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

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

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SB 320, Beall, Acquired Brain Injury (4/19/13) SB 320 would prohibit DMHC-regulated plans and CDI-regulated policies from denying coverage for medically necessary medical or rehabilitation treatment for ABI at specified facilities.	Preponderance of evidence suggests: • Among those with mTBI, only those requiring hospitalization benefit from post-acute multidisciplinary rehab. • Multidisciplinary interventions seem to work compared to minimal or no intervention Studies also suggest: • There is insufficient evidence to determine settings in which multidisciplinary rehab interventions occur affects' patients outcomes • Delivery of rehabilitation in specialized vs. unspecialized settings are ambiguous.	Unknown impact	Unknown impact	Unknown impact	Unknown impact	The California Department of Public Health reported that Californians aged 0 to 64 experienced 19,164 nonfatal TBI hospitalizations in 2011; 15,515 of those patients were treated and released, 1,144 were transferred to an acute care hospital, and 2,044 transferred to a nonacute care hospital (the remainder were classified as unknown). About 350,000 Californians are living with TBI.	Unknown impact

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SB 189, Monning, Wellness Programs (4/25/13) SB 189 would place requirements on DMHC-regulated plans and CDI-regulated insurers regarding their offering of and/or interaction with wellness programs established after January 1, 2014. The requirements would not be applicable to wellness programs established prior to January 1, 2014.	Participating in workplace wellness programs that address tobacco and alcohol use are effective at improving health outcomes. The effectiveness of participating in workplace wellness programs that address diet, exercise, obesity, and stress is ambiguous. The evidence suggests that financial incentives other than those linked to premiums or cost-sharing increase participation in workplace wellness programs but there is insufficient evidence to assess the relative effectiveness of different types of financial incentives.	CHBRP is unable to project any impact on benefit coverage for this mandate.	CHBRP is unable to project any impact on benefit coverage, and so cannot project any impact on utilization.	CHBRP is unable to project any impact on benefit coverage, and so cannot project any impact on total health care expenditures.	CHBRP is unable to project any impact on benefit coverage, and so cannot project any impact on expenditures and PMPM amounts by payer category.	Among insured Californians: • 11.4% smoke Among Californians: • 18.6% binge drink • 22.8% are obese	SB 189 could impact enrollee coverage or utilization of work-based wellness programs affecting health behaviors and outcomes such as tobacco use, excessive alcohol consumption, poor diet, physical inactivity, and related health outcomes. However, CHBRP is unable to estimate any change in coverage or utilization of work-based wellness programs. Therefore, the public health impact is unknown.

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SB 126, Steinberg, Health care coverage: Pervasive Developmental Disorder or Autism (3/24/13) SB 126 would extend the sunset date of an existing state benefit mandate requiring coverage for behavioral health treatment for pervasive developmental disorder or autism (PDD/A). Specifically, the existing state benefit mandate, and thus SB 126, requires coverage for applied behavioral analysis (ABA) and other intensive behavioral intervention therapies for enrollees with PDD/A.	Literature suggests that intensive behavioral intervention therapies are more effective than usual treatment and less intensive intervention therapies in improving adaptive behavior and intelligence quotient. However, the literature is ambiguous as to the effects of intensive behavioral intervention therapy on language and academic placement.	Because SB 126 extends the sunset date of an existing benefit mandate, 100% of enrollees in DMHC-regulated plans and CDI-regulated policies subject to SB 126 currently have coverage for intensive behavioral intervention therapy.	No impact. It is estimated that of the 127,000 enrollees diagnosed with PDD/A in DMHC-regulated plans and CDI-regulated policies subject to SB 126, 12,700 currently use intensive behavioral intervention therapies.	No impact. Current annual expenditures for intensive behavioral intervention therapies among enrollees in DMHC-regulated plans and CDI-regulated policies subject to SB 126 is estimated to be $686 million.	No impact.	CHBRP estimated the prevalence of PDD/A in California in 2012 is: • 240/10,000 children aged 5 to 9; • 180.7/10,000 children aged 10 to 14; and • 133.4/10,000 children aged 15 to 19. The lower prevalence rates in the older population are artifacts of differences in true risk, changes to diagnostic criteria, and other factors. CHBRP estimated there are 127,000 enrollees diagnosed with PDD/A in DMHC-regulated plans and CDI-regulated policies subject to SB 126.	No impact.

