

# California Health Benefits Review Program

---

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

---

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

---





The California Health Benefits Review Program (CHBRP) was established in 2002 to respond to requests from the California Legislature to provide an independent analysis of the medical, financial, and public health impacts of proposed health insurance benefit mandates and repeals per its authorizing statute.<sup>1</sup> The program was reauthorized in 2006 and again in 2009. CHBRP's authorizing statute defines legislation proposing to mandate or proposing to repeal an existing health insurance benefit as a proposal that would mandate or repeal a requirement that a health care service plan or health insurer: (1) permit covered individuals to obtain health care treatment or services from a particular type of health care provider; (2) offer or provide coverage for the screening, diagnosis, or treatment of a particular disease or condition; (3) offer or provide coverage of a particular type of health care treatment or service, or of medical equipment, medical supplies, or drugs used in connection with a health care treatment or service; and/or (4) specify terms (limits, timeframes, copayments, deductibles, coinsurance, etc.) for any of the other categories.

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

---

<sup>1</sup> Available at: [www.chbrp.org/documents/authorizing\\_statute.pdf](http://www.chbrp.org/documents/authorizing_statute.pdf).

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

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

**October 4, 2013**

**California Health Benefits Review Program  
1111 Franklin Street, 11<sup>th</sup> Floor  
Oakland, CA 94607-5200  
Tel: 510-287-3876  
Fax: 510-763-4253  
[www.chbrp.org](http://www.chbrp.org)**

Additional free copies of this and other CHBRP bill analyses and publications may be obtained by visiting the CHBRP website at [www.chbrp.org](http://www.chbrp.org).

### **Suggested Citation:**

California Health Benefits Review Program (CHBRP). (2013). *Implementation of Assembly Bill 1540: Analysis of Legislation Mandating or Repealing Health Care Benefits and Services: A Report to the California State Governor and Legislature*. Oakland, CA: CHBRP.

# TABLE OF CONTENTS

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

## LIST OF TABLES AND FIGURES

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

## EXECUTIVE SUMMARY

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

Currently set to sunset on June 30, 2015, CHBRP was established by Assembly Bill (AB) 1996 (Thomson, 2002), which "requested the University of California (UC) to assess legislation proposing mandated health care benefits to be provided by health care service plans and health insurers." In California, more than 40 health insurance benefit mandates had been enacted by the close of 2001. In response to concerns about benefit mandates serving their intended purposes without creating unintended consequences (including, but not limited to, large premium increases), by the end of 2002, California and 16 other states passed laws requiring benefit mandate evaluation. Since then, 12 additional states have formalized benefit mandate evaluation, bringing the total to 29 as of 2013.<sup>2</sup>

The annual number of benefit mandate bills introduced in California's Legislature remained steady between 2002 and 2006, and the Legislature deemed it valuable to continue requesting evaluations of mandate bills (SBFI Committee, 2006). As a result, CHBRP was reauthorized by Senate Bill (SB) 1704 (Kuehl, 2006) and again by AB 1540 (Assembly Health Committee, 2009). Since 2006, the number of introduced benefit mandate bills remained relatively steady, until passage of the Affordable Care Act (ACA).<sup>3</sup> Perhaps in response to the ACA, the California Legislature saw the number of introduced benefit mandate bills swell to 15 in 2011 and then fall to 3 in 2012, before rising back to 9 in 2013.<sup>4</sup>

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

CHBRP's most recent reauthorization, AB 1540, requested a report be submitted to the Governor and the Legislature by January 1, 2014, describing implementation of the bill as enacted. This report is provided in response to that request, and describes how CHBRP has fulfilled the mission outlined in its authorizing statute<sup>5</sup> during the years 2009 through 2013.

---

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

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

<sup>4</sup> Although CHBRP was only asked to analyze eight benefit mandate bills in 2013, Senator Hernandez, Chair of the Senate Health Committee, has testified that nine were introduced. See the Senate Health Committee analysis of SB 18. Available at: [www.leginfo.ca.gov/pub/13-14/bill/sen/sb\\_0001-0050/sb\\_18\\_cfa\\_20130430\\_093208\\_sen\\_comm.html](http://www.leginfo.ca.gov/pub/13-14/bill/sen/sb_0001-0050/sb_18_cfa_20130430_093208_sen_comm.html).

<sup>5</sup> Available at: [www.chbrp.org/docs/authorizing\\_statute.pdf](http://www.chbrp.org/docs/authorizing_statute.pdf).

