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Publication Date

2009-02-26



ISSUE ANALYSIS

Policy Considerations Relevant to Assembly Bill 786: Individual Health Care Coverage: Coverage Choice Categories

The California Health Benefits Review Program (CHBRP) was asked to analyze *Assembly Bill (AB) 786: Individual Health Care Coverage: Coverage Choice Categories*. This bill was introduced by Assembly Member Dave Jones on February 26, 2009. The bill contains several provisions that would affect the individual insurance market, and that therefore were determined by the Assembly Committee on Health to include benefit mandate provisions subject to CHBRP review.^{1,2}

These provisions are as follows: “*All health service plan contracts and health insurance policies offered and sold to individuals on or after January 1, 2011, shall contain a maximum dollar limit on out-of-pocket costs; shall cover physician services, hospitals, and preventive services; and shall, at a minimum, meet existing coverage requirements.*”

AB 786 is similar to Senate Bill (SB) 1522 (Steinberg, 2008) for which CHBRP also provided an issue analysis that summarized relevant policy considerations. SB 1522 passed the Senate and failed to pass the Assembly Floor in 2008.

AB 786, in effect, requires minimum benefit standards, but those minimum benefits are not specified. Instead, if AB 786 were to be enacted, what constituted minimum benefits would have to be determined by the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI). AB 786 would also require the minimum benefits to be reviewed and potentially reconfigured in subsequent years by the DMHC and CDI. Since the benefits that could potentially be mandated as a result of AB 786 are not specified, a traditional CHBRP analysis³ is not feasible.

¹ AB 786 also contains provisions requesting the University of California, through CHBRP, to provide relevant analyses related to the addition of Section 127664.5 to the Health and Safety Code. This issue analysis does not address those provisions.

² CHBRP received the request to analyze AB 786 on February 13, 2009.

³ CHBRP is authorized under law to produce analyses for the legislature that examine the medical, financial, and public health impacts of proposed health insurance benefit mandates and repeals.

CHBRP prepared this issue analysis to provide relevant contextual information to inform deliberations on this bill. This issue analysis is divided into six sections:

- The first section provides a brief discussion of the intent and key provisions of AB 786.
- The second section provides an overview of the individual market: its size, product offerings, recent trends in premiums, cost sharing, and potential for risk segmentation.
- The third section looks at current minimum coverage requirements in the individual market in California and other states.
- The fourth section provides a summary of the evidence on the relationship between altering coverage requirements (i.e., covered services, out-of-pocket maximums, and cost sharing) and health care utilization.
- The fifth section provides a summary of the evidence on the effects of standardizing information on health insurance in facilitating informed consumer choice. It also provides a summary of the limited evidence available on the effects of standardizing health insurance products.
- The sixth section summarizes other policy considerations related to the potential impacts of AB 786, including impacts on the availability of health insurance products, and product pricing.

In addition, this issue analysis includes two attachments:

- Attachment A: Specifications of *Assembly Bill 786: Individual Health Care Coverage: Coverage Choice Categories*, as introduced on February 26, 2009
- Attachment B: A list of California health insurance benefit mandates by topic

I. AB 786: INTENT AND KEY PROVISIONS

According to the bill sponsor, the intent of the proposed legislation is to remedy two problems in the individual market: (1) health insurance products that leave consumers with significant gaps in coverage; and (2) a lack of information that allows consumers to compare coverage, make price comparisons across health insurance carriers, and be informed about potential out-of-pocket costs associated with various health insurance products (Health Access, 2008a; Health Access, 2009). To remedy these problems, the proposed legislation:

- establishes minimum scope of benefit standards for individual health insurance products regulated by the CDI;
- requires that all individual health insurance products regulated by the DMHC and CDI have limits on out-of-pocket maximums;
- requires the DMHC and CDI to categorize all health insurance products sold to individuals into a five-tiered classification system;
- requires the DMHC and CDI to develop a notice that plans and insurers must use when marketing, selling or renewing a plan contract or policy that discloses the estimated out-of-pocket costs and share of expenses covered by the contract or policy; and

- authorizes plans and insurers to offer health insurance products in any of the five tiers of the new classification system, subject to specified restrictions (see *Attachment A* for the AB 786 specifications).

II. INDIVIDUAL MARKET: CURRENT PROFILE AND TRENDS IN CALIFORNIA

For individuals who are not employed, whose employers do not offer health insurance or who do not otherwise have access to employer-based coverage, and who do not qualify for government programs, the individual (or “nongroup”) insurance market may be their only option for obtaining health insurance.

Individual health insurance products frequently are unavailable to those with preexisting health conditions. Premiums are often more expensive and benefits are more limited than those offered in the group market. A national study found that 89% of working-age adults who sought coverage in the individual market between 2003 and 2006 ended up never buying an health insurance policy. A majority (58%) found it very difficult or impossible to find affordable coverage. One-fifth (21%) of those who sought to buy coverage were turned down, were charged a higher price because of a preexisting condition, or had a health problem excluded from coverage⁴ (Collins et al., 2006).

Compared to the number of those with employment-based coverage, the individual market is small. In 2006, 17.7 million, or 6.8%, of the non-elderly U.S. population purchased health insurance in the private individual market. In contrast, in California, a larger portion of the non-elderly population—about 2 million, or 11.5% of those who are commercially insured—purchased products in the individual market (See Table 1). Since 1994, the proportion of non-elderly purchasing health insurance in the individual market has remained relatively stable, ranging between 6.5% and 7.5% nationally. Compared to the nation as a whole, California appears to have a larger individual insurance market because a smaller portion of the state’s non-elderly population has employment-based insurance (55.1% vs. 62.7% nationally) (Fronstin, 2007).

Premium and Cost-Sharing Trends

Prices for individual products vary considerably.

- Nationally, in late 2006/early 2007 average annual premiums were \$2,613 for single coverage and \$5,799 for family plans. At that time, national average annual premiums for single coverage varied by age from \$1,163 to \$5,090, and between \$2,325 and \$9,201 for family coverage depending on the age and number of family members covered (AHIP, 2007).
- In California, in late 2006/early 2007, average annual premiums were \$2,565 for single coverage and \$5,884 for family plans. (AHIP, 2007). As of September 2008, CHBRP estimates that the average annual family premium in the individual market was \$7,146 for

⁴ Provisions in health insurance policies that exclude a specific set of conditions are called “exclusion” or “elimination” riders and these are prohibited in California (Kaiser State Health Facts, 2008).

a family of 2.99. The corresponding average annual single-coverage individual plans/policy premium was \$2,905.

- In 2006, the average deductible in single-coverage individual plans/policies in California was \$2,136 with out-of-pocket maximums averaging \$3,998 (Gabel et al., 2007).

One measure of financial protection provided by an insurance product is the limit placed on consumers' annual out-of-pocket spending. A study of individual products sold nationally determined that the vast majority have *some* out-of-pocket maximum.⁵ The proportion of products with some out-of-pocket maximum varied by type of plan/policy. Indemnity and high-deductible health plans (HDHPs) paired with a Health Savings Account (HSA) all had an out-of-pocket maximum for both single and family plans/policies. Policies that were preferred provider organizations (PPO) or point-of-service (POS) virtually all had an out-of-pocket maximum (less than 1% had no out-of-pocket limit). Health maintenance organization (HMO) and exclusive provider organization (EPO) policies had an out-of-pocket maximum for 86% of single and 94.9% of family plans/policies. Average out-of-pocket maximums varied, ranging from \$2,383 for single coverage in an HMO to \$7,664 for family coverage in an indemnity plan (AHIP, 2007). A study of the California individual market estimated that all individuals were in plans/policies with some out-of-pocket maximum. This analysis was based on enrollment from the six leading individual insurance carriers in the state representing about 90% of the individual insurance market in California (Gabel et al., 2007).

“Consumer-directed health plan” (CDHP) is the term used to describe a health insurance product conceived to give more financial responsibility to consumers through increased cost sharing, aided by increased information and decision-making tools. CDHPs have emerged as a market response to rising health care costs and aim to reduce costs by increasing cost-sensitive choices in health care (Buntin et al., 2005). HDHPs are one type of CDHP and are typically defined as those plans/policies having a deductible (the amount the consumer is expected spend before coverage begins) that is \$1,000 or more for an individual and \$2,000 or more for a family. For calendar year 2009, the IRS defines a “high-deductible health plan” as a health plan/policy with an annual deductible that is not less than \$1,150 for single coverage or \$2,300 for family coverage, and the annual out-of-pocket expenses (deductibles, copayments, and other amounts, but not premiums) cannot exceed \$5,800 for single coverage or \$11,600 for family coverage.⁶ In a high-deductible cost-sharing arrangement, consumers would be expected to be more careful about how they spend their first \$1,150 on health care (CHBRP, 2006).

Implementing higher deductibles is the most direct method to increase a consumer's share of health care costs, more so than increased copayments (Claxton et al., 2005). Using HDHPs, insurers have increasingly shifted costs to purchasers. In the individual market, insurers have been structuring plans/policies—usually through increases in the deductibles and copayments—so that enrollees incur higher out-of-pocket costs when using the health care system. (A copayment is cost sharing that occurs each time a service is provided, usually defined as a fixed dollar amount. When cost sharing is defined as a percentage of the amount charged, it is usually referred to as “coinsurance.”)

