



## ISSUE BRIEF

# Policy Considerations Relevant to Senate Bill 1522: Coverage Choice Categories

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On April 10, 2008, the California Health Benefits Review Program (CHBRP) received a request to analyze *Senate Bill (SB) 1522: Health Care Coverage: Coverage Choice Categories* from the Senate Committee on Health. As introduced by Senator Darrell Steinberg on February 22, 2008, and amended on April 2, 2008, the legislative proposal contains several provisions that would affect the individual insurance market.

CHBRP was requested to analyze SB 1522 because the bill includes the following language that the Senate Committee on Health determined to be a health insurance benefit mandate provision subject to CHBRP review<sup>1</sup>: “*All health insurance policies offered and sold to individuals on or after January 1, 2009 shall cover physicians, hospitals, and preventive services, and shall, at a minimum, meet existing coverage requirements.*”

This provision requires minimum benefit standards but those minimum benefits are not specified and instead are dependent on future determinations by the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI), if SB 1522 were to be enacted. Further, SB 1522 would 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 SB 1522 are not specified, a traditional CHBRP analysis<sup>2</sup> is not feasible.

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

- The first section provides a brief discussion of the intent and key provisions of SB 1522.
- 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.

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<sup>1</sup> Pursuant to CHBRP’s authorizing statute, Health and Safety Code Section 127660 et seq

<sup>2</sup> 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.

- The third section looks at current minimum coverage requirements in the individual market in California and other states, followed by a summary of the evidence on the relationship between altering coverage requirements (i.e., covered services, out-of-pocket maximums, cost sharing) and health care utilization.
- The fourth 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 fifth section summarizes other policy considerations related to the potential impacts of SB 1522 including impacts on the availability of health insurance products, product pricing, and provider networks.

## I. SB 1522: 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 to allow consumers to compare coverage and make price comparisons across health insurance carriers (Health Access, 2008a). To remedy these problems, the proposed legislation:

- establishes minimum 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 DMHC and CDI to categorize all health insurance products sold to individuals into a five-tiered classification system, and
- requires health plans and insurers to offer products in each of the five tiers of the new classification system (see Attachment A for the SB 1522 specifications).

## II. Individual Market: Current Profile and Trends in California

The individual (or “nongroup”) insurance market may be the only health insurance alternative for those who do not have access to employer-based coverage, cannot afford their share of the premium for employment-based coverage, or do not qualify for government programs.

Individual policies frequently are unavailable to those with pre-existing 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 2003–2006 ended up never buying a plan. 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 pre-existing condition, or had a health problem excluded from coverage (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—2.9 million or (9.0%)—purchased policies in the individual market (Fronstin, 2007). 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%).

### **Premium and Cost Sharing Trends**

Prices for individual policies vary considerably. Nationally, average annual premiums are \$2,623 for single coverage and \$5,799 for family plans. Over the 2006–2007 time period, 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. In California, the average annual family premium was \$5,884 with an average of 3.02 members enrolled in a policy (AHIP, 2007). In 2006, the average deductible in single-coverage individual plans was \$2,136 with out-of-pocket maximums averaging \$3,998 (Gabel, 2007).

One measure of financial protection provided by an insurance policy is the limit placed on consumers’ annual out-of-pocket spending. A study of individual policies sold nationally determined that the vast majority of policies have *some* out-of-pocket maximum. The proportion of policies with some out-of-pocket maximum varied by type of plan. 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 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 policies and 94.9% of family policies. Average out-of-pocket maximums varied, ranging from \$2,400 for single coverage in a 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 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 percent of the individual insurance market in California (Gabel, 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 having a deductible (the amount the consumer is expected spend before coverage

begins) that is \$1000 or over for an individual and \$2000 and over for a family.<sup>3</sup> Compared to increased copayments, deductibles offer the most direct method to increase the consumer's share of health care costs (Claxton et al., 2005). In this kind of cost-sharing arrangement consumers would be expected to be more careful about how they spend their first \$1000 dollars on health care (CHBRP, 2006). Using HDHPs, insurers have increasingly shifted costs to purchasers. In the individual market, insurers have been structuring 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.”)

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 a qualified HDHPs.<sup>4</sup> 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 and build up of tax-free interest and investment earnings.