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

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

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

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AB 219, Perea, Oral Anticancer Medications (4/4/13) AB 219 prohibits cost sharing over $100 per oral chemotherapy prescription.	The number of oral anticancer drugs has grown dramatically over the past decade, with 13 new drugs introduced since 2011. Many do not have IV equivalents.	N/A	No measureable increase	Total expenditures increase by $454,000 (0.0003%)	PRIVATE Employers (0.0025%) Individuals w/group insurance (0.0024%) Individuals w/individual coverage (0.0037%) PUBLIC CalPERS (0.0000%) Medi-Cal (0.0000%) Enrollees' out-of-pocket expenditures (c) Copayment (−0.0176%) Enrollee expenses for noncovered benefits (−0%)	144,800 cancer cases/55,415 deaths in 2012.	No measurable change in utilization/therefore no expected reduction in premature death or economic loss

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

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AB 1800, Ma, Health Care Coverage (4/23/12) AB 1800 would require health care service plans and health insurance policies to provide coverage for at least two courses of treatment within a 12-month period for all tobacco cessation services rated "A" or "B" by the U.S. Preventive Services Task Force (USPSTF). It would also prohibit CDI-regulated policies and DMHC-regulated plans from: • Imposing copayments, coinsurance, or deductibles for those services; and • Imposing prior authorization or stepped care7 requirements on tobacco cessation treatments.	The preponderance of evidence suggests that persons who face higher cost sharing use fewer health care services. No studies were found that directly address the sort of annual out-of-pocket maximum requirement proposed in AB 1800. No studies were found that addressed having a single deductible as opposed to separate deductibles for prescription drugs and other covered benefits. However, there is a preponderance of evidence from studies on high-deductible health plans (HDHPs) that enrollment in HDHPs is associated with poorer adherence to drug therapy for certain chronic conditions.	AB 1800 does not require new coverage for any tests, treatments, or services. AB 1800 modifies the terms and conditions of coverage for 21.7 million enrollees with coverage subject to AB 1800. For the annual out-of-pocket maximum requirement of AB 1800, 13.9 million enrollees were estimated to have coverage that was not compliant.	CHBRP estimated that there would not be a change in the number of users of health care services. However, due to a decrease in enrollee out-of-pocket expenses, CHBRP estimated an increase in utilization that would shift costs from enrollees to plans/policies. CHBRP estimated a 1% increase in plans/policies' total medical costs per user and a 3% decrease in total medical costs per user paid by the user.	$246.5 million (0.24%)	PRIVATE Employers (0.60%) Individuals w/group insurance (0.60%) Individuals w/individual coverage (0.96%) PUBLIC CalPERS, Medi-Cal, and MRMIB plans (0%) Enrollees' out-of-pocket expenses for covered benefits: −$275.5 million (3.23%)	N/A	To the extent that the financial burden from out-of-pocket expenses for covered benefits is reduced under AB 1800, there is a potential for a public health impact. However, due to a lack of data CHBRP was not able to estimate the potential magnitude. The increase in premiums in the CDI-regulated markets were estimated to result in an increase in the uninsured of 5,151.