⁵ While certain plans include out-of-pocket maximums, not all cost-sharing for all benefits accrue to these maximums. For example, coinsurance for the durable medical equipment benefit or outpatient prescription drug benefit may not accrue to the out-of-pocket maximum.

⁶ U.S. Internal Revenue Code Section 223(c)(2)(A). See www.irs.gov/irb/2008-22_IRB/ar10.html.

HDHPs have become a popular product nationally, because the Medicare Modernization Act of 2003 changed the federal tax code to provide federal income tax incentives for designated savings accounts, called Health Savings Accounts (HSAs), that are paired with qualified HDHPs.⁷ This approach increases enrollees' financial stake by permitting them to amass tax-free savings that can be used to pay cost sharing for covered services or for noncovered health care services. Alternatively, enrollees can try to minimize withdrawals from HSAs to maximize account balances resulting in the build up of tax-free interest and investment earnings because a balance at the end of a year may be "rolled over" into the following years. Nationally, about 40% of individual private insurance products are HDHPs (Cohen and Martinez, 2009).

HDHPs are currently a substantial segment of the California individual market. According to data collected from the seven largest carriers in California, from 2006 to 2009, HDHPs represented over half of the individual insurance market in California (see Table 1).

⁷ A Health Savings Account (HSA) is a tax-exempt account set up with a qualified HSA trustee to pay for or reimburse the accountholder for certain medical expenses. See www.irs.gov/irb/2008-22_IRB/ar10.html.

Table 1: Enrollees in Privately Insured Individual HDHPs, California, 2006-2009

	2006		2007		2008		2009	
	Number of Enrollees	Percent of Total Enrollees	Number of Enrollees	Percent of Total Enrollees	Number of Enrollees	Percent of Total Enrollees	Number of Enrollees	Percent of Total Enrollees
DMHC-Regulated Individual Plans								
Enrollees in HDHPs	435,000	21.6%	632,000	30.6%	647,000	30.6%	435,000	21.7%
Total enrollees	984,000	48.9%	1,268,000	61.5%	1,299,000	61.5%	966,000	48.2%
CDI-Regulated Individual Products								
Enrollees in HDHPs	674,000	33.5%	462,000	22.4%	472,000	22.3%	666,000	33.2%
Total enrollees	1,030,000	51.1%	794,000	38.5%	812,000	38.5%	1,038,000	51.8%
Enrollees in DMHC- and CDI-Regulated Individual HDHPs								
Total	1,109,000	55.1%	1,094,000	53.1%	1,119,000	53.0%	1,101,000	54.9%
Enrollees in DMHC- and CDI-Regulated Individual Market								
Total	2,014,000	100.0%	2,062,000	100.0%	2,111,000	100.0%	2,004,000	100.0%

Source: California Health Benefits Review Program, 2009. These figures are estimates based on analysis of 2003-07 California Health Interview Survey (CHIS) and the 2005-08 CHBRP Carrier Enrollment Surveys. These figures are not actual enrollment counts from administrative data but are estimates, primarily from CHIS.

Note: HDHP means those plans that met the definition of HDHP under the U.S. Internal Revenue Code § 223(c)(2)(A) for that particular year. This includes the subset of HDHPs that are paired with HSAs and those that are not. Data on what proportion of these HDHPs that are paired with HSAs in the California individual market are not available.

Risk Segmentation in the Individual Market

Risk segmentation can occur when consumers are offered a choice of products that vary in their scope of benefits. Healthier consumers tend to select the least extensive (and least expensive) product, and those anticipating the need for more health care services tend to select more extensive (and more expensive) products. In other words, benefit package design is an effective tool for segmenting insurance pools by health care risk. Health insurance products offering less than comprehensive insurance, at lower prices, will tend to attract healthier enrollees. CHBRP's recent analysis of maternity benefits in the individual market provides evidence of risk segmentation (CHBRP, 2009). The number of insured Californians in the individual market without maternity benefits has more than quadrupled between 2004 and 2008, from an estimated 192,000 in 2004 (12% of the CDI-regulated individual market) to the current estimate of 805,000 (78% of the CDI-regulated individual market).

Other methods to segment risk are by underwriting plans/policies based on age, gender, and health risk factors and by requiring waiting periods for preexisting conditions. Gender-rating of premiums is permitted in most states, including California, and is frequently used nationwide (NWLC, 2008). Based on CHBRP's survey of health insurers, currently premiums are gender-rated for 59% of individually purchased CDI-regulated health insurance products in California (CHBRP, 2009).

The impact of greater market segmentation is highly controversial. Advocates for greater segmentation argue that the current health insurance market generally provides an insufficient number of product choices with basic benefits, effectively forcing individuals to purchase more generous benefits than they prefer or can necessarily afford. Advocates also argue that pricing products to reflect expected use of services (i.e., differentially underwriting) is a more equitable way of allocating insurance costs. For example, why should a nonsmoker subsidize a smoker's health care costs? (PRI, 2009) Opponents argue that greater segmentation without adequate mechanisms to risk-adjust premiums encourages favorable selection of lower-risk individuals into lower-cost products. This risk segmentation can result in a "death spiral" for health plans/policies with extensive coverage, because over time they attract a progressively sicker mix of enrollees and become more and more expensive (Families USA, 2006).

Another concern with greater risk segmentation in the individual market is that it leads to those individuals with greatest health care needs bearing a greater share of financial risk for their use of health care services. This could potentially increase the number of underinsured individuals with private insurance, i.e., individuals who have insurance that is inadequate in some manner (Blewett et al., 2006). Underinsurance, usually defined in terms of the proportion of household income spent on health care, is difficult to measure, because it involves both *increases* in cost sharing for covered benefits as well as *decreases* in the scope of covered benefits. The former is often included in health surveys, whereas detailed information about the latter is often lacking, particularly in the individual market. Increased cost sharing and decreased scope of coverage are likely to place individuals and families purchasing health care in the individual market at greater financial risk, and thus to result in a higher proportion of household income being spent on health care.

Several studies have addressed the financial risk of exposing families to greater cost sharing for medical care. One recent national study found that 20% of those insured all year, or 25 million people, were underinsured in 2007—a 60% increase from the number of underinsured in 2003 (Schoen et al., 2008). This analysis classified adults as underinsured if they experienced at least one of the three indicators: (1) out-of-pocket medical expenses for care amounted to 10% or more of household income; (2) among low-income adults (below 200% of the federal poverty level), medical expenses amounted to at least 5% of income; or (3) deductibles equaled or exceeded 5% of income.

A study of the affordability of health insurance in California examined the impact of total out-of-pocket spending, including premiums plus deductibles and copayments, on family household spending (Jacobs et al., 2007). This analysis showed that families with group insurance coverage had a 10% likelihood of spending more than 12% of total family income on health care expenses, whereas families with coverage in the individual market had a 10% likelihood of spending more than 26.4% of total family income on health care expenses. These effects are even greater on families with low incomes. Therefore, families with individual coverage face considerably greater financial risk, on average, than those with employer-based coverage. Greater cost sharing for medical care is a contributing factor to medical debt and personal bankruptcies (Dranove and Millenson, 2006; Himmelstein and Warren, 2006; Hollingworth et al., 2007; Seifer and Rukavina, 2006).

III. MINIMUM COVERAGE REQUIREMENTS

AB 786 would alter minimum coverage requirements in three ways.

- First, AB 786 would increase the minimum services that must be provided as a covered benefit by requiring all health insurance products regulated by the CDI to cover physicians, hospitals, and preventive services.
- Second, AB 786 would require all health insurance products to have a maximum dollar limit on out-of-pocket costs for covered benefits.
- Third, AB 786 would effectively require plans and insurers that sell individual health insurance plans/policies to offer at least a standard HMO and/or PPO product that is not a “bare bones” plan/policy.

This section provides background information on the current requirements pertaining to benefits levels and limits on out-of-pocket costs and the potential changes required under AB 786. This section also provides a discussion of current requirements in other states as they pertain to minimum coverage requirements.

Minimum Benefit Levels: Current Requirements

California has two regulatory agencies that provide oversight of health insurance products. The CDI licenses and regulates carriers and health insurance products through the authority of the California Insurance Code.⁸ The DMHC licenses and regulates health care service plans,

⁸ CDI “license” refers to the certificate of authority conferred on carriers to transact business in California Insurance Code Sections 699 et seq.

principally HMOs, through the authority of the Knox-Keene Health Care Service Plan Act of 1975.⁹

All DMHC-regulated health plans must offer “basic health care services” as covered benefits, which are defined as:

- physician services
- inpatient and outpatient hospital services
- diagnostic laboratory tests
- diagnostic and therapeutic radiology
- home health care
- preventive health services
- emergency services
- hospice care

These mandated basic health care service benefits, originally required by the Knox-Keene Act of 1975, have been supplemented by subsequently enacted laws that mandate insurers to either cover or offer coverage for specific benefits and services. Ultimately, however, DMHC-regulated plans are required to cover “medically necessary” items or services that are more extensive than the specific benefits and services listed in mandate legislation. (See *Attachment B* for a list of mandates that apply to DMHC-regulated health plans.) Health plans also offer benefits that are not mandated by law. For example, coverage for outpatient prescription drugs is not a required benefit; however, about 96% of members in DMHC-regulated plans sold directly to individuals, are in plans that cover this benefit.¹⁰

In contrast to the requirements on DMHC-regulated health plans, there is no minimum or basic set of services required of CDI-regulated health insurance products. These health insurance products are required to cover those services specified under a number laws that mandate insurers to either cover or offer coverage for specific benefits and services. (See *Attachment B* for the list of mandates that apply to CDI policies.) Coverage for outpatient prescription drugs is not a required benefit; however, about 86% of members in CDI-regulated products sold directly to individuals, have policies that cover this benefit.¹¹

Minimum Benefit Levels: Potential Changes Required under AB 786

As mentioned, AB 786 would require all CDI-regulated health insurance products to cover “physician services, hospitals, and preventive services, and shall, at a minimum, meet existing coverage requirements.” There is some ambiguity regarding how this provision may be interpreted and subsequently enforced. Some examples are provided for illustrative purposes:

⁹ Health maintenance organizations in California are licensed under the Knox-Keene Health Care Service Plan Act, which is part of the California Health and Safety Code.

