluded	Excluded
HIV/AIDS, HIV Testing	1367.46	10123.91	Mandate	Individual and group	Excluded	Included
Phenylketonuria	1374.56	10123.89	Mandate	No mention	Included as part of maternity services	Included as part of maternity services

Part C. Mental Illness

Description of Benefit	**Health & Safety Code Section**	**California Insurance Code Section**	**Type of Requirement Mandate or Mandated Offering**	**Markets Affected**	**DMHC Individual** N/A=mandate doesn't apply	**DMHC Small and Large Group** N/A=mandate doesn't apply
Coverage for mental and nervous disorders	N/A	10125	Mandated offering	Group	N/A	N/A
Coverage and premiums for persons with physical or mental impairment	1367.8	10122.1	Mandate	Individual and group	Included under mental health services (SMI only with limits)	Included under mental health services (SMI only with limits)
Parity in coverage for severe mental illness	1374.72	10123.15 (10144.5)	Mandate	Group	Included under mental health services (SMI only with limits)	Included under mental health services (SMI only with limits)

Part C. Mental Illness (Cont'd)

Description of Benefit	**Health & Safety Code Section**	**California Insurance Code Section**	**Type of Requirement Mandate or Mandated Offering**	**Markets Affected**	**DMHC Individual** N/A=mandate doesn't apply	**DMHC Small and Large Group** N/A=mandate doesn't apply
Alcoholism treatment	1367.2	10123.6	Mandated offering	Group	N/A	Excluded under chemical dependency services
Alcohol and drug exclusion	N/A	10369.12	Mandate	Group	N/A	Excluded

Part D. Orthotics and Prosthetics

Description of Benefit	**Health & Safety Code Section**	**California Insurance Code Section**	**Type of Requirement Mandate or Mandated Offering**	**Markets Affected**	**DMHC Individual** N/A=mandate doesn't apply	**DMHC Small and Large Group** N/A=mandate doesn't apply
Orthotic and prosthetic devices and services	1367.18	10123.7	Mandated offering	Group	N/A	Excluded
Prosthetic devices for laryngectomy	1367.61	10123.82	Mandate	No mention	Excluded	Included
Special footwear for persons suffering from foot disfigurement	1367.19	10123.141	Mandated offering	No mention	Excluded as orthotic and prosthetic items and devices	Excluded as orthotic and prosthetic items and devices

Part E. Pain Management

Description of Benefit	**Health & Safety Code Section**	**California Insurance Code Section**	**Type of Requirement Mandate or Mandated Offering**	**Markets Affected**	**DMHC Individual** N/A=mandate doesn't apply	**DMHC Small and Large Group** N/A=mandate doesn't apply
Acupuncture	N/A	10127.3	Mandated offering	Group	N/A	Excluded
Pain management medication for terminally ill	1367.215	N/A	Mandate	No mention	Included	Included

Part E. Pain Management (Cont'd)

Description of Benefit	**Health & Safety Code Section**	**California Insurance Code Section**	**Type of Requirement Mandate or Mandated Offering**	**Markets Affected**	**DMHC Individual** N/A=mandate doesn't apply	**DMHC Small and Large Group** N/A=mandate doesn't apply
General anesthesia for dental procedures	1367.71	10119.9	Mandate	No mention	Excluded	Included

Part F. Pediatric Health

Description of Benefit	**Health & Safety Code Section**	**California Insurance Code Section**	**Type of Requirement Mandate or Mandated Offering**	**Markets Affected**	**DMHC Individual** N/A=mandate doesn't apply	**DMHC Small and Large Group** N/A=mandate doesn't apply
Comprehensive preventive care for children aged 16 years or younger	1367.35	10123.5	Mandate	Group	N/A	Included
Comprehensive preventive care for children aged 17 or 18 years	1367.3	10123.55	Mandated offering	Group	N/A	Included
Asthma management	1367.06	N/A[77]	Mandate	No mention	Included	Included
Screening children for blood lead levels	1367.3(b)(2)(D)	10119.8	Mandate	Individual and group	Included	Included

[77] An N/A in either the Health & Safety Code column or the California Insurance Code column indicates that a mandate does not apply to plans covered under that code.