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

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

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

### **California Cost and Coverage Model**

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

### **Benefit Floors and Essential Health Benefits**

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

---

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

<sup>7</sup> CHBRP maintains a list of mandates applicable in California, available at [http://www.chbrp.org/other\\_publications/index.php](http://www.chbrp.org/other_publications/index.php)

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

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

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

*Source:* California Health Benefits Review Program, 2013.

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

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

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



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

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

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

## **CHBRP's Charge: Analyses and Approach**

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

### **CHBRP Analyses During the Legislative Process**

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

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

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

---

<sup>9</sup> See CHBRP's website at [www.chbrp.org](http://www.chbrp.org).

## **CHBRP Analyses Beyond the Legislative Cycle**

Highlighting the strength of CHBRP's contributions, the analyses remain relevant as references even beyond the legislative process. For example, health insurers and regulators report having used CHBRP analyses in discussion of appropriate rate increases when analyzed bills have passed into law and health plans also report using CHBRP's medical effectiveness analysis to evaluate their benefit coverage offerings. Outside of California, a report<sup>10</sup> by the Center for Consumer Information and Insurance Oversight (CCIIO) cited a CHBRP analysis' estimate regarding the marginal cost of covering applied behavioral analysis as an EHB (CCIIO, 2011), and the Institute of Medicine (IOM) recommended that CHBRP's approach serve as a guide for further defining EHBs in the future (IOM, 2011).<sup>11</sup> Academics in California and beyond, as well as state governments across the country often cite CHBRP analyses when considering similar legislation.

## **Benefit Mandates as Multifaceted Instruments**

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

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

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

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

---

<sup>10</sup> CCIIO, 2011, *Essential Health Benefits Bulletin*. Available at: [www.cms.gov/CCIIO/Resources/Files/Downloads/essential\\_health\\_benefits\\_bulletin.pdf](http://www.cms.gov/CCIIO/Resources/Files/Downloads/essential_health_benefits_bulletin.pdf).

<sup>11</sup> IOM, 2011. *Essential Health Benefits: Balancing Coverage and Cost*. Available at: [www.iom.edu/Reports/2011/Essential-Health-Benefits-Balancing-Coverage-and-Cost.aspx](http://www.iom.edu/Reports/2011/Essential-Health-Benefits-Balancing-Coverage-and-Cost.aspx).

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

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

*Source:* California Health Benefits Review Program, 2013.

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

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

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

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

## Academic Rigor on Demand

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

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

### **Broad Multidisciplinary Expertise**

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

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

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

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

### **Unbiased and Neutral Analyses**

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

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

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

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

### **Unique Information in a CHBRP Report**

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

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

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

---

<sup>12</sup> For the full list of existing mandates in California, see Appendix 19.

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

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

### **Summary of CHBRP Report Findings**

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

### **Fulfilling CHBRP's Mission**

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

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

# INTRODUCTION

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

Currently set to sunset on June 30, 2015, CHBRP was established by Assembly Bill (AB) 1996 (Thompson, 2002) which "requested the University of California (UC) to assess legislation proposing mandated health care benefits to be provided by health care service plans and health insurers." The provisions of AB 1996, originally set to sunset on January 1, 2007, were extended by Senate Bill (SB) 1704 (Kuehl, 2006) and further extended by AB 1540 (Assembly Health Committee, 2009). SB 1704 added a provision that requested the University of California (UC), through CHBRP, analyze legislation that would repeal existing benefit mandates, and AB 1540 extends those provisions. AB 1540 also requested that UC to submit a report to the Governor and the Legislature describing the implementation of the program's authorizing statute by January 1, 2014.<sup>13</sup> This implementation report is written in response to that request, and describes how the program has fulfilled the mission outlined in its authorizing statute<sup>14</sup> during the years 2009 through 2013.

## History and Trends in Benefit Mandate Legislation

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

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

---

<sup>13</sup> CHBRP provided similar reports to the Legislature and Governor in compliance with AB 1996 on December 22, 2005, and in compliance with SB 1704 on December 22, 2009. Both of those reports can be found at [www.chbrp.org](http://www.chbrp.org).

<sup>14</sup> Available at: [www.chbrp.org/docs/authorizing\\_statute.pdf](http://www.chbrp.org/docs/authorizing_statute.pdf).

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

In California, more than 40 mandated benefits had been enacted into state law by the close of 2001, and during the 2001–2002 session, 10 benefit mandate bills were introduced. At that time, concerns arose regarding cost containment and whether well-intended mandates actually served their intended purposes. In response, 17 states, including California, passed laws requiring the evaluation of health benefits mandates during 2001–2002.<sup>16</sup>

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

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

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

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

---

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



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

In March 2010, the federal government passed the ACA<sup>17</sup>, enacting health care reform laws that dramatically impacted California's health insurance markets and its regulatory environment. The ACA included a number of provisions, such as the expansion of Medicaid, the establishment of private health insurance exchanges, and the requirement to provide essential health benefits (EHBs), that impacted California health insurance benefit coverage, as well as directly and indirectly prompted changes to health care delivery and finance.