¹⁰ 2009 CHBRP carrier survey, unpublished data.

¹¹ 2009 CHBRP carrier survey, unpublished data.

- Three of the major differences between DMHC-regulated health plans and CDI-regulated products are that CDI-regulated products are not required to cover preventive services, hospitalization, or maternity services. If AB 786 were to be enacted, this provision could be interpreted as requiring all CDI-regulated health insurance products to cover preventive services and hospital costs, but not maternity services, since maternity services are not currently mandated under “existing coverage requirements.” However, if the CDI and DMHC were to determine that maternity services were included in “physician” and “hospital” services in their process of determining the coverage choice categories and the associated minimum benefit requirements, then maternity services may be required for CDI-regulated policies.
- Currently, CDI-regulated health insurance products are required to cover specific preventive treatments, such as cervical cancer screening. However, as a matter of enforcement, products that cover only hospital services would not be required to cover this service because cervical cancer screening is generally covered on an outpatient basis. AB 786 may be interpreted as requiring *all* CDI-regulated health insurance products to cover preventive and physician services, thereby making the licensing and sales of health insurance products that only cover hospital services illegal.¹²

Because the CDI does not routinely collect information on the types of services offered as covered benefits for all types of health insurance policies issued by carriers that it licenses, CHBRP is unable to estimate the number of insured who potentially would be affected by this particular provision of AB 786.

As mentioned, AB 786 would effectively require plans and insurers that sell individual health insurance products to at least offer a standard HMO and/or PPO product that is not a “bare bones” plan/policy. Specifically, AB 786 authorizes health plans and health insurers to offer a health insurance product in *any* coverage choice category. There are some restrictions and they are as follows:

- If the plan or insurer offers a product in the least comprehensive category, it must also offer *the standard* HMO and/or PPO in the *least comprehensive* category, *the standard* product in *one of the two most comprehensive* categories, and *the standard* product in the *middle* category.
- Every plan or insurer must offer *at least the standard* HMO and/or PPO in the *middle* category, *unless* the plan offers a standard HMO and/or PPO in a more generous category.

Figure 1 illustrates what product offerings could be permitted under AB 786. For example Carrier #1’s proposal would not be permitted because they only seek to market products in the least comprehensive coverage choice category. The impacts of this provision are dependent on the characteristics of the coverage choice categories determined by the DMHC and CDI and those products (in each category) that the DMHC and CDI determine to be “standard”. In terms of the benefit package, the DMHC would have less leeway to develop a range of coverage choice categories since DMHC-regulated individual health insurance plans are already subject to existing benefit mandates and the requirement to cover medically necessary basic health care services.

¹² AB 786 would not apply to hospital indemnity products because the Insurance Code does not include these products in the definition of health insurance. See Insurance Code Section 106(b)(2).

Figure 1: Illustration of Health Insurance Product Offerings that would be Permitted under AB 786

Coverage Choice Category (set by DMHC and CDI)	Range of coverage provided under specific health insurance products (a)	Carrier #1 Proposal	Carrier #2 Proposal	Carrier #3 Proposal	Carrier #4 Proposal	Carrier #5 Proposal
1 <i>Most Comprehensive Coverage</i>						
	→ Standard Product					
			X			
2						
	→ Standard Product			X		X
3						
	→ Standard Product		X	X	X	
4						
	→ Standard Product					
5						
	→ Standard Product	X	X	X		
	<i>Least Comprehensive Coverage</i>	X	X	X		
Permitted under AB 786?		No (b)	No (c)	Yes	Yes	Yes (d)

Notes: (a) For each health insurance product permitted under each category, the DMHC and CDI determine the “standard” product. (b) Carrier #1 proposal only offers products in the least comprehensive coverage choice category. (c) Carrier #2 proposal does not offer the standard product in one of the two most comprehensive coverage choice categories. (d) Carrier #5 does not offer a standard product in the middle category but they provide the standard product in one of the two most comprehensive coverage choice category
Key: X indicates the product that the carrier is offering. Location of the X indicates (1) under which coverage choice category the product would fall and (2) how comprehensive the coverage provided under that product would be. **X** [bolded] indicates that the carrier is offering the standard HMO/PPO in that category.

Limits on Out-of-Pocket Costs: Current Requirements

DMHC-regulated plans do not place any requirements on product offerings to establish limits on what an enrollee will pay in terms of out-of-pocket costs for covered benefits. The DMHC has regulatory authority to review cost-sharing arrangements and other limitations to ensure that the contract requirements are “fair, reasonable, and consistent with the objectives of the chapter” and are not held to be objectionable by the director.¹³ Copayments, deductibles, and other limitations cannot “render the benefit illusory.”¹⁴ This concept is not further defined in regulation or policy, except in regulations for outpatient prescription drug benefits. Under these regulations, copayment or percentage coinsurance cannot exceed 50% of the cost to the plan.¹⁵

CDI-regulated products place limits on expenses paid by the insured by focusing on establishing an “economic value” for the product. All policies (group and individual) are to be economically sound.¹⁶ Individual policies must provide “real economic value” to the insured.¹⁷ However, the insurer need not pay the full amount of any loss to provide a benefit of real economic value.¹⁸ For individual policies, loss ratios (the percentage of each premium dollar that must be spent on health care benefits, as opposed to administrative costs), are subject to review both when they are first submitted as new policies, and when rates are revised.¹⁹ As of July 2007, the loss ratio requirement for new policies and rate revisions has been 70%.²⁰ California has no requirement for health plans and insurers to disclose the “actuarial value” of their products to regulatory agencies.

There are also limits on expenses borne by the insured as a result of “parity” mandates. These laws require that the coverage for services be equal to the coverage for other medical conditions. For example, mental health benefits for serious mental illnesses must be covered under the same terms and conditions applied to other medical conditions.²¹ The maternity benefits mandate also requires that coverage be at parity with other medical benefits.²²

Limits on Out-of-Pocket Costs: Potential Changes Required Under AB 786

As mentioned, AB 786 would require that health insurance products “contain a maximum dollar limit on out-of-pocket costs for covered benefits, including, but not limited to, copayments, coinsurance, and deductibles for covered benefits.”²³ This provision may be interpreted to require health plans/insurers to simply disclose out-of-pocket costs to facilitate price

¹³ Health & Safety Code Section 1367(h) and 1367(i).

¹⁴ California Code of Regulations, Title 28, section 1300.67.4.

¹⁵ California Code of Regulations, Title 28, section 1300.67.24

¹⁶ Insurance Code Section 10291.5(a)(1)

¹⁷ Insurance Code Section 10291.5(b)(7)(A) and 10270.95

¹⁸ Insurance Code Section 10291.5

¹⁹ California Code of Regulations Section 2222.10

²⁰ California Code of Regulations Section 2222.12

²¹ Health and Safety Code Section 1374.72 and California Insurance Code Section 10144.5

²² Health and Safety Code Section 1367.18 and Insurance Code Section 10123.7 These statutes require that *if* a health plan or insurer covers maternity services, they must do so at the same levels as for other medical benefits—for example, there cannot be a higher copayment for hospitalization for labor and delivery versus hospitalization for other conditions.

²³ This provision focuses disclosure on out-of-pocket costs for covered benefits. While health insurance products may only practically be able to disclose information on the expected out-of-pocket costs of covered benefits, potential out-of-pocket costs for benefits not covered, especially for those insurance products that are less comprehensive in nature, may be of concern for a consumer or prospective enrollee.

comparisons by consumers. Alternatively, regulatory agencies may establish a maximum level of out-of-pocket costs for each coverage choice category. If AB 786 was interpreted to require regulatory agencies to establish out-of-pocket maximums, this provision could have implications for the use of health care services and the cost of insurance. Table 2 illustrates the effects of various out-of-pocket maximums on premiums for health insurance products. As the out-of-pocket limitations included in a plan/policy are allowed to increase, the associated premium would decrease. Using comprehensive benefit packages as the base for comparison (i.e., non-HDHPs), premium increases would range from 1% to 25%, depending on the maximum level of the out-of-pocket costs. Products associated with less comprehensive benefit packages would likely face greater premium effects, when altering just out-of-pocket maximums, and holding all other plan/policy design elements constant.

Table 2: Illustrative Effects of Out-of-Pocket Maximums on Premiums

Annual Out-of-Pocket Maximum per Individual	Relative Premium for a Plan /Policy with \$2,500 Annual Deductible per Individual, 20% Coinsurance
None	1.00
\$50,000	1.01
\$25,000	1.03
\$10,000	1.07
\$5,000	1.13
\$2,500	1.25

Source: Milliman analysis of national claims data, 2009.