HDHPs are currently a substantial segment of the California individual market. According to data collected from the seven largest carriers in California, from 2006–2008, HDHPs represented over half of individual insurance market in California (see Table 1).

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<sup>3</sup> For calendar year 2009, a “high-deductible health plan” is defined under the U.S. Internal Revenue Code Section 223(c)(2)(A) as a health plan with an annual deductible that is not less than \$1,150 for self-only coverage or \$2,300 for family coverage, and the annual out-of-pocket expenses (deductibles, copayments, and other amounts, but not premiums) do not exceed \$5,800 for self-only coverage or \$11,600 for family coverage. See: [www.irs.gov/irb/2008-22\\_IRB/ar10.html](http://www.irs.gov/irb/2008-22_IRB/ar10.html)

<sup>4</sup> 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](http://www.irs.gov/irb/2008-22_IRB/ar10.html).

**Table 1: Enrollees in Privately Insured Individual HDHPs, California, 2006-2008**

	2006		2007		2008	
	Number of Enrollees	Percent of Total Enrollees	Number of Enrollees	Percent of Total Enrollees	Number of Enrollees	Percent of Total Enrollees
<b>DMHC-Regulated Individual Plans</b>						
Enrollees in HDHPs	435,000	21.6%	632,000	30.6%	647,000	30.6%
Total enrollees	984,000	48.9%	1,268,000	61.5%	1,299,000	61.5%
<b>CDI-Regulated Individual Products</b>						
Enrollees in HDHPs	674,000	33.5%	462,000	22.4%	472,000	22.3%
Total enrollees	1,030,000	51.1%	794,000	38.5%	812,000	38.5%
<b>Enrollees in DMHC- and CDI-Regulated Individual HDHPs</b>						
<b>Total</b>	1,109,000	55.1%	1,094,000	53.1%	1,119,000	53%
<b>Enrollees in DMHC- and CDI-Regulated Individual Market</b>						
<b>Total</b>	2,014,000	100.0%	2,062,000	100.0%	2,111,000	100.0%

*Source:* California Health Benefits Review Program, 2008. Data derived from CHBRP surveys (2006, 2007, and 2008; unpublished data) of the eight largest health plans and insurers.

*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.

Nationally, about one-quarter of individual private insurance products are HSA/HDHP products. Total enrollment in HSA/HDHP products in California for all market segments, including the group markets, was 640,000 in January 2008, or 3.1% of enrollment in all private health insurance products (AHIP, 2008).

### **Risk Segmentation in the Individual Market**

One consequence of the introduction of HDHPs has been greater 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 the less healthy, 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—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, 2008). The number of insured Californians in the individual market without maternity benefits has more than tripled between 2004 and 2007, from an estimated 192,000 in 2004 to the current estimate of 600,800.

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 policy choices with basic benefits, effectively forcing individuals to purchase more generous benefits than they prefer or can necessarily afford. Opponents argue that greater segmentation without adequate mechanisms to risk-adjust premiums encourages favorable selection of lower-risk individuals into lower-cost policies, thereby driving up the cost of higher-cost policies (such as those that cover maternity services), because only those people expecting to use the services would purchase them.

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; (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 12.0% 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. 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, 2007; Seifer and Rukavina, 2006).

### III. Minimum Coverage Requirements

SB 1522 would alter minimum coverage requirements in two ways. First, SB 1522 would increase the minimum services that must be provided as a covered benefit by requiring all health insurance products regulated by CDI to cover physicians, hospitals, and preventive services.

Second, SB 1522 would require all health insurance products to have a maximum limit on out-of-pocket costs for covered benefits. 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 SB 1522. In addition this section then presents the potential impacts of altering minimum benefit requirements based on a review of the existing evidence.

### **Minimum Benefit Levels: Current Requirements**

California has two regulatory agencies to provide oversight of health insurance products. The CDI licenses and regulates carriers and health insurance products through the authority of the California Insurance Code. The Department of Managed Care (DMHC) licenses and regulates health care service plans, principally Health maintenance organization (HMOs, or health plans) through the authority of the Knox-Keene Health Care Services Plan Act of 1975.<sup>5</sup>

All DMHC-regulated health plans must offer “basic health care services” as a covered benefit defined as:

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

These mandated “basic health care services” 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, DMHC-regulated plans are required to cover “medically necessary” items or services. Health plans also offer benefits that are not mandated by law. For example, coverage for outpatient prescription drugs is not a required benefit; however, 93% of all health plans offer this benefit in the individual market.<sup>6</sup>

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 a list of mandates that apply to CDI policies). Coverage for outpatient prescription drugs is not a required benefit; however, about 83% of all individual CDI-regulated products cover this benefit.<sup>7</sup>

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<sup>5</sup> Requirement for Knox-Keene licensed health plans are codified in the Health and Safety Code.