Part G. Reproductive

Description of Benefit	**Health & Safety Code Section**	**California Insurance Code Section**	**Type of Requirement Mandate or Mandated Offering**	**Markets Affected**	**DMHC Individual** N/A=mandate doesn't apply	**DMHC Small and Large Group** N/A=mandate doesn't apply
Contraceptive devices requiring a prescription	1367.25	10123.196	Mandate	No mention	Excluded	Excluded
Infertility treatments	1374.55	10119.6	Mandated offering	Group	N/A	Excluded
Conditions associated with exposure to diethylstilbestrol	1367.9	10119.7	Mandate	No mention	Excluded	Excluded
Prenatal diagnosis of genetic disorders	1367.7	10123.9	Mandated offering	Group	N/A	Included under maternity services
Expanded alpha-fetoprotein	1367.54	10123.184	Mandate	Individual and group	Included as part of maternity services	Included as part of maternity services
Maternity benefits – minimum length of stay[78]	1367.62	10123.87	Mandate	Individual and group	Included under maternity services	Included under maternity services
Maternity coverage – amount of copayment or deductible for inpatient services	1373.4	N/A	Mandate	No mention	Included (plan prototypes did not vary cost sharing_	Included (plan prototypes did not vary cost sharing)

[78] The federal Newborns' and Mothers' Health Protection Act of 1996 requires coverage for a minimum length of stay following delivery *if* the plan covers maternity service.

Part H. Mandates related to Surgery

Description of Benefit	Health & Safety Code Section	California Insurance Code Section	Type of Requirement Mandate or Mandated Offering	Markets Affected	DMHC Individual N/A=mandate doesn't apply	DMHC Small and Large Group N/A=mandate doesn't apply
Jawbone or associated bone joints	1367.68	10123.21	Mandate	No mention	Excluded under TMJ and dental disorders	Excluded under TMJ and dental disorders
Reconstructive surgery[79]	1367.63	10123.88	Mandate	Individual and group	Included (federal)	Included (federal)

Part I. Hospice and Home Health Care Benefit Mandates

Description of Benefit	Health & Safety Code Section	California Insurance Code Section	Type of Requirement Mandate or Mandated Offering	Markets Affected	DMHC Individual N/A=mandate doesn't apply	DMHC Small and Large Group N/A=mandate doesn't apply
Hospice care	1368.2	N/A	Mandate	Group	N/A	Included
Home health care	N/A	10123.10	Mandated offering	Group	N/A	N/A

[79] The federal Women's Health and Cancer Rights Act requires coverage for postmastectomy reconstructive surgery so that service would still have to be covered, even if this mandate were to be waived.

Part J. Other Mandates Regarding Terms and Conditions of Coverage

Description of Benefit	**Health & Safety Code Section**	**California Insurance Code Section**	**Type of Requirement Mandate or Mandated Offering**	**Markets Affected**	**DMHC Individual** N/A=mandate doesn't apply	**DMHC Small and Large Group** N/A=mandate doesn't apply
Prescription drugs: coverage of "off-label" use	1367.21	10123.195	Mandate	No mention	Included	Included
Prescription drugs: coverage for previously prescribed drugs	1367.22	N/A	Mandate	No mention	Excluded	Included
Authorization for nonformulary prescription drugs	1367.24	N/A	Mandate	No mention	Excluded	Included
Coverage for persons with blindness or partial blindness	1367.4	N/A	Mandate	Individual and group	Included	Included

Part K. Other Provider Mandates

Description of Benefit	**Health & Safety Code Section**	**California Insurance Code Section**	**Type of Requirement Mandate or Mandated Offering**	**Markets Affected**	**DMHC Individual** N/A=mandate doesn't apply	**DMHC Small and Large Group** N/A=mandate doesn't apply
Medical transportation services – direct reimbursement	1367.11	10126.6	Mandate	No mention	Included under ambulance services	Included under ambulance services
OB-GYNs as primary care providers	1367.69	10123.83	Mandate	No mention	Included	Included
Pharmacists – compensation for services within their scope of practice	1368.5	N/A	Mandate	No mention	Included	Included

Part L. Reproductive

Description of Benefit	**Health & Safety Code Section**	**California Insurance Code Section**	**Type of Requirement Mandate or Mandated Offering**	**Markets Affected**	**CDI Individual** N/A=mandate doesn't apply	**CDI Group** N/A=mandate doesn't apply
Contraceptive devices requiring a prescription	1367.25	10123.196	Mandate	No mention	Excluded	Excluded
Infertility treatments	1374.55	10119.6	Mandated offering	Group	N/A	Excluded
Conditions associated with exposure to diethylstilbestrol	1367.9	10119.7	Mandate	No mention	Excluded	Excluded
Prenatal diagnosis of genetic disorders	1367.7	10123.9	Mandated offering	Group	N/A	Included under maternity services
Expanded alpha-fetoprotein	1367.54	10123.184	Mandate	Individual and group	Excluded	Included as part of maternity services
Maternity benefits – minimum length of stay[80]	1367.62	10123.87	Mandate	Individual and group	Excluded	Included under maternity services
Maternity coverage – amount of copayment or deductible for inpatient services	1373.4	N/A	Mandate	No mention	N/A	N/A