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

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

---

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

**Table 2.** 2013 California Mandate Bills and Essential Health Benefits

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

Source: California Health Benefits Review Program, 2013.

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

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

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

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

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

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

---

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

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

## CHBRP'S CHARGE: ANALYSES AND APPROACH

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

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

### CHBRP's Initial Objectives and Charge

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

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

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

---

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

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

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

## **CHBRP Reports**

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

## **Topics of Bills Analyzed**

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

**Table 3. CHBRP Analyzed Bills: Topics Addressed and Final Bill Status, 2009–2013<sup>21</sup>**

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

Source: California Health Benefits Review Program, 2013.

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

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

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

Source: California Health Benefits Review Program, 2013.

### **Summary of CHBRP Reports**

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

#### *Medical effectiveness*

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

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



### *Cost impact*

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

### *Public health impacts*

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

### **Use of CHBRP's Reports**

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

### *CHBRP analyses during the legislative process*

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

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

Additionally, sometimes information cited in CHBRP reports is used when considering another California bill on a related topic. Such a situation occurred with CHBRP's analyses of AB 171 (Beall, 2011), a bill that would have required health plans and insurers to cover test, treatments, and services related to Pervasive Developmental Disorders and Autism (PDD/A). The medical effectiveness analysis section of CHBRP's AB 171 report, as well as the fiscal impact estimates, were used to examine two related bills, SB 770 (Steinberg and Evans, 2011) and SB 946<sup>23</sup> (Steinberg, 2011), both of which also addressed coverage for PDD/A. The latter of the two eventually became a health insurance benefit mandate law.

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

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

#### *CHBRP analyses beyond the legislative cycle*

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

Outside of California, a recent federal report<sup>24</sup> cited a CHBRP analysis's estimate regarding the marginal cost of covering applied behavioral analysis as an EHB, and the Institute of Medicine (IOM) also recommended that CHBRP's approach serve as a guide for further defining EHBs in the future.<sup>25</sup> Other states considering their own benefit mandate bills have also utilized CHBRP's analyses. Several recent instances appear in Table 4, although the list is certainly an undercount, given that CHBRP is not always made aware of such citations.

---

<sup>23</sup> SBD 946 was originally known as SB TBD-1.

<sup>24</sup> Center for Medicare & Medicaid Services, Center for Consumer Information and Insurance Oversight, *Essential Health Benefits Bulletin*. December 16, 2011. Available at: [www.cms.gov/CCIIO/Resources/Files/Downloads/essential\\_health\\_benefits\\_bulletin.pdf](http://www.cms.gov/CCIIO/Resources/Files/Downloads/essential_health_benefits_bulletin.pdf).

<sup>25</sup> IOM, 2011. *Essential Health Benefits: Balancing Coverage and Cost*. Available at: [www.iom.edu/Reports/2011/Essential-Health-Benefits-Balancing-Coverage-and-Cost.aspx](http://www.iom.edu/Reports/2011/Essential-Health-Benefits-Balancing-Coverage-and-Cost.aspx).

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

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

## Other Publications

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

## Resources

### *Estimates of the Sources of Health Insurance*

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

### *Health Insurance Benefit Mandates in California State Law*

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

### *Federal Preventive Services Benefit Mandate and California Benefit Mandates*

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

## **Policy and Issue Briefs**

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

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

### *Immunization Mandates, Benchmark Plan Choices, and Essential Health Benefits*

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

### *Mammography Mandates, Benchmark Plan Choices, and Essential Health Benefits*

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

### *Pediatric Dental and Pediatric Vision Essential Health Benefits*

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

## Legislative Outreach and Briefings

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

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

## Disseminating Knowledge Obtained Through CHBRP's Experiences

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

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

---

<sup>26</sup> A full list of presentations and publication can be found in Appendix 8.