<sup>6</sup> 2008 CHBRP carrier survey, unpublished data.

<sup>7</sup> 2008 CHBRP carrier survey, unpublished data.

## **Minimum Benefit Levels: Potential Changes Required under SB 1522**

As mentioned, SB 1522 would require all CDI-regulated health insurance products to cover “physicians, 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:

- 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 SB 1522 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 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 only cover hospital services would not be required to cover this service because cervical cancer screening is generally covered on an outpatient basis. SB 1522 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 that only cover hospital services illegal.<sup>8</sup>

Because 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 they license, CHBRP is unable to estimate the number of insured who potentially would be affected by this particular provision of SB 1522.

## **Limits on Out-of-Pocket Costs: Current Requirements:**

DMHC-regulated plans are governed by the Health and Safety Code which does 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. 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.<sup>9</sup> Copayments, deductibles and other limitations cannot “render the benefit illusory.”<sup>10</sup> This concept is not further defined in regulation or policy, except in regulations for outpatient

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<sup>8</sup> SB 1522 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).

<sup>9</sup> Health & Safety Code Section 1367(h) and 1367(i).

<sup>10</sup> California Code of Regulations, Title 28, section 1300.67.4.

prescription drug benefits. Under these regulations, copayment or percentage coinsurance cannot exceed 50% of the cost to the plan.<sup>11</sup>

CDI-regulated products are governed by the Insurance Code which places 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.<sup>12</sup> Individual policies must provide “real economic value” to the insured.<sup>13</sup> However, the insurer need not pay the full amount of any loss to provide a benefit of real economic value.<sup>14</sup> 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.<sup>15</sup> As of July 2007, the loss ratio requirement for new policies and rate revisions has been 70%.<sup>16</sup> California has no requirement for health plans and insurers to disclose the actuarial value of their products to regulatory agencies. It is estimated that actuarial values in the individual market range from 0.32 to 0.85 (Gabel et al., 2007).

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.<sup>17</sup> The maternity benefits mandate also requires that coverage be at parity with other medical benefits.<sup>18</sup>

### **Limits on Out-of-Pocket Costs: Potential Changes Required under SB 1522**

As mentioned, SB 1522 would require that health insurance products have a maximum limit on out-of-pocket costs for covered benefits, including, but not limited to, copayments, coinsurance, and deductibles. This provision may be interpreted to require health insurers to simply disclose out-of-pocket costs to facilitate price comparisons by consumers. Alternatively, this requirement may also require that adherence to a prescribed maximum level of out-of-pocket costs be established by regulatory agencies. If SB 1522 was interpreted to require regulatory agencies to establish an out-of-pocket maximum, this provision could have implications for the use of health care services and the cost of insurance. Table 2 is provided to illustrate effects of various out-of-pocket maximums on premiums for health insurance policies. As the out-of-pocket limitations included in a policy are allowed to increase, the premium associated with that policy would decrease. Using comprehensive benefit packages as the base for comparison (non-HDHPs), premium increases would range from 1% to 25%, depending on the maximum level of the out-of-pocket costs.

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<sup>11</sup> California Code of Regulations, Title 28, section 1300.67.24.

<sup>12</sup> Insurance Code Section 10291.5(a)(1).

<sup>13</sup> Insurance Code Section 10291.5(b)(7)(A) and 10270.95.

<sup>14</sup> Insurance Code Section 10291.5.

<sup>15</sup> California Code of Regulations Section 2222.10.

<sup>16</sup> California Code of Regulations Section 2222.12.

<sup>17</sup> Health and Safety Code Section 1374.72 and California Insurance Code Section 10144.5.

<sup>18</sup> 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.