Coverage Requirements in Other States

States have taken different approaches to designing minimum coverage packages in the individual health insurance market. Massachusetts, New Jersey, and Maine are three examples of states that legislatively impose minimum benefit standards on HMO and non-HMO health insurance products and out-of-pocket maximum amounts for covered benefits.

Massachusetts

In 2006, Massachusetts became the first state to pass a law requiring all adult residents to show proof of health insurance coverage. With some exceptions, residents who lack group insurance are required to purchase individual health insurance. Massachusetts regulations, which became effective on July 1, 2007, established criteria for the lowest threshold health benefit plan that an individual must purchase in order to satisfy the legal requirement that a Massachusetts resident has health insurance that constitutes “minimum creditable coverage.” Minimum creditable coverage is designed to provide individuals (and dependents) purchasing the coverage with financial access to a broad range of health care services, including preventive health care, without incurring severe financial losses as a result of serious illness or injury.

As of January 1, 2009, a health plan with “minimum creditable coverage” is one that covers a broad range of medical benefits, including preventive and primary care, emergency services,

hospital stays, outpatient services, prescription drugs, and mental health and substance abuse services.²⁴

Effective January 1, 2010, the definition of a “broad range of medical benefits” is clarified to include outpatient services (including ambulatory surgical centers and anesthesia), diagnostic imaging and screening services (including x-rays), emergency services, hospitalization (including an acute care services), maternity and newborn care, medical/surgical care (including preventive and primary care), mental health and substance abuse services, prescription drugs, and radiation and chemotherapy.

In addition, a plan must:

1. Cover three regular doctor visits and check-ups for an individual, or six for a family before any deductibles
2. Cover preventive services in accordance with nationally recognized preventive care guidelines (that are comparable to the Massachusetts Health Quality Partners’ Preventive care recommendations and guidelines)
3. Cap the in-network deductible at \$2,000 for an individual, or \$4,000 for a family each year
4. Cap out-of-pocket spending for in-network nonprescription health services at \$5,000 for an individual or \$10,000 for a family each year, for plans with a deductible or coinsurance
5. Not impose an annual maximum benefit limit (e.g., caps on visits or dollar visits)

New Jersey

In 1992, the New Jersey Legislature created the Individual Health Coverage (IHC) Program to regulate the individual market. This legislative reform allows only standard plans (Plan A/50; Plans B, C, and D; and the HMO Plan) and “Basic & Essential” (B&E) plans to be sold in the individual market. The standard plans are prescribed by the IHC Program Board of Directors. The B&E plans were prescribed in statute by the Legislature.

Standard Plan A/50 is designed primarily to cover inpatient services and expenses for up to 30 days in the hospital/year, and has a \$1,000,000 lifetime maximum. Standard Plans B through D and the HMO Plan are comprehensive health plans, providing coverage for both inpatient and outpatient professional and facility services. These plans have no limits on inpatient days or medically necessary office visits; limits on some, but not all, therapy and mental health services; and no annual or lifetime policy maximums. There are maximum out-of-pocket amounts listed for all of the standard plans. However, carriers are allowed to offer a range of maximums (just as they offer a range of deductibles). Out-of-pocket maximums range from \$6,000 to \$15,000 (Plan A/50), \$4,000 to \$13,000 (Plan B), \$3,500 to \$12,500 (Plan C), and \$3,000 to \$12,000 (Plan D).

The B&E plan covers a more limited range of services, and is more limited in terms of benefits than the standard plans (except Plan A/50). For instance, a B&E plan covers 90 days in the hospital and only a few physician visits per year. Notably, B&E plans do not cover maternity or

²⁴ 956, Code of Massachusetts Regulations Section 5.03

outpatient pharmacy. Carriers may offer riders that increase the covered services and/or enhance the benefits for B&E.

Except for HMOs, carriers offering individual coverage must offer both the standard plans and a B&E plan. HMOs may offer only the HMO Plan.²⁵

Maine

In Maine, health insurance carriers that choose to offer individual health insurance, and all HMOs, must offer a standardized policy to all consumers. However, those carriers may also sell nonstandardized plans. Standardized policies—which can be “basic” or “standard”—cover hospitalization, physician office visits, maternity care, prescription drugs, lab tests, limited rehabilitation services, and other care. A choice of annual deductibles is offered, ranging from \$250 to \$1,500. Nonstandardized plans refer to those policies that do not necessarily include those basic services.

IV. The Potential Impact on the Use of Health Care Services by Altering Current Coverage Requirements: A Review of the Evidence

Minimum benefit requirements and limits on out-of-pocket expenditures are intended to ensure that health insurance policies protect consumers against catastrophic expenses and cover the range of health care services they are most likely to need. Another major rationale for such requirements is to increase utilization of effective health care services, such as preventive screening examinations, and medications and self-management services for chronic conditions.

Minimum Benefit Requirements

The sources of catastrophic expenditures have changed since private health insurance was developed in the 1930s. At that time, most expensive health care services were provided in acute care hospitals on an inpatient basis. The volume and range of services provided outside acute care hospitals has grown dramatically since the mid-1980s due to technological innovations and changes in reimbursement policy (Bernstein et al., 2001; Duffy and Farley, 1995; Hoerger et al., 1992; Leader and Moon, 1989). A large proportion of surgical procedures are now performed in non-hospital settings, as are large proportions of diagnostic imaging services and radiation and chemotherapy treatments for cancer. Persons who have had strokes or major fractures are now treated in acute care hospitals for shorter periods of time and then transferred to nursing homes or rehabilitation hospitals and/or provided with home health services. In addition, some conditions are now treated with very expensive specialized pharmaceuticals, including biological agents.

These trends in health care delivery suggest that plans/policies that only cover hospital care are no longer adequate to prevent people from incurring catastrophic expenditures. By requiring coverage of physician services and preventive services as well as hospital care, AB 786 would require health insurance products to provide coverage for a more comprehensive range of

²⁵ Personal communication with Chanell McDevitt, Deputy Executive Director, May 29, 2008. Individual & Small Employer Health Benefits Programs, NJ Dept. of Banking & Insurance.

expensive health care services performed in outpatient settings than what is currently offered by some CDI-regulated policies.

Several studies have addressed the impact of coverage for preventive services or office visits on use of preventive services. One study reported that people who had coverage for all or most preventive services were more likely to receive periodic health exams, blood pressure screening, and cholesterol screening than people who did not have coverage for preventive services. Women who had coverage for preventive services were also more likely to obtain Pap smears, clinical breast exams, and mammograms (Faulkner and Schauffler, 1997). Coverage for office visits may also increase use of preventive services, because persons with coverage may be more likely to make office visits during which they may receive preventive services or referrals for them. One study found that women who had coverage for office visits were more likely to receive Pap smears and mammograms than women who did not have coverage for office visits (Friedman et al., 2002). Another study found that persons who had coverage for office visits were more likely to receive colorectal cancer screening tests (Varghese et al., 2005). A more recent study found that women who faced higher cost-sharing levels for mammography may forgo the screening and that the effects of cost sharing were greater for women of lower income and education levels (Trivedi et al., 2008).

One study examined the effects of coverage on use of diabetes self-management services. The authors found that persons with diabetes whose health plans covered test strips for self-monitoring of blood glucose were more likely to perform daily self-monitoring than persons who did not have coverage for test strips. Persons who had coverage for diabetes health education or dilated eye examinations were more likely to obtain these services (Karter et al., 2003).

Limits on Out-of-Pocket Expenditures

Compared to coverage of preventive services, less literature has been published on the impact of limits on out-of-pocket expenditures. The only studies CHBRP identified that assessed limits on out-of-pocket expenditures was related to prescription drugs. One study investigated whether limiting annual out-of-pocket costs affected use of angiotensin-blocking drugs, one of the classes of drugs used to treat hypertension (Zhang et al., 2007). The authors found that persons who were enrolled in a health plan/policy that limited annual out-of-pocket costs for drugs had fewer days without medication. In other words, persons whose health plans/policies would cover the full cost of medications once their out-of-pocket expenditures reached a certain level were more likely to take their medications as directed. Another study of Canadian senior citizens reported that a limit on out-of-pocket costs lessened the effects of copayment and coinsurance requirements on utilization of histamine-receptor antagonists and antihyperglycemic agents, drugs that are used to treat ulcers and Type 2 diabetes, respectively (Kephart et al., 2007). No studies were identified that addressed the effects of limits on out-of-pocket expenses for all covered health care services or services other than drugs.²⁶

²⁶ The RAND Health Insurance Experiment does not provide evidence regarding the impact of limits on out-of-pocket costs because out-of-pocket costs for all persons enrolled in the study were limited to the lesser of a fixed dollar amount or a percentage of family income (Newhouse, 1993). Thus, the researchers could not compare the effects of limiting versus not limiting out-of-pocket costs.