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

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

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

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

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

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

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

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

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

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

## Continuous Quality Improvement

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

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

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

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



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

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

### **Readability, Reliability, and Content of the Reports**

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

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

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

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

### **CHBRP's Analytic and Research Translation Process**

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

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

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

### **Challenges Inherent to CHBRP's Analytic Process**

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

#### **Identifying Mandate Bills**

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

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

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

### **Workflow and Timing**

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

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

### **Estimating Public Health Projections With Data Limitations**

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

## **Applicability and Limitations of the Medical Literature**

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

## ACADEMIC RIGOR ON DEMAND

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

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

### Overall Structure

Operating support for CHBRP is provided through a non-General Fund source, specifically, fees levied by the California Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI) on health care service plans and health insurers, the total annual amount of which has been capped at \$2 million annually, or about \$0.0077 per member per month (in 2012 dollars) since 2003.<sup>28</sup> Additional in-kind support has also been provided by UC.

### Broad Multidisciplinary Expertise

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

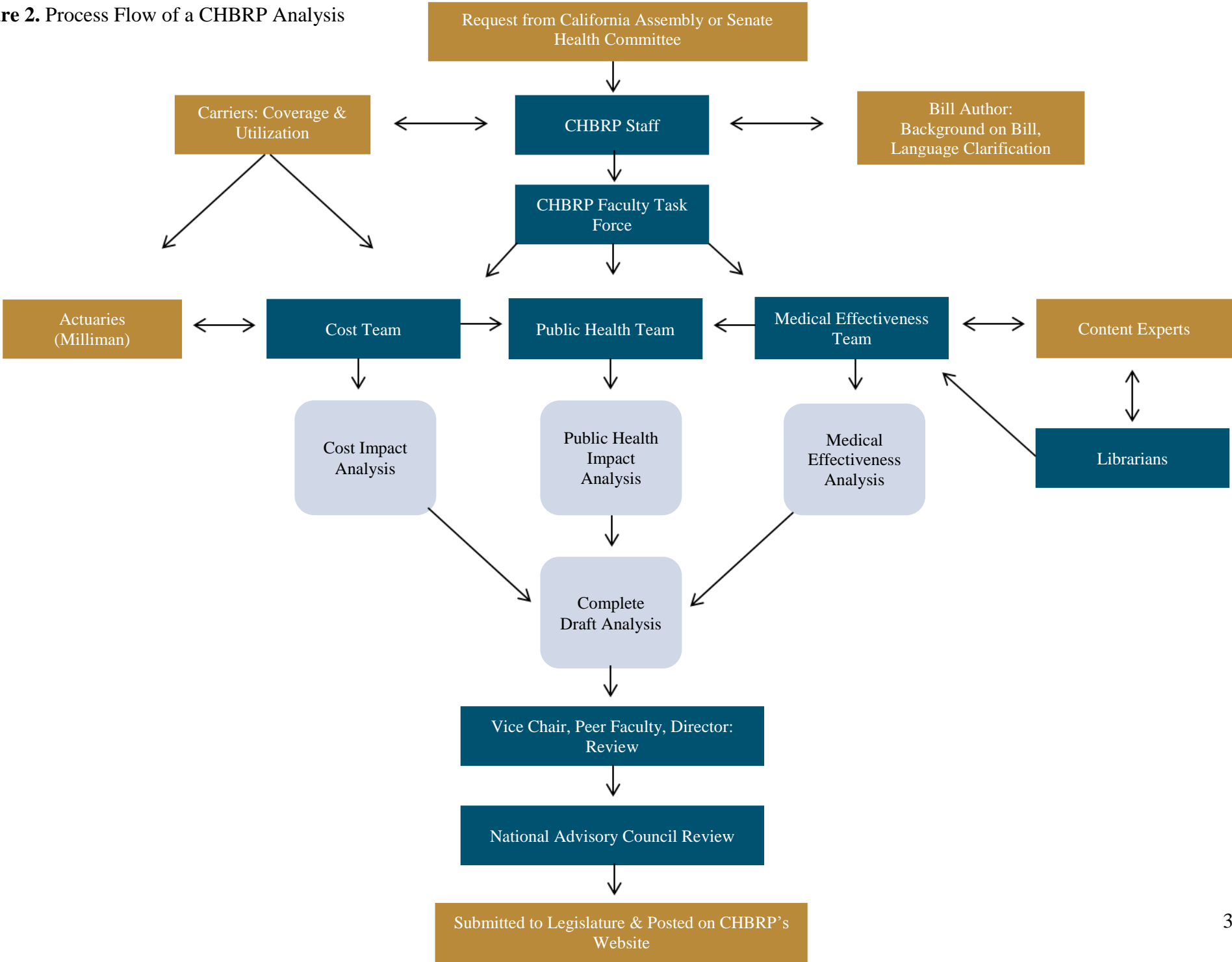
- University of California, Berkeley
- University of California, Davis
- University of California, Irvine
- University of California, Los Angeles
- University of California, San Diego
- University of California, San Francisco

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

---

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

**Figure 2.** Process Flow of a CHBRP Analysis



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

*Research capacity and expertise: faculty task force*

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

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

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

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

---

<sup>29</sup> For a complete list of current FTF members, see Appendix 3.