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AB 1738, Huffman, Tobacco Cessation Services (4/20/12) AB 1738 would require a limit on annual out-of-pocket expenses for all covered benefits, including prescription drugs.	Counseling intervention, brief advice from physicians and clinical staff, and FDA-approved pharmacotherapy are effective treatments for tobacco cessation, as measured by abstinence or quit rates. The preponderance of evidence suggests that full coverage for these three treatments and services is associated with improved abstinence from smoking, relative to no coverage for these treatments.	Full coverage is defined as coverage for all three treatments/services: cessation counseling, FDA-approved prescription and over-the-counter drugs. CHBRP found that 79.4% of enrollees with state-regulated health insurance had benefit coverage for counseling, 21.5% had benefit coverage for OTC drugs, and 23.5% had benefit coverage for prescription drugs.	Utilization would increase by 27.4% or 83,300 individuals using one or more services.	Net increase of $38.4 million or .04%. Out-of-pocket expenses would be reduced by $11.1 million. Noncovered expenses reduced by $16.3 million.	PRIVATE Employers: Group market (0.06%) Individual market (0.18%) PUBLIC CalPERS HMO (0.09%) Medi-Cal HMO (0%) MRMIB(0.03%)	Percentage mortality attributable to smoking (though not limited to these conditions): • 19% of heart disease mortality • 6% trachea cancer • 5% bronchus cancer • 5% lung cancer	Increase successful quitters by 5,287 per year; between 37,009 and 65,559 life years gained.

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

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

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

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AB 428, Portantino, Fertility Preservation (4/15/11) AB 428 would require health plans and policies to cover "medically necessary expenses for standard fertility preservation services when a necessary medical treatment may directly or indirectly cause iatrogenic infertility to an enrollee."	Medical effectiveness of fertility preservation varies depending on the type of procedure: • There is a preponderance of evidence that sperm cryopreservation with sperm collected through ejaculate, embryo cryopreservation, and conservative gynecologic surgery are effective methods of fertility preservation. • There is insufficient evidence to conclude that ovarian transposition and testicular/ovarian shielding during radiation are effective methods of fertility preservation.	AB 428 would apply to the 21.9 million enrollees in all DMHC-regulated, privately funded plans and DMHC-regulated, publicly funded plans, as well as all CDI-regulated policies. Standard medical services for fertility preservation include procurement and storage of sperm and embryos. Approximately 5.4% of the 21.9 million enrollees currently have coverage for fertility preservation services. If enacted, AB 428 would increase this to 100% of enrollees. No publicly funded DMHC-regulated plans currently include coverage for fertility preservation services.	CHBRP estimates that currently, 1,057 male enrollees use sperm cryopreservation and 222 female enrollees use embryo cryopreservation. If AB 428 is enacted, CHBRP estimates total postmandate utilization to equal 1,263 male enrollees and 578 female enrollees. This is primarily due to the reduction in costs associated for benefits that were previously not covered. This represents a 19% increase among male enrollees and a 161% increase among female enrollees. In total, postmandate, CHBRP estimates a 44% increase in the use of fertility preservation services, as measured by the number of new users.	Total net health expenditures are projected to increase by $6.5 million (0.0068%) (Table 1). This is due to an $8.5 million increase in premiums partially offset by a net reduction in enrollee out-of-pocket expenditures of $2 million, comprised of a reduction in enrollee expenses for noncovered benefits ($3.2 million) and an increase in enrollee out-of-pocket expenses for the newly covered benefits ($1.2 million).	Increases in per member per month (PMPM) premiums for the newly mandated benefit coverage vary slightly by market segment. Increases as measured by percentage changes in PMPM premiums are estimated to range from an average of 0.00% (for DMHC-regulated Medi-Cal Managed Care plans for ages 65+) to an average of 0.0173% (for CDI-regulated individual policies) in the affected market segments. Among publicly funded DMHC-regulated plans, CHBRP estimates that premiums will increase for Medi-Cal Managed Care Plans, Managed Risk Medical Insurance Board (MRMIB) Plans, and CalPERS HMOs. The increase would range from an average of 0.00% to 0.0125%.	Loss of fertility can negatively impact the quality of life for cancer survivors of reproductive age. As a result of AB 428, it is expected that the quality of life could improve for some of the 6,346 cancer patients at risk for iatrogenic infertility each year who would gain coverage for fertility preservation services.	Although CHBRP is unable to quantify the effects, there would likely be a benefit to patients of reproductive age being treated for autoimmune disorders such as Crohn's disease, where loss of fertility may result from treatment of their disease. AB 428 would decrease expenses paid directly by enrollees who use fertility preservation services by almost $2 million. Therefore, AB 428 is estimated to reduce financial hardship for enrollees who face the risk of iatrogenic infertility. No evidence was found on potential disparities in the use of fertility preservation treatments by race/ethnicity. Therefore, the extent to which AB 428 would have an impact on disparities is unknown.