General Effects of Cost Sharing

Generally, studies of the effects of cost sharing for health care services are most relevant to provisions of AB 786 that require the DMHC and CDI to categorize health insurance products by level of health care benefits, because they address the consequences of requiring consumers to pay a larger versus a smaller share of total expenditures for health care services. The most authoritative study on this topic is the RAND Health Insurance Experiment (HIE), a randomized controlled trial conducted in the late 1970s and early 1980s. The RAND HIE found that consumers enrolled in fee-for-service plans who paid a larger share of costs were less likely to use health care services and used smaller amounts of services than consumers who paid a smaller share of costs (Newhouse, 1993). The RAND researchers also found that consumers who faced higher cost sharing were less likely to use both essential and nonessential health care services. Their findings have been largely corroborated by subsequent nonrandomized studies of cost sharing (Austvoll-Dahlgren et al., 2008; Goldman et al., 2007; Hsu et al., 2006; Kessler et al., 2007; Lee and Zapert, 2005; Solanki et al., 2000; Trivedi et al., 2008).

Certain articles focus on the effects of cost sharing on the use of prescription drugs. Two Canadian studies on the elderly population with rheumatoid arthritis showed that increases in cost sharing reduced expenditures for prescription drugs, but at the same time, increased costs associated with outpatient services (Anis et al, 2005; Li et al, 2007). Goldman and colleagues (2006) in their examination of the effects of cost sharing and use of specialty drugs (for example, those used for the treatment of cancer, kidney disease, rheumatoid arthritis, and multiple sclerosis) found that price elasticity of demand is relatively low. In other words, dramatic increase in cost sharing has small effects on the use of specialty drugs.

High-Deductible Health Plans

Two specific forms of cost sharing are deductibles and caps on benefits. A deductible is an amount of out-of-pocket expenditures that a consumer must incur before his or her health plan or insurer will cover services to which the deductible applies. Enrollment in high-deductible health plans has grown rapidly in recent years. As discussed previously, HDHPs now account for a large share of products sold in the individual insurance market in California.

Only a few studies have examined the effects of HDHPs on utilization of health care services, most likely because these types of products are relatively new. The RAND HIE found that consumers enrolled in products that resembled HDHPs used fewer health care services than persons who received free care or faced lower cost sharing (Newhouse, 1993). However, the largest gap in utilization was between persons who received free care and persons enrolled in a health plan/policy with a moderate level of cost sharing (e.g., 25% coinsurance). One study examined the impact of perceived out-of-pocket cost (including deductibles and copayments) for those enrolled in HDHPs versus conventional products. Researchers found that those enrolled in HDHPs were more likely to forgo filling a prescription and more likely to forgo preventive services due to perceived notions of high out-of-pocket costs (Lee and Zapert, 2005).

Three studies have assessed effects of HDHPs sold in the group insurance market. These studies have yielded conflicting findings regarding effects on use of acute care services. One study found that persons enrolled in an HDHP were less likely to make multiple emergency department (ED) visits than persons enrolled in an HMO, and that this difference was primarily due to a reduction in repeat visits for low-severity conditions. HDHP enrollees with ED visits were also

less likely to be admitted to the hospital and had shorter lengths of stay, which suggests that they did not delay seeking care until problems became so severe that they needed extensive inpatient care (Wharam et al., 2007). In contrast, a study that compared persons enrolled in an HDHP to persons enrolled in a POS plan found that persons enrolled in the HDHP were more likely to be hospitalized than persons enrolled in the POS plan (Feldman et al., 2007). This study also found some evidence that HDHP enrollees with chronic illness filled fewer prescriptions than POS enrollees with chronic illness. However, filling fewer prescriptions was not associated with greater ED or hospital use (Parente et al., 2008).

In some cases, these HDHPs were coupled with health reimbursement accounts or HSAs to which employers contributed. Such contributions lower out-of-pocket costs for enrollees and may reduce the impact of high deductibles on their use of services. In addition, some HDHPs provide full coverage for preventive and/or disease management services. A study that compared persons enrolled in an HDHP that provided full coverage to persons enrolled in a PPO that required enrollees to pay part of the cost for such services found that levels of and trends in use of preventive, cancer screening, and diabetes monitoring services were similar in the two groups (Rowe et al., 2008).

Caps on Benefits

Two systematic reviews have examined the effects of caps on benefits for prescription drugs (Austvoll-Dahlgren et al., 2008; Goldman et al., 2007). The authors identified multiple studies of the impact of caps on drug benefits on use of drugs by Medicaid or Medicare recipients. They concluded that caps were associated with reductions in use of both “essential” and “nonessential” drugs. An individual study published subsequent to the studies included in the systematic reviews reached the same conclusion (Joyce et al., 2007). No studies were found that assessed the effects of caps on total benefits or on benefits for other health care services.

Effects on Health Outcomes

Little is known about the effects of cost sharing on health outcomes. Most studies that address health outcomes assess proxy measures of health, such as hospital admissions. The systematic reviews on the impact of caps on prescription drug coverage found that for persons with chronic conditions, enrollment in health plans/policies that capped drug benefits was associated with increased use of emergency departments, hospitals, nursing homes, and mental health services (Austvoll-Dahlgren et al., 2008; Goldman et al., 2007).

The RAND HIE is one of the few studies to directly assess effects on health outcomes. The RAND researchers found that low-income persons with poor health status who faced cost sharing had a higher mortality rate, poorer blood pressure control, and worse functional vision than those who received free care (Newhouse, 1993). These effects were similar for persons who faced modest, moderate, and high levels of cost sharing. No statistically significant differences were found for other health outcomes assessed or for persons who were in good health or had higher incomes.

IV. IMPACTS OF STANDARDIZING INFORMATION ON CONSUMER DECISION MAKING

AB 786 contains two specific provisions related to facilitating consumers' decision making. First, AB 786 requires the DMHC and CDI to "use standard definitions and terminology for covered benefits and cost sharing between health care service plans and health insurers in the same marketplace." Second, AB 786 requires the DMHC and CDI to develop a notice that plans and insurers must use when marketing, selling, or renewing a plan contract or policy that discloses the estimated out-of-pocket costs and share of expenses covered by the contract or policy. AB 786 sponsors believe these provisions are an important step in providing consumer information to make "apples to apples" comparisons in the health care market (Health Access, 2009). This section examines the evidence regarding the impact of providing information about health insurance products on consumers and the market.

Current Requirements to Provide Comparative, Standardized Information

Current law requires the DMHC and the CDI to ensure that health plans and insurers selling products in the individual and small-group market have a disclosure form for prospective subscribers and enrollees. The disclosure form is required to include basic information, including (1) the principal benefits and coverage of the plan/policy (i.e., coverage for acute care and subacute care); (2) the exceptions, reductions, and limitations that apply to the plan/policy; (3) the full premium cost of the plan/policy; and (4) any copayment, coinsurance, or deductible requirements that may be incurred by the member or the member's family in obtaining coverage under the plan/policy.

In addition, the disclosure form is to state where the health plan/policy benefits and coverage matrix is located for the prospective subscriber or enrollee to review. The uniform matrix, or benefit summary, is to include all of the following:

- deductibles, copayments, or coinsurance
- lifetime maximums
- professional services
- outpatient services
- hospitalization services
- emergency health coverage
- ambulance services
- prescription drug coverage
- durable medical equipment
- mental health services
- chemical dependency services
- home health services

Health plans and insurers must also provide information to the DMHC and CDI for three specific products sold in the individual market so that the agencies can jointly develop two benefit matrices for consumers to more easily compare benefit packages.²⁷ The first matrix compares individual conversion coverage plans/policies (i.e., products offered to individuals who have lost their employer-sponsored group coverage) and plans/policies offered to individuals with individually purchased coverage who chose to buy a product that is compliant with the Health Insurance Portability and Accountability Act (HIPAA). The DMHC provides a Web site for consumers to compare these conversion and HIPAA products at http://www.dmhc.ca.gov/dmhc_consumer/hp/hp_hipaacp.aspx. This site includes links to each plan's or policy's summary of benefits. A summary of benefits includes a list of benefits covered, and corresponding cost-sharing requirements.

The second matrix compares all Managed Risk Medical Insurance Program (MRMIP) Graduate products. The MRMIP offers health insurance benefits to California residents who are unable to purchase health insurance due to a preexisting medical condition. At the end of 36 months, MRMIP enrollees are given a one-time opportunity to purchase health coverage that is substantially the same as the health coverage offered while on MRMIP. These post-MRMIP "Graduate" products are separate from other individual health coverage that is available in the marketplace. The DMHC provides a link on its Web site for consumers to compare rates between products at http://www.dmhc.ca.gov/dmhc_consumer/hp/hp_mrmip.aspx. This site also includes links to each plan's or policy's summary of benefits which lists out benefits covered, and corresponding cost-sharing requirements.

Impact of Standardizing Information

The numerous health insurance options in California make choosing a health plan/policy a highly complex task. Making an informed choice would include an understanding of provider networks, covered benefits, coinsurance rates, deductibles, formulary structure, and many other important health plan/policy features. Research has found that many individuals in the United States have a limited understanding of health insurance products and thus struggle with selecting a health plan/policy (Garnick et al., 1993; Henrickson et al., 2006; Lubalin and Harris-Kojetin, 1999; Wroblewski, 2007).

Many individuals do not become familiar with the specific attributes of their health insurance plan/policy until they use health care services. A 2006 survey of Californian adults enrolled in HMOs (CHI, 2006) found that more than 40% of HMO consumers—most of whom were covered by employer-based plans, Medi-Cal Managed Care, or Medicare Advantage—reported a problem with their HMO in the last year, with 12% of adults enrolled in HMOs discovering that important benefits they needed were not covered, and 10% reporting they had misunderstood their coverage or benefits.