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

#### *Professional analytic and administrative staff*

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

#### *Actuarial analysis*

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

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

#### *National Advisory Council: internal review*

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

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

---

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

<sup>31</sup> Further information regarding CHBRP's contracting actuaries is included in Appendix 5.

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

<sup>33</sup> See Appendix 16, NAC Review Criteria and Guidelines.



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

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

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

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

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

---

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

### *Librarians: timely and relevant literature searches*

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

## **Process and Workflow**

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

### **Conflict-of-Interest Policy**

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

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

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

---

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

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

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

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

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

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

### **Clarifying Bill Language**

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

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

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

---

<sup>38</sup> For the full questionnaire, see Appendix 17.

## **Obtaining Data From Health Plans**

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

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

### *Annual Enrollment and Premium Survey*

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

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

### *Bill-specific surveys*

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

---

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

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

### **Obtaining Information From Consumer Groups and Other Stakeholders**

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

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

### **60-Day Timeline**

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

---

<sup>40</sup> Any interested party may request that he or she be added to the mailing list, or may add themselves via the CHBRP website at [www.chbrp.org](http://www.chbrp.org).

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

**Figure 3. 60-Day Timeline**

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

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

## **Disseminating CHBRP Reports**

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

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

## **Analytic Methods**

### **Medical Effectiveness Analysis**

CHBRP's authorizing statute requires the program to analyze the following with regard to the analyses of medical effectiveness<sup>43</sup>:

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

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

#### *CHBRP's approach to medical effectiveness analysis*

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

---

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

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

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

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

**Table 6.** Domains in Which Medical Effectiveness Ranks Studies

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

*Source:* California Health Benefits Review Program, 2013.

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

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



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

#### *Content of the medical effectiveness sections of CHBRP reports*

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

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

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

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

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

#### *Enhancing the medical effectiveness analysis*

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

#### *Grey literature*

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

### *Clinical practice guidelines*

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

### *Presentation of the findings of the medical effectiveness analysis*

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

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

### **Cost Impact Analysis**

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

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

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

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

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

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

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

#### *California Cost and Coverage Model*

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

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

---

<sup>45</sup> For full detail on CHBRP's cost approach, see Appendix 11.

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

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

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

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

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

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

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

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

#### *Definitions/components of the Cost and Coverage Model*

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

In evaluating aggregate expenditures, CHBRP includes:

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

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

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

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

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

---

<sup>46</sup> CHBRP estimated Covered California enrollment using CalSIM.

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

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

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

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

#### *Coverage and demographic data sources.*

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

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

---

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

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

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

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

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

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

---

<sup>49</sup> CalPERS enrollment as of September 30 of the previous year.

<sup>50</sup> For more information about this policy, see Appendix 18.