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

<b>Annual Out-of-Pocket Maximum per Individual</b>	<b>Relative Premium for a Plan with \$2,500 Annual Deductible per Individual, 20% Coinsurance</b>
None	1.00
\$50,000	1.01
\$25,000	1.02
\$10,000	1.07
\$5,000	1.13
\$2,500	1.25

Source: Milliman analysis of national claims data, 2008.

### **Minimum Benefit Levels: 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 maximums 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 coverage that constitutes “minimum creditable coverage” so as to avoid paying tax penalties. Minimum credible 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.

The minimal credible coverage requirement does not take effect until January 2009 in order to catch up with the renewal cycle for existing policies. As of January 1, 2009, a health plan with “minimum credible coverage” is one that covers a broad range of medical benefits, including preventative and primary care, emergency services, hospital stays, outpatient services, prescription drugs, and mental health services.<sup>19</sup> Specifically, a plan must:

1. Cover prescription drugs.

<sup>19</sup> 954, Code of Massachusetts Regulations Section 5.03.

2. Cover three regular doctor visits and check-ups for an individual, or six for a family before any deductibles.
3. Cap the deductible at \$2,000 for an individual, or \$4,000 for a family each year.
4. Cap out-of-pocket spending for nonprescription health services at \$5,000 for an individual or \$10,000 for a family each year, for plans with a deductible or co-insurance.
5. Not cap total benefits for a sickness or for each year.

## 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, Plan B, C, D, and the HMO Plan) and “Basic & Essential” plans to be sold in the individual market. The standard plans are prescribed by the IHC Program Board of Directors. The Basic & Essential (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 in-patient and out-patient professional and facility services. These plans have no limits on in-patient 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-pockets prescribed for all of the Standard Plans. However, carriers are allowed to offer a range of maximums (just as they offer a range of deductibles). Maximum out-of-pocket maximums range from \$6,000–\$15,000 (Plan A/50), \$4,000–\$13,000 (Plan B), \$3,500–\$12,500 (Plan C), and \$3,000–\$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 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.<sup>20</sup>

## 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.

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<sup>20</sup> Personal communication with Chanell McDevitt, Deputy Executive Director, May 29, 2008. Individual & Small Employer Health Benefits Programs, NJ Dept. of Banking & Insurance.

## **The Potential Impact of 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 and biological agents.

These trends in health care delivery suggest that 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, SB 1522 would require health insurance policies to provide coverage for a more comprehensive range of expensive health care services performed in outpatient settings than the range of services covered by some policies currently sold in California.

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).

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

Even less literature has been published on the impact of limits on out-of-pocket expenditures. The only studies CHBRP identified assessed limits on out-of-pocket expenditures for 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 that limited annual out-of-pocket costs for drugs had fewer days without medication. In other words, persons whose health plans 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 which are used to treat ulcers and Type 2 diabetes, respectively (Kephart et al., 2007). No studies that addressed the effects of limits on out-of-pocket expenses for all covered health care services or services other than drugs were identified.<sup>21</sup>

### General Effects of Cost Sharing

Generally, studies of the effects of cost sharing for health care services are most relevant to provisions of SB 1522 that require DMHC and CDI to categorize health insurance policies 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; Solanki et al., 2000; Trivedi et al., 2008)

### High-Deductible Health Plans

Two specific forms of cost sharing that the State Legislature may wish to consider 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 will cover services to which the deductible applies. Enrollment in high-deductible health plans (HDHPs) has grown rapidly in recent years.

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<sup>21</sup> 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.

As discussed previously, these health plans now account for a large share of policies 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 health plans are relatively new. The RAND HIE found that consumers enrolled in a health plan 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 with a moderate level of cost sharing (e.g., 25% coinsurance).

Three studies that 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 a HDHP were less likely to make multiple emergency department 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 a 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 (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 health savings accounts 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 a 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 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. However, the RAND HIE may not have had sufficient statistical power to detect differences in other health outcomes.

#### IV. Use of Information to Make Health Care Coverage Decisions

According to the bill sponsor, an average, healthy Californian looking for health insurance on the individual market would be confronted with 88 health plan choices (Health Access, 2008b). The bill sponsor's intent through SB 1522 is to reduce the confusion and simplify choices by enabling consumers to make comparisons of comparable products between insurers. This section examines the evidence on the impact of providing information on health insurance products on consumers and the market.

##### **Current Requirements to Provide Comparative Information**

Current law requires health plans and insurance carriers selling products in the