Health plans/insurers and employers often provide detailed health plan/policy information in order to increase consumers' understanding of health insurance. The provision of information on its own, however, is not sufficient in clarifying confusion around decisions since individuals can only process a limited number of factors when making a decision (Hibbard and Peters, 2003;

²⁷ Health and Safety Code Section 1363.06

Shaller, 2005). As such, many interventions to improve consumer knowledge have focused on simplified, standardized health insurance information to better facilitate comparison shopping among health insurance products, minimize unexpected outcomes, and improve consumer satisfaction (Kirsch, 2002).

The 2006 health reform in Massachusetts required the standardization of product offerings and health insurance information for consumers who do not have access to employer-sponsored insurance. These products are administered by six private insurance companies who offer the Commonwealth Choice (CommChoice) plans through the Commonwealth Health Insurance Connector Authority (“Connector”). With the standardization of product offerings, the Connector also created a mechanism to standardize product information and create a more transparent marketplace in which consumers can compare commercial health plans (Commonwealth Health Insurance Connector Authority, 2008). As part of this effort, the Connector launched a Web site (www.mahealthconnector.org) that allows consumers and employers to comparison shop for health insurance. The Web site features a matrix that includes the following information about each plan:

- Plan Tier (Gold, Silver, Bronze, or for Young Adults)
- Plan name
- Monthly premium
- Deductible
- Copayments for doctors’ office visits, ER visits, prescription drugs, and hospital stays
- Link to available doctors in the plan
- Link to further plan details

Early evidence indicates that CommChoice has made it easier for those shopping for individual insurance (Draper et al., 2008). The Connector asserts that CommChoice members have benefited from clearer information of plan benefits, cost-sharing requirements and premium prices (Commonwealth Health Insurance Connector Authority, 2008).

The Centers for Medicare and Medicaid Services (CMS) also provide standardized information on insurance product offerings to Medicare beneficiaries. Residing at medicare.gov, Medicare Options Compare and The Medicare Prescription Drug Plan Finder are interactive tools that allow individuals to compare information and choose among Medicare Part C (Medicare Advantage) and D (Prescription Drug) plans. Using these tools, beneficiaries may perform a general or personalized comparison of plans. Personalized search results are based on individual health needs, such as current prescriptions, and geographic area. For example, the Medicare Prescription Drug Plan Finder prompts beneficiaries searching for a Part D plan to enter information regarding their current prescription drug use and zip code. It then generates tailored comparison of plan designs, and allows beneficiaries to compare plans based on monthly drug premiums, annual deductible, number and location of network pharmacies near the individual’s home, and estimated annual costs using retail and mail-order pharmacies. The Medicare Options Compare tool presents analogous information for Part C health plans. In addition, the sites present performance metrics that allow beneficiaries to view information regarding plan quality, plan performance ratings, and the extent to which the plans have received complaints about their services. A summary score of the plans’ performance allows an overall comparison of cost, quality, and performance ratings.

While these online tools make plan comparison easier, they have limitations. Medicare beneficiaries with limited computer skills may find the tool too complex to use, and those without Web access or computer skills will lack access altogether. While Medicare distributes print materials explaining the use of the Medicare Options Compare and Medicare Prescription Drug Finder, a print-based substitute for these online tools is not available and may not be feasible to develop. In addition, the use of a current medication list as a basis for plan selection has come under some scrutiny. Domino and colleagues (2007) found that because prescription use for some groups may be highly variable over time, using current medication usage as a basis for decision making may not lead to the beneficiary reliably selecting the most appropriate (i.e., lowest out-of-pocket cost) plan. Domino and colleagues investigated how changes in actual drug use during a one-year period affected estimated annual costs. Results revealed that 43% of beneficiaries who had selected the most appropriate plan based on their current medication usage at the beginning of the year experienced increases in their drug expenses over the course of the year. This group of beneficiaries experienced an average increase of \$556 in annualized expenses. This suggests that another plan may have been more financially advantageous.

Other organizations have also provided standardized information to their employees or to the general public to improve health insurance decision making for individuals. One study conducted by the Consumers Union found that a uniform plan summary reduced confusion among consumers in the individual market and assisted them in making informed decisions about their health coverage (Wroblewski, 2007). Hoy and colleague's (1996) study of organizations who applied the consumer-choice model to their employees found that this approach could be successful as long as organizations limited the number of products offered, provided standardized information through an objective third party, and supported employees with education.

V. Impacts of Standardizing Health Insurance Products

As described, one of the aims of AB 786 is to facilitate informed consumer choice by creating a five-tiered system to categorize all health insurance products. The intent is to reduce confusion and simplify choices by enabling consumers to compare products offered by various plans and insurers and ensure that available products are comparable. Much of the success in achieving this aim depends on how AB 786 is implemented; particularly in ensuring that the standard products developed by the DMHC and CDI are available in the market and the comparative information on the various products is relevant, understandable, objective, and not overwhelming to the consumer (Hoy et al., 1996; Lubalin and Harris-Kojetin, 1999; Wroblewski, 2007). According to the bill sponsor, an average healthy Californian looking for health insurance on the individual market would be confronted with 88 health plan/policy choices (Health Access, 2008b).

In the early 1990s, supplemental Medicare plans (Medigap policies) were required to adhere to 1 of 10 standardized benefit packages.²⁸ Researchers found that the Medigap reform resulted in reduced confusion among policyholders, broader benefit packages, increased coverage for certain benefits, reduced marketing abuses, and reduced consumer complaints (Fox et al., 2003;

²⁸ The details of the Medigap reform and AB 786 differ substantially; although, both classify health plans into a tiered continuum with the aim to standardize product offerings for individuals purchasing insurance.

McCormack et al., 1996; MedPAC, 1999; Rice et al., 1997). However, the Medigap reforms did not appear to result in lower insurance premiums or lower the proportion of premiums that were paid in benefits as opposed to profit and administration (Fox et al., 2003; Rice et al., 1997).

As discussed earlier, the Medicare program began offering coverage for outpatient prescription drug benefits (Part D) in 2006. Though all Medicare beneficiaries are eligible for this coverage, over 4.6 million of these individuals still had no drug benefit in mid-2008 (Hoadley, 2008). In nearly all the states, there are more than 50 Medicare drug plans to choose from. Plans are difficult to compare, with different deductibles, cost-sharing amounts, and formularies (Cummings et al., 2009). Some observers suggest that the complex process of choosing a plan may have discouraged Medicare beneficiaries from enrolling (Hoadley, 2008). Even among those who did sign up for Part D in the program's first two years, nearly a quarter reported that the benefit was too complicated, and research has shown that many enrollees have limited knowledge of their plans' benefits (Cummings et al., 2009; Hsu et al., 2008). These complex insurance coverage and benefit structures may deter potential beneficiaries from enrolling in coverage for which they are eligible.

As previously discussed, Massachusetts Health Care reform of 2006 standardized product offerings in the individual market called CommChoice plans. The Connector allows for four levels of plans: Gold (approximately 100% of actuarial value), Silver (approximately 80% of actuarial value), Bronze (approximately 60% actuarial value), and Young Adult plans (for those aged 19 to 26 years) (McDonough et al., 2008). The Gold plans have no deductibles and small copayments, while Silver plans require more cost sharing. The Bronze plans typically include deductibles of \$2,000 for single coverage and \$4,000 for family coverage. The Young Adult plans are less expensive, "bare bones" policies designed to appeal to 18- to 26-year-olds who represent a disproportionate share of uninsured adults (Haislmaier and Owcharenko, 2006; Holahan and Kenney, 2008). The benefit designs and cost sharing are permitted to vary as long as the actuarial value meets standards set by the Connector (Holahan and Blumberg, 2009). The Connector grants these plans a "seal of approval." Early evidence indicates that CommChoice has made it easier for those shopping for individual insurance (Draper et al., 2008). By March 2008, approximately 18,000 had purchased CommChoice plans. This represents approximately 60% of the individual market and includes about 4,000 young adults (aged 19 to 26 years).

VI. OTHER POLICY CONSIDERATIONS RELATED TO AB 786

This section provides a brief overview of other policy considerations related to AB 786. This section does not provide an exhaustive list of all the potential implications related to the current version of AB 786 or the potential regulatory issues surrounding the implementation of AB 786 if it were to be enacted.

Some CDI Insurance Products That Pay Medical Benefits May Not be Subject to AB 786

AB 786 would include in its coverage categories all CDI-regulated "health insurance" products. In 2001, the California Legislature defined "health insurance" as "an individual or group

insurance policy that provides coverage for hospital, medical, or surgical benefits.”²⁹ This includes comprehensive health insurance products, such as a PPO or a fee-for-service indemnity policy, and limited health insurance products that reimburse for medical expenses incurred by policyholders.

It is possible that disability insurance products offered as alternatives to comprehensive major medical plans may be exempt because they do not fall into the subset of disability insurance policies defined as “health insurance.” For example, “cash benefit plans”—those plans that provide lump sum or periodic cash payments related to specific events such as hospitalization, accidents, defined disability, catastrophic illness, or illness out of the country—are not considered “health insurance” and would not be subject to AB 786. It is possible that “scheduled health benefit plans” that pay amounts based upon the plan’s schedule of benefits rather than based upon reimbursement of hospital or physician charges may also fall outside the scope of AB 786. Scheduled benefit plans sold through associations would also fall outside the scope of AB 786. Scheduled benefit plans are also known as “mini medical” plans.