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

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AB 310, Ma, Prescription Drugs (4/14/11) AB 310 would: • Prohibit coinsurance as the basis for cost sharing for outpatient prescription drug benefits • Limit copayments for outpatient prescription drugs to $150 per one-month supply or its equivalent for prescriptions for longer periods • If a plan or policy has an annual out-of-pocket maximum, require outpatient prescription drug benefit cost sharing to be included under that annual out-of-pocket maximum.	Prescription drugs can be divided into two major categories: traditional agents and specialty drugs. The medical effectiveness analysis for AB 310 focused on the impact of cost sharing (i.e., the portion of expenditures paid by enrollees) on use of prescription drugs. <u>Specialty drugs</u> The *preponderance of evidence* from these studies suggests that demand for specialty drugs is sensitive to price but that the size of the effect is small. Estimates of the price elasticity of demand6 for specialty drugs suggest that each 10% increase in cost sharing for specialty drugs would reduce spending for these drugs by 0.1% to 2.1% depending on the disease a specialty drug is used to treat. <u>Traditional drugs</u> The *preponderance of evidence* from these studies suggests that demand for traditional agents is more sensitive to price than demand for specialty drugs.	AB 310 applies to all plans and policies that have an outpatient prescription drug benefit (96% of the plans and policies that may be subject to state level mandates). Therefore, the mandate would directly affect the health insurance of 20.9 million people (56% of Californians).	Premandate, CHBRP estimates that 0.018% of enrollees with outpatient prescription drug benefit have filled prescriptions where the cost share exceeded $150 for a one-month supply. The utilization rate among such persons was approximately 8.8 prescriptions per 1,000 enrollees. These enrollees' out-of-pocket costs were on average $271 per prescription. Postmandate, overall utilization rates are expected to change. Prescriptions for which coinsurance cost sharing would have exceeded $150 per one-month supply would be limited to that amount. The average cost share for those prescriptions would therefore fall from $271 premandate to $150 per one-month supply postmandate. As a result, CHBRP estimates an 4% increase in utilization for these prescriptions.	Total net health expenditures are projected to increase by $31.7 million (0.033%) (Table 1). This is due to a $220.3 million increase in health insurance premiums partially offset by reductions in enrollee cost sharing ($188.6 million). There are likely to be long-term cost impacts but the magnitude is unknown at this time. Advances in drug development are likely to yield new, higher-cost drugs. CHBRP recognizes that a decrease in out-of-pocket expenditures may interact with these trends and thereby further increase the demands for these medications as a result of AB 310.	Premium expenditures by private employers for group insurance: 0.2907% Premium expenditures for individually purchased insurance: 0.1741% Premium expenditures by persons with group insurance, CalPERS HMOs, Healthy Families Program, AIM or MRMIP: 0.2927% CalPERS HMO employer expenditures: 0.3167% Medi-Cal Managed Care Plan expenditures: 0.0000% MRMIB Plan expenditures: 0.0000%	Prescription drugs can be divided into two major categories: traditional agents and specialty drugs. Specialty drugs are new, high-cost drugs, primarily biologics that are primarily used to treat complex chronic conditions, such as anemia, cancer, growth hormone deficiency, hemophilia, hepatitis, multiple sclerosis, and rheumatoid arthritis. Traditional agents consist of generic and brand-name drugs that are produced using traditional pharmaceutical manufacturing processes. They are used to treat a wide range of chronic and acute conditions. They play major roles in the prevention and treatment of common conditions such as heart disease, diabetes, asthma, and depression.	CHBRP estimates no public health impact of the provision capping copayments at $150 per prescription per one-month supply since CHBRP estimates that no enrollees are currently in plans and policies with outpatient prescription drug copayments exceeding $150. AB 310's provision requiring those plans or policies that have an annual OOP maximum to include out-of-pocket cost for the prescription drug benefit may have a public health impact; however, given lack of evidence and data, the potential public health impact is unknown.