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

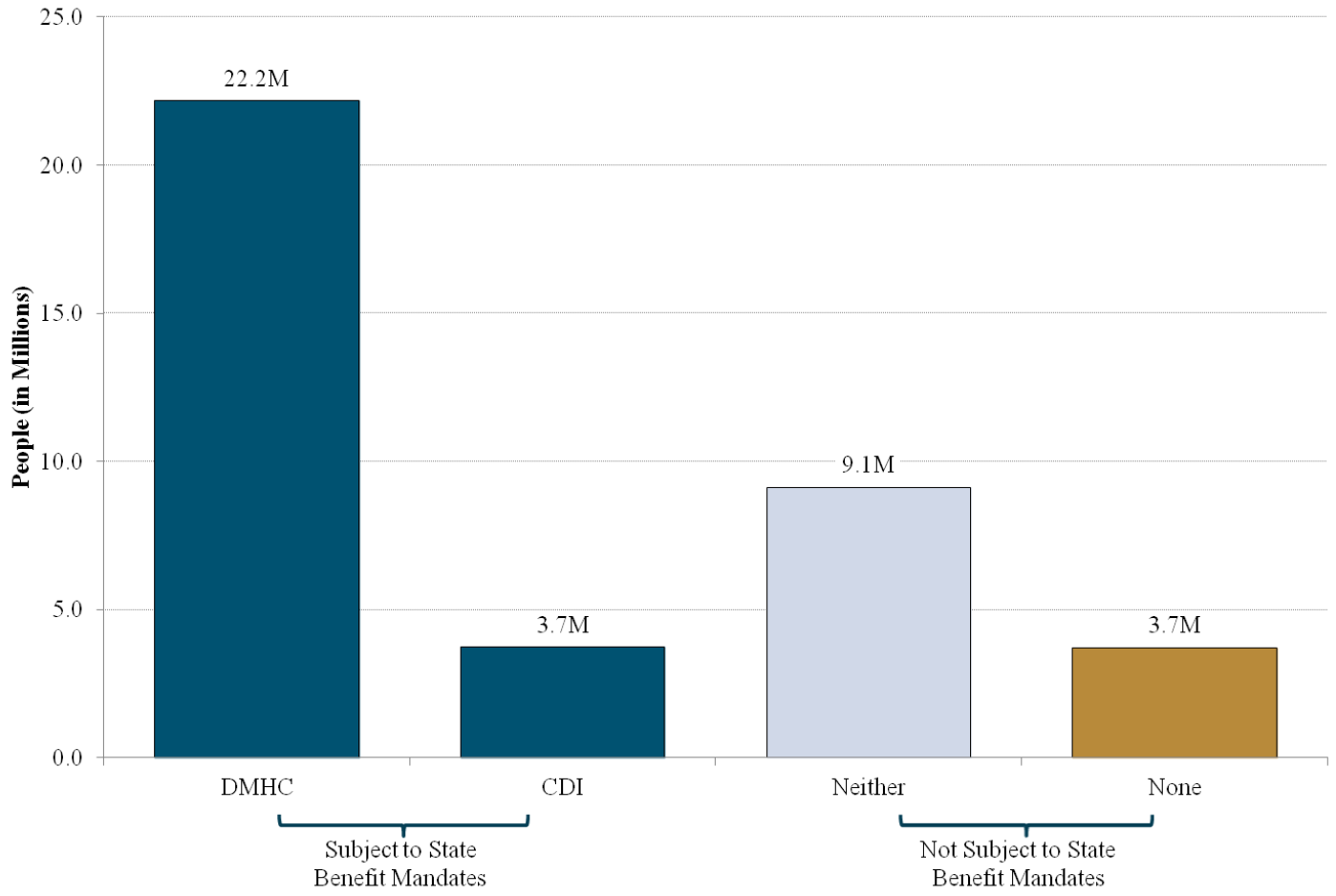
<b>Publicly Funded Health Insurance</b>						
	<b>Age, Years</b>	<b>DMHC-Regulated</b>	<b>Not State-Regulated</b>	<b>Total</b>		
<b>Medi-Cal (non Medicare)</b>	0–17	3,143,000	860,000	4,003,000		
	18–64	2,060,000	1,256,000	3,316,000		
	65+	17,000	32,000	49,000		
<b>Medi-Cal, formerly Healthy Families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

Source: California Health Benefits Review Program, 2013.