Required Product Offerings

As discussed under Section III, AB 786 authorizes health plans and health insurers to offer a health insurance product in any coverage choice category. But, if the plan or insurer offers a “bare bones” product in the least comprehensive category, it must also offer the standard HMO and/or PPO in the least comprehensive category, the standard product in one of the two most comprehensive categories, and the standard product in the middle category. Every plan or insurer must offer at least the standard HMO and/or PPO in the middle category, unless the plan offers a standard HMO and/or PPO in a more generous category.

As discussed in Section II, individuals buying coverage segregate into small risk pools that reflect their expected risk of incurring medical expenses and are charged premiums accordingly. While AB 786 would require the DMHC and CDI to develop methods to standardize product offerings, the bill would not be expected to eliminate this likely dynamic. As a result of this risk segmentation, AB 786 may lead to a widening gap in premiums among products because risk will not be widely shared. Premiums associated with products that attract low-risk individuals may be driven lower and attract those who are currently uninsured. On the other hand, in the absence of regulations that subsidize costs associated with high-risk individuals, the premiums associated with comprehensive products that attract high-risk individuals may be driven up to a point that causes some individuals to drop health insurance entirely.

Product Pricing

AB 786 states that a plan or insurer “shall not establish a standard risk rate for a product in a coverage choice category at a lower rate than a product offered in a lower coverage choice category for a consumer of the same age and the same risk rate living in the same geographic region.” These provisions would ensure that the coverage choice categories are somewhat comparable in terms of risk mix but would not affect current underwriting policies and procedures. Absent regulation or requirements to ensure that all Californians are included in the insurance pool, insurers will likely use strategies to avoid enrolling a disproportionate share of high-cost enrollees. These strategies can take a variety of forms, including:

²⁹ Insurance Code Section 106(b)

- excluding preexisting medical conditions from coverage for defined periods,
- medical underwriting (the process whereby insurers assess an applicant's relative health risk and then charge higher premiums to those whose risk is deemed to be higher than average), or
- refusing to sell insurance to individuals applying for first-time coverage (Blumberg, 2004).

Although the five coverage choice categories would facilitate direct product comparisons, they do not require that the same underwriting policies and procedures be applied to different coverage choice categories. As a result, the rates produced for each tier may not reflect a “reasonable continuum” of coverage if a health plan or insurer uses different underwriting standards by category.

ATTACHMENTS

Attachment A: Specifications of Assembly Bill 786: Individual Health Care Coverage: Coverage Choice Categories, as Introduced on February 26, 2009

Requirements on Regulatory Agencies to Provide Information on Health Insurance Products

On or before September 1, 2010, the DMHC and the CDI must jointly develop, via regulation, a system to categorize all health care service plan contracts and health insurance policies offered and sold to individuals into five coverage choice categories. The coverage choice categories will:

- (1) Reflect a reasonable continuum between the coverage choice category with the lowest level of health care benefits and the coverage choice category with the highest level of health care benefits based on the actuarial value of each product
- (2) Permit reasonable benefit variation within each coverage choice category
- (3) Be enforced consistently between health care service plans and health insurers in the same marketplace regardless of licensure
- (4) Within each coverage choice category, include one standard HMO contract and/or one standard PPO contract (The coverage choice category associated with the highest cost sharing and the least comprehensive benefit package may *not* have a standard HMO or PPO contract with the lowest benefit level in that category.)
- (5) Within each coverage choice category, have a maximum dollar limit on out-of-pocket costs, including but not limited to copayments, coinsurance, and deductibles for covered benefits
- (6) Use standard definitions and terminology for covered benefits and cost sharing between health care service plans and health insurers in the same marketplace regardless of licensure
- (7) Be developed by taking into account any written analysis provided by the University of California pursuant to Section 127664.5.³⁰

The regulations that the DMHC and CDI are required to develop are to identify and require the submission of any information needed to categorize health care service plan contracts and health insurance policies. The DMHC and the CDI are to require data from plans and insurers in order to assist the University of California in fulfilling its responsibilities pursuant to Section 127664.5.

The DMHC and the CDI are to develop a notice that provides consumers information about the coverage choice categories that have been developed. The notice is to include:

- (1) The range of cost sharing and the benefits and services permitted in each category, including any variation in those benefits and services
- (2) For the individual health insurance product, the percentage of health care expenses that are covered by the product

³⁰ This section would request the University of California through CHBRP to provide relevant analyses. This Issue analysis does not address those provisions.

- (3) For the individual health insurance product, the estimated annual out-of-pocket costs, estimated total annual costs (including premium and out-of-pocket costs) for a consumer with average health care costs and a consumer with high health care costs

The director of the DMHC and the insurance commissioner are to annually report on the contracts and policies offered in each coverage choice category and on the enrollment in those contracts and policies.

Commencing January 1, 2013, and every 3 years thereafter, the director of the DMHC and the insurance commissioner are to jointly determine whether the coverage choice categories should be revised to meet the needs of consumers.

Requirements on Health Plans and Health Insurers for Filing Prior to Offering Products

Health care service plans selling an individual health care service plan contract must submit a filing to the DMHC for categorization prior to offering or selling an individual health care service plan contract.

Health insurers selling an individual health insurance policy must submit a filing to the CDI for categorization prior to offering or selling an individual health care service plan contract.

The director of the DMHC and the insurance commissioner are to categorize each individual health care plan contract and individual health insurance policy offer by a plan or insurer into the appropriate coverage choice category within 90 days of the date the contract is filed.

Requirements on Health Plans and Health Insurers for Product Offerings

Health care service plans and insurers are prohibited from offering or selling an individual health insurance product until the director or insurance commissioner has categorized the product.

Health care service plans and health insurers are authorized to offer a health insurance product in any coverage choice category. However, if the plan or insurer offers a product in the least comprehensive category, it must also offer the standard HMO and/or PPO in the least comprehensive category, the standard policy in one of the two most comprehensive categories, and the standard product in the middle category. Every plan or insurer must offer at least the standard HMO and/or PPO in the middle category, unless the plan offers a standard HMO and/or PPO in a more generous category.

Individual health care service plan contracts and individual health insurance policies would be required to contain a maximum dollar limit on out-of-pocket costs for covered benefits. Out-of-pocket maximums include, but are not limited to, copayments, coinsurance, and deductibles for covered benefits.

All health insurance policies offered and sold to individuals shall cover physician services, hospitals, and preventive services, and shall, at a minimum, meet existing coverage requirements.

Requirements on Health Plans and Health Insurers for Product Pricing

Health care service plans and health insurers must establish prices for the products offered to individuals that reflect a reasonable continuum between the products offered in the coverage choice category with the lowest level of benefits and the products offered in the coverage choice category with the highest level of benefits based on the actuarial value of each product.

Health care service plans and carriers will not establish a standard risk rate for a product in a coverage choice category at a lower rate than a product offered in a lower coverage choice category for a consumer of the same age and the same risk rate living in the same geographical region.

Attachment B

Table B-1. California Health Insurance Benefit Mandates, by Topic

#	Topic	Health & Safety Code (DMHC)	California Insurance Code (CDI)	Mandate to Cover or Mandate to Offer	Markets Subject to the Mandate	Mandate Category
Knox-Keene Health Plan Minimum Benefits						
0	Knox-Keene Licensed Health Plans regulated by the DMHC are required to cover medically necessary basic health care services, including: (1) Physician services; (2) Hospital inpatient services and ambulatory care services; (3) Diagnostic laboratory and diagnostic and therapeutic radiologic services; (4) Home health services; (5) Preventive health services; (6) Emergency health care services, including ambulance and ambulance transport services, out-of-area coverage, and ambulance transport services provided through the "911" emergency response system; (7) Hospice care	Multiple Sections	N/A ³¹	<i>Not a mandate but ...</i> Coverage	<i>Not a mandate but ...</i> Group and Individual	<i>Not a mandate</i>
Cancer Benefit Mandates						
1	Breast cancer benefits	1367.6	10123.8	Coverage	N/M ³²	a
2	Cancer screening tests	1367.665	10123.2	Coverage	Group and Individual	b
3	Cervical cancer screening	1367.66	10123.18	Coverage	Group and Individual	a
4	Mammography	1367.65	10123.81	Coverage	N/M	a
5	Mastectomy and lymph node dissection—length of stay	1367.635	10123.86	Coverage	Group and Individual	c
6	Patient care related to clinical trials for cancer	1370.6	10145.4	Coverage	N/M	c
7	Prostate cancer screening and diagnosis	1367.64	10123.83	Coverage	Group and Individual	a
Chronic Conditions Benefit Mandates						
8	Diabetes management and treatment	1367.51	10176.61	Coverage	N/M	a
9	HIV/AIDS, AIDS vaccine	1367.45	10145.2	Coverage	Group and Individual	a
10	HIV/AIDS, HIV Testing	1367.46	10123.91	Coverage	Group and Individual	a
11	HIV/AIDS, Transplantation services for persons with HIV	1374.17	10123.21	Coverage	N/M	c
12	Osteoporosis	1367.67	10123.185	Coverage	N/M	a
13	Phenylketonuria	1374.56	10123.89	Coverage	N/M	a

³¹ N/A indicates that mandate does not apply to products governed under that code.