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

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

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

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SB 155, Evans, Maternity Services (4/1/11) SB 155 would require health insurance policies regulated by the CDI to cover maternity services, therefore affecting the health insurance of approximately 2.86 million Californians (13% under state-regulated health insurance).	Studies of prenatal care can be divided into two major groups: • Studies of the impact of variation in the number of prenatal care visits that pregnant women receive, and • Studies of the effectiveness of specific medical services provided to pregnant women (e.g., laboratory tests and medications). Randomized controlled trials (RCTs) have consistently found no statistically significant association between the number of prenatal visits pregnant women receive and birth outcomes for either infants or for mothers. However, there is clear and convincing evidence from multiple RCTs that several prenatal care services are effective in producing better birth outcomes for mothers and infants.	SB 155 would apply only to CDI-regulated health insurance policies subject to the California Insurance Code. It would require all CDI-regulated policies to cover maternity services. About 2,858,000 Californians, or 13% of enrollees in health insurance plans and policies subject to state regulation, are in the CDI-regulated market. SB 155 would expand maternity services coverage to approximately 1,184,000 enrollees with CDI-regulated individual policies, including about 268,181 women aged 19 to 44 years.	CHBRP estimates that approximately 8,574 pregnancies would be newly covered under CDI-regulated insurance policies postmandate. CHBRP is unable to estimate the precise impact SB 155 would have on the utilization of prenatal care.	Among all enrollees in state-regulated policies (both CDI-regulated and DMHC-regulated), total annual health expenditures are estimated to increase by $22.2 million, or 0.02%, as a result of this mandate.	Mandating maternity coverage is expected to increase per member per month (PMPM) premiums for CDI-regulated individual policies by $6.92, or 3.5%, on average. Premium impacts are summarized as follows: CHBRP estimates that for the majority (88%) of enrollees in the CDI-regulated individual market who do not currently have maternity benefits, SB 155 would *increase* average premiums by 2% to 28% among those aged 19 to 44 years, depending on the age of the enrollee. Among the minority (12%) of enrollees in the CDI-regulated individual market who currently have maternity benefits, SB 155 is expected to *decrease* average premiums by 0.5% to 23%, depending on the age of the enrollee among those aged 19 to 44 years.	SB 155 mandates coverage for maternity services. Maternity services generally include prenatal care, such as office visits and screening tests; labor and delivery services, including hospitalization; care resulting from complications related to a pregnancy; and postnatal care. In 2009, there were more than 526,000 births in California, of which 3.1% were to women either not receiving prenatal care or receiving prenatal care starting in the third trimester.	To the extent that SB 155 increases utilization of effective prenatal care services, there is a potential that this mandate could lead to a reduction in infant and maternal mortality and improve health outcomes, such as the rates of low birth weight or preterm births, infectious disease transmissions, and respiratory distress syndrome.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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AB 754, Chesbro, Durable Medical Equipment (6/24/10) AB 754 would require that enrollees with health insurance regulated by the DMHC or CDI have DME coverage and have coverage at the same level or "at parity" with other health care benefits.	There is insufficient evidence to assess the impact of health insurance coverage for DME on use of DME and health outcomes for persons who use DME. • The few studies that have been conducted suggest that need is the primary factor associated with use of DME. • No studies were found that specifically address the effects of increasing annual or lifetime limits for DME coverage on DME usage or the impact of reducing deductibles, coinsurance, or copayments for DME on such usage. • No studies were found that address the impact of coverage for DME on health outcomes.	Prior to the mandate, approximately 93.32% of enrollees with health insurance subject to the mandate have at least some coverage for DME. Post-mandate, the 1,301,462 (6.68%) of enrollees previously without DME coverage would gain DME benefits compliant with AB 754.	Post-mandate, CHBRP estimates that there would be a $52.01 (6.99%) per DME user per year increase in DME utilization and related expenses.	Total net annual expenditures are estimated to increase by $135,933,000 annually, or 0.18%.	The mandate is estimated to increase premiums by $276,306,000. The distribution of the impact on premiums is as follows: Total premiums for private employers are estimated to increase by $161,681,000, or 0.37%. Enrollee contributions toward premiums for group insurance are estimated to increase by $50,314,000, or 0.39%. Total premiums for those with individually purchased insurance are estimated to increase by $64,311,000, or 1.07%. Total premium expenditures for CalPERS HMOs would not increase because the DME coverage is already compliant with the mandate.	N/A	The health outcomes associated with the use of DME vary according to the type of DME that is being used. Some health outcomes include increased independence, mobility, functionality, survival, and decreased morbidity. AB 754 is not expected to affect the number of DME users, but is expected to increase the amount of DME used by each current DME user. The impact on health outcomes of this increase is unknown.