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

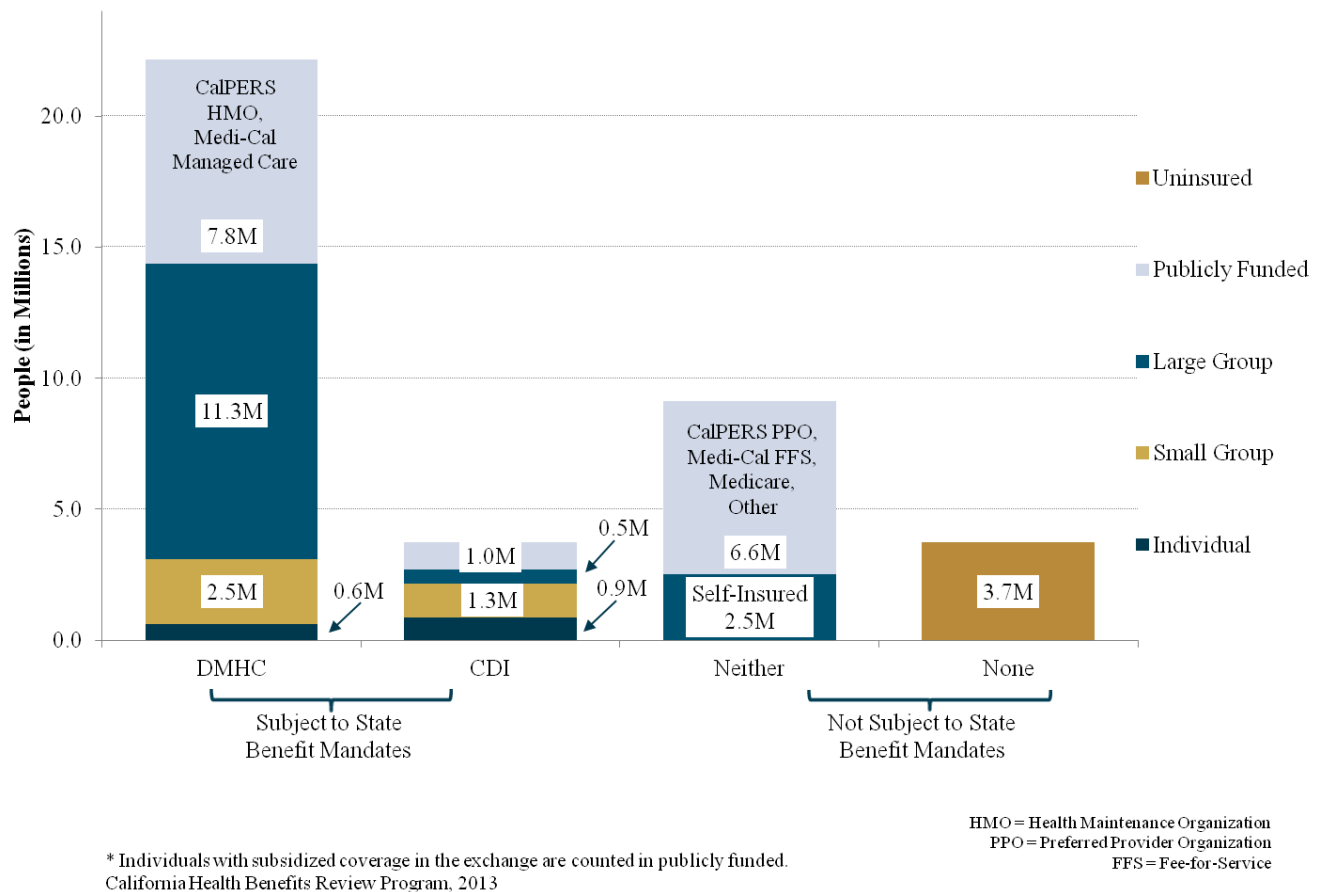


**Figure 4.** Health Insurance by Regulatory Agency in California, 2014



California Health Benefits Review Program, 2013

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



## Public Health Impact Analysis

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

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

### Health outcomes and data sources

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

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

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

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

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

### *Impact on public health*

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

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

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

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

#### *Impact on gender and racial disparities*

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

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

#### *Impact on premature death and economic loss*

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

#### *Long-term impacts*

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

### **Analyzing Repeal Bills**

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

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

- Permit a person insured or covered under the policy or contract to obtain health care treatment or services from a particular type of health care provider;
- Offer or provide coverage for the screening, diagnosis, or treatment of a particular disease or condition;
- Offer or provide coverage of a particular type of health care treatment or service, or of medical equipment, medical supplies, or drugs used in connection with a health care treatment or service.

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

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

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

### *Overall approach*

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

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

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

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

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

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

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

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

- **Scenario 1: Maximum Impact.** This extreme hypothetical scenario assumes that limited-mandate plans would be purchased by all (i.e., 100%) currently insured Californians in lieu of their current plans. Buyers in all market segments (large group, small group, and individual) and all insurance products (high-deductible, low-deductible, and no-deductible policies) would respond to the lower premiums offered by limited-mandate policies, and would switch to those policies in response to a lower-cost alternative. This scenario projects the impacts of all currently insured persons purchasing policies that are otherwise identical to their current policies, except without a subset of the benefit mandates. This scenario represents the most extreme possible response and should be considered an absolute upper bound. The probability of this scenario occurring is small; therefore, the report offered two more scenarios.
- **Scenario 2: Low-Income Impact.** Because of evidence that employees in the group market prefer generous benefits, and because there is evidence that those in the individual market are the most price-sensitive, this scenario assumes that limited-mandate policies would only have an impact only on the price-sensitive segment of the individual market. However, in contrast to Scenario 1 where it is assumed that all plan participants will switch over, and based on actuarial experience demonstrating take-up by only part of the considered population, this scenario assumes that only 40% of all those insured in this market segment with incomes below 350% of the 2010 federal poverty level (FPL) would switch; thus this scenario assumes that about 16% of the individual market participants will switch to limited-mandate plans. This scenario falls within the range of possibility should AB 1904 be enacted.
- **Scenario 3: Very Low-Income Impact.** This scenario is similar to Scenario 2, and assumes that limited-mandate policies would only have an impact on the most price-