³² An N/M indicates that the language of the law does not mention which market is affected.

Table B-1. California Health Insurance Benefit Mandates, by Topic (Cont'd)

Hospice & Home Health Care Benefit Mandates						
14	Home health care	N/A	10123.10	Offer	Group	b
15	Hospice care	1368.2	N/A	Coverage	Group	b
Mental Health Benefit Mandates						
16	Alcohol and drug exclusion	N/A	10369.12	Coverage	Group	c
17	Alcoholism treatment	1367.2(a)	10123.6	Offer	Group	a
18	Coverage and premiums for persons with physical or mental impairment	1367.8	10122.1	Coverage	Group and Individual	c
19	Coverage for mental and nervous disorders	N/A	10125	Offer	Group	a
20	Nicotine treatment in licensed chemical dependency facilities	1367.2(b)	10123.14 10123.6	Coverage	N/M	b
21	Coverage for severe mental illnesses (in parity with coverage for other medical conditions) ³³	1374.72	10123.15 (10144.5)	Coverage	Group	c
Orthotics & Prosthetics Benefit Mandates						
22	Orthotic and prosthetic devices and services	1367.18	10123.7	Offer	Group	b
23	Prosthetic devices for laryngectomy	1367.61	10123.82	Coverage	N/M	b
24	Special footwear for persons suffering from foot disfigurement	1367.19	10123.141	Offer	N/M	a
Pain Management Benefit Mandates						
25	Acupuncture	N/A	10127.3	Offer	Group	d
26	General anesthesia for dental procedures	1367.71	10119.9	Coverage	N/M	b
27	Pain management medication for terminally ill	1367.215	N/A	Coverage	N/M	b
Pediatric Care Benefit Mandates						
28	Asthma management	1367.06	N/A	Coverage	N/M	a
29	Comprehensive preventive care for children aged 16 years or younger	1367.35	10123.5	Coverage	Group	b
30	Comprehensive preventive care for children aged 17 or 18 years	1367.3	10123.55	Offer	Group	b
31	Coverage for the effects of diethylstilbestrol	1367.9	10119.7	Coverage	N/M	a
32	Screening children for blood lead levels	1367.3 (b)(2)(D)	10119.8	Coverage	Group and Individual	b

³³ The federal Mental Health Parity and Addition Equity Act of 2008 requires that *if* a group plan or policy covers mental health, it must do so at parity with coverage for medical and surgical benefits.

Table B-1. California Health Insurance Benefit Mandates, by Topic (Cont'd)

Provider Reimbursement Mandates						
33	Emergency 911 transportation	1371.5	10126.6	Coverage	N/M	d
34	Medical transportation services—direct reimbursement	1367.11	10126.6	Coverage	N/M	d
35	OB-GYNs as primary care providers	1367.69	10123.83	Coverage	N/M	d
36	Pharmacists—compensation for services within their scope of practice	1368.5	N/A	Coverage	N/M	d
Reproduction Benefit Mandates						
37	Contraceptive devices requiring a prescription	1367.25	10123.196	Coverage	N/M	b
38	Expanded alpha fetoprotein	1367.54	10123.184	Coverage	Group and Individual	a
39	Infertility treatments	1374.55	10119.6	Offer	Group	a
40	Maternity benefits—minimum length of stay ³⁴	1367.62	10123.87	Coverage	Group and Individual	c
41	Maternity coverage—amount of copayment or deductible for inpatient services	1373.4	10119.5	Coverage	N/M	c
42	Prenatal diagnosis of genetic disorders	1367.7	10123.9	Offer	Group	b
Surgery Benefit Mandates						
43	Jawbone or associated bone joints	1367.68	10123.21	Coverage	N/M	a
44	Reconstructive surgery ³⁵	1367.63	10123.88	Coverage	Group and Individual	b
Terms & Conditions of Coverage Benefit Mandates						
45	Authorization for nonformulary prescription drugs	1367.24	N/A	Coverage	N/M	c
46	Coverage for persons with blindness or partial blindness	1367.4	N/A	Coverage	Group and Individual	c
47	Prescription drugs: coverage for previously prescribed drugs	1367.22	N/A	Coverage	N/M	c
48	Prescription drugs: coverage of “off-label” use	1367.21	10123.195	Coverage	N/M	c

Notes: Mandate Category – The listed mandates fall into one or more types. Mandates can do one or more of the following:

- a. 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. An example of a mandate to cover screening tests would be a mandate to cover prostate cancer screening.
- b. Offer or provide coverage for the screening, diagnosis, or treatment of a particular disease or condition. An example of a mandate to cover a set of services for treatment of condition is the mandate that requires coverage for all services to screen and treat breast cancer.
- c. Offer or provide coverage for services from a specified type of health provider that fall within the provider’s scope of practice. An example would be a mandate that requires coverage for services provided by a licensed acupuncturist.
- d. Offer or provide any of the forms of coverage listed above per specific terms and conditions. For example, the mental health parity law requires coverage for serious mental health conditions to be on par with other medical conditions, so that mental health benefits and other benefits are subject to the same co-payments, limits, etc.

³⁴ The federal Newborns’ and Mothers’ Health Protection Act of 1996 requires coverage for a minimum length of stay in a hospital after delivery *if* the plan covers maternity services.

³⁵ The federal Women’s Health and Cancer Rights Act of 1998 requires coverage for post-mastectomy reconstructive surgery.

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ACKNOWLEDGEMENTS

Contributing authors include: Edward Yelin, PhD, Janet Coffman, MPP, PhD, and Mi-Kyung (Miki) Hong, MPH, all of the University of California, San Francisco; Nicole Bellows, PhD, of the University of California, Berkeley; Gerald Kominski, PhD, of the University of California, Los Angeles; and Susan Philip, MPP, Angela Killilea, and Cynthia Robinson, MPP, of CHBRP staff. Penny Coppernoll-Bach, MLIS, of the University of California, San Diego, conducted the literature search. Jay Ripps, FSA, MAAA, of Milliman provided actuarial analysis. Sarah Ordódy provided editing services. Thomas MaCurdy of Stanford and a subcommittee of CHBRP's National Advisory Council reviewed the analysis for its accuracy, completeness, clarity, and responsiveness to the Legislature's request.

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

**California Health Benefits Review Program
1111 Franklin Street, 11th Floor
Oakland, CA 94607
Tel: 510-287-3876
Fax: 510-763-4253
www.chbrp.org**

All CHBRP bill analyses and other publications are available on the CHBRP Web site, www.chbrp.org.

Susan Philip, MPP
Director

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

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

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

Faculty Task Force

Helen Halpin, ScM, PhD, *Vice Chair for Public Health Impacts*, University of California, Berkeley

Gerald Kominski, PhD, *Vice Chair for Financial Impacts*, University of California, Los Angeles

Ed Yelin, PhD, *Vice Chair for Medical Effectiveness*, University of California, San Francisco

Wayne S. Dysinger, MD, MPH, Loma Linda University Medical Center

Susan Ettner, PhD, University of California, Los Angeles

Theodore Ganiats, MD, University of California, San Diego

Sheldon Greenfield, MD, University of California, Irvine

Kathleen Johnson, PharmD, MPH, PhD, University of Southern California

Richard Kravitz, MD, University of California, Davis

Thomas MaCurdy, PhD, Stanford University

Task Force Contributors

Wade Aubry, MD, University of California, San Francisco

Nicole Bellows, MHSA, PhD, University of California, Berkeley

Tanya G. K. Bentley, PhD, University of California, Los Angeles

Meghan Cameron, MPH, University of California, Los Angeles

Janet Coffman, MPP, PhD, University of California, San Francisco

Mi-Kyung Hong, MPH, University of California, San Francisco

Stephen McCurdy, MD, MPH, University of California, Davis

Sara McMenamin, PhD, University of California, Berkeley

Ying-Ying Meng, DrPH, University of California, Los Angeles

Nadereh Pourat, PhD, University of California, Los Angeles

Dominique Ritley, MPH, University of California, Davis

Chris Tonner, MPH, University of California, San Francisco

National Advisory Council

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

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Troyen A. Brennan, MD, MPH, Executive Vice President, Chief Medical Officer, CVS Caremark, Woonsocket, R.I.

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

Michael Connelly, JD, President and CEO, Catholic Healthcare Partners, Cincinnati, OH

Maureen Cotter, ASA, Founder and Owner, Maureen Cotter & Associates, Inc., Dearborn, MI

Susan Dentzer, Editor-in-Chief of Health Affairs, Washington, DC.

Joseph Ditre, JD, Executive Director, Consumers for Affordable Health Care, Augusta, ME

Allen D. Feezor, 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

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

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

Michael Pollard, JD, MPH, Consultant, Federal Policy and Regulation, Medco Health Solutions, Washington, DC

Karen Pollitz, MPP, Project Director, Georgetown University Health Policy Institute, 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, 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

CHBRP Staff

Susan Philip, MPP, Director

Angela Killilea, Public Policy Intern

John Lewis, MPA, Principal Analyst

Cynthia Robinson, MPP, Principal Analyst

Jackie Shelton, Program Assistant

California Health Benefits Review Program

1111 Franklin Street, 11th Floor

Oakland, CA 94607

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

info@chbrp.org 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, John D. Stobo, M.D., Senior Vice President – Health Sciences and Services.