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2009							
AB 513, de Leon, Breast-Feeding (4/17/2009) AB 513 mandates coverage of lactation consultation by International Board Certified Lactation Consultants and coverage of breast pump rental.	Multiple guidelines recommend lactation consultation and use of breast pumps as means of supporting breast-feeding—which is recommended as a means of reducing morbidity and improving health outcomes. Breast pumps are effective. Lactation consultation is effective.	If the mandate is enacted, CHBRP makes the following estimates for changes in coverage: • 8.5 million enrollees would gain coverage for outpatient lactation consultation. • 2.8 million enrollees would gain coverage for breast pump rental.	Lactation Consultation +0% Breast Pumps +50%	+$2.4 million (+0.0028%)	PRIVATE Employers (+0.0064%) Individuals w/group insurance (+0.0065%) Individuals w/individual coverage (+0.0061%) PUBLIC CalPERS (0.0066%) Medi-Cal (0.1879%) HFP (0.0000%) Members' out-of-pocket expenditures (c) Copayment (−0.0419%) Direct payment (−94.3529%)	N/A	Increased use of breast pumps is expected to promote duration of breast-feeding and/or exclusivity of breast-feeding, which may result in health benefits.

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

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

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

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

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SB 92, Aanestad, Health Care Reform (4/13/2013) SB 92 is a legislative proposal with numerous provisions to reform the system of health care delivery in California. Among the many provisions in this 126-page omnibus bill, there are four that fall within the purview of CHBRP for review.	The amount and strength of the evidence regarding the medical effectiveness of the services for which coverage may be excluded under SB 92 varies. The outcomes that are most important for assessing effectiveness also differ. Nevertheless, many of the mandates and mandated offerings require health insurance products to provide coverage for health care services for which there is strong evidence of effectiveness.	CHBRP analyzed two different scenarios to assess the coverage impacts of SB 92. Under Scenario 1: 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. Under Scenario 2: 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.	The impact on utilization of SB 92 is unclear.	Under Scenario 1: The combined effect on overall health expenditures of this scenario would be a net savings of $1.985 billion, or 2.12%. Under Scenario 2: The combined effect on overall health expenditures of this scenario would be a net savings of $71.582 million, or 0.08%.	Individual benefit mandates typically raise premiums by less than 1%; the cumulative annual cost of the state's mandated benefits is between 5% and 19% of the total premium for the health insurance product. Studies of the *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 5% of premiums.	N/A	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.

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

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

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

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

Notes:(a) Total expenditures include total premiums and out-of-pocket spending for copayments and noncovered benefits.
(b) Percentages differ from those in published reports due to rounding to the second decimal place.
(c) Members' out-of-pocket expenditures refer to privately insured members' out-of-pocket expenditures, copayments, and direct payments for services not covered under the benefit.