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

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

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

## Fulfilling CHBRP's Mission

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

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

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



## REFERENCES

- Blendon RJ, Brodie M, Benson JM, et al. Understanding the managed care backlash. *Health Affairs (Millwood)*. 1998;17:80-94.
- Blue Cross Blue Shield Association (BCBSA). State Legislative Healthcare and Insurance Issues: 2012 Survey of Plans. December 2012.
- Center for Consumer Information and Insurance Oversight (CCIIO). *Essential Health Benefits Bulletin*. Baltimore, MD: CCIIO; 2011. Available at: [www.cms.gov/CCIIO/Resources/Files/Downloads/essential\\_health\\_benefits\\_bulletin.pdf](http://www.cms.gov/CCIIO/Resources/Files/Downloads/essential_health_benefits_bulletin.pdf). Accessed September 30, 2013.
- Institute of Medicine (IOM). *Clinical Practice Guidelines: Directions for a New Program*. Washington, DC: National Academy Press; 1990:38.
- Institute of Medicine (IOM). Essential Health Benefits: Balancing Coverage and Cost. 2011. Available at: [www.iom.edu/Reports/2011/Essential-Health-Benefits-Balancing-Coverage-and-Cost.aspx](http://www.iom.edu/Reports/2011/Essential-Health-Benefits-Balancing-Coverage-and-Cost.aspx). Accessed September 30, 2013.
- Laugesen MJ, Paul RR, Luft HS, Aubry W, Ganiats TG. A Comparative analysis of mandated benefit laws, 1949–2002. *Health Services Research*. 2006;41:(Part II):1081-1103.
- Oliver TR, Singer RF. Health services research as a source of legislative analysis and input: the role of the California Health Benefits Review Program. *Health Services Research*. 2006;41:(3Part 2):1124-1158.
- Senate Banking, Finance and Insurance Committee (SBFI Committee). Bill Analysis of SB 1704. April 5, 2006. Available at: [www.leginfo.ca.gov/pub/05-06/bill/sen/sb\\_1701-1750/sb\\_1704\\_cfa\\_20060403\\_142516\\_sen\\_comm.html](http://www.leginfo.ca.gov/pub/05-06/bill/sen/sb_1701-1750/sb_1704_cfa_20060403_142516_sen_comm.html).
- Senate Rules Committee. *Bill Analysis of SB 1704*. May 20, 2006. Available at: [www.leginfo.ca.gov/pub/05-06/bill/sen/sb\\_1701-1750/sb\\_1704\\_cfa\\_20060510\\_125121\\_sen\\_floor.html](http://www.leginfo.ca.gov/pub/05-06/bill/sen/sb_1701-1750/sb_1704_cfa_20060510_125121_sen_floor.html).
- Schauffler HH. Politics trumps science: rethinking state mandated benefits. *American Journal of Preventive Medicine*. 2000;19:2:136-137.
- Wilson JQ. *The Politics of Regulation*. New York, NY: Basic Books; 1980.

## APPENDICES

All of the appendices listed below are available on CHBRP's website at [www.chbrp.org](http://www.chbrp.org).

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

## **Acknowledgments**

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

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

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

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

All CHBRP bill analyses and other publications are available on the CHBRP website, [www.chbrp.org](http://www.chbrp.org).

Garen Corbett, MS  
Director

## California Health Benefits Review Program Committees and Staff

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

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

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

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

### Task Force Contributors

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

## **National Advisory Council**

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

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

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

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

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

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

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

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

**Donald E. Metz**, Executive Editor, *Health Affairs*, Bethesda, Maryland

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

**Carolyn Pare**, CEO, Buyers Health Care Action Group, Bloomington, MN

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

**Christopher Queram**, President and CEO, Wisconsin Collaborative for Healthcare Quality, Madison, WI

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

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

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

**Prentiss Taylor, MD**, Regional Center Medical Director, Advocate Health Centers, Advocate Health Care, Chicago, IL

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

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

## **CHBRP Staff**

**Garen Corbett, MS**, Director

**John Lewis, MPA**, Associate Director

**Laura Grossmann, MPH**, Principal Analyst

**Chelsea Kelleher**, Graduate Health Policy Intern

**Hanh Kim Quach**, Principal Analyst

**Nimit Ruparel, MPP**, Policy Analyst

**Karla Wood**, Program Specialist

**California Health Benefits Review Program**

**University of California**

**Office of the President**

**1111 Franklin Street, 11<sup>th</sup> Floor**

**Oakland, CA 94607-5200**

**Tel: 510-287-3876 Fax: 510-763-4253**

[chbrpinfo@chbrp.org](mailto:chbrpinfo@chbrp.org)

[www.chbrp.org](http://www.chbrp.org)

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