[80] The federal Newborns' and Mothers' Health Protection Act of 1996 requires coverage for a minimum length of stay following delivery *if* the plan covers maternity service.

Part M. Mandates related to Surgery

Description of Benefit	Health & Safety Code Section	California Insurance Code Section	Type of Requirement Mandate or Mandated Offering	Markets Affected	CDI Individual N/A=mandate doesn't apply	CDI Group N/A=mandate doesn't apply
Jawbone or associated bone joints	1367.68	10123.21	Mandate	No mention	Excluded under TMJ and dental disorders	Excluded under TMJ and dental disorders
Reconstructive surgery[81]	1367.63	10123.88	Mandate	Individual and group	Included (federal)	Included (federal)

Part N. Hospice and Home Health Care Benefit Mandates

Description of Benefit	Health & Safety Code Section	California Insurance Code Section	Type of Requirement (Mandate or Mandated Offering)	Markets Affected	CDI Individual N/A=mandate doesn't apply	CDI Small Group N/A=mandate doesn't apply
Hospice care	1368.2	N/A	Mandate	Group	N/A	N/A
Home health care	N/A	10123.10	Mandated offering	Group	N/A	Excluded

Part O. Other Mandates Regarding Terms and Conditions of Coverage

Description of Benefit	Health & Safety Code Section	California Insurance Code Section	Type of Requirement (Mandate or Mandated Offering)	Markets Affected	CDI Individual N/A=mandate doesn't apply	CDI Small Group N/A=mandate doesn't apply
Prescription drugs: coverage of "off-label" use	1367.21	10123.195	Mandate	No mention	Excluded	Excluded
Prescription drugs: coverage for previously prescribed drugs	1367.22	N/A	Mandate	No mention	N/A	N/A
Authorization for nonformulary prescription drugs	1367.24	N/A	Mandate	No mention	N/A	N/A

[81] The federal Women's Health and Cancer Rights Act requires coverage for postmastectomy reconstructive surgery so that service would still have to be covered, even if this mandate were to be waived.

Part O. Other Mandates Regarding Terms and Conditions of Coverage (Cont'd)

Description of Benefit	**Health & Safety Code Section**	**California Insurance Code Section**	**Type of Requirement** (Mandate or Mandated Offering)	**Markets Affected**	**CDI Individual** N/A=mandate doesn't apply	**CDI Small Group** N/A=mandate doesn't apply
Coverage for persons with blindness or partial blindness	1367.4	N/A	Mandate	Individual and group	N/A	N/A

Part P. Other Provider Mandates

Description of Benefit	**Health & Safety Code Section**	**California Insurance Code Section**	**Type of Requirement** (Mandate or Mandated Offering)	**Markets Affected**	**CDI Individual** N/A=mandate doesn't apply	**CDI Small Group** N/A=mandate doesn't apply
Medical transportation services – direct reimbursement	1367.11	10126.6	Mandate	No mention	Included under ambulance services	Included under ambulance services
OB-GYNs as primary care providers	1367.69	10123.83	Mandate	No mention	Included	Included
Pharmacists – compensation for services within their scope of practice	1368.5	N/A	Mandate	No mention	N/A	N/A

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A group of faculty and staff undertakes most of the analysis that informs reports by the California Health Benefits Review Program (CHBRP). The CHBRP **Faculty Task Force** comprises rotating representatives from six University of California (UC) campuses and three private universities in California. In addition to these representatives, there are other ongoing contributors to CHBRP from UC. This larger group provides advice to the CHBRP staff on the overall administration of the program and conducts much of the analysis. The CHBRP **staff** coordinates the efforts of the Faculty Task Force, works with Task Force members in preparing parts of the analysis, and coordinates all external communications, including those with the California Legislature. The level of involvement of members of the CHBRP Faculty Task Force and staff varies on each report, with individual participants more closely involved in the preparation of some reports and less involved in others.

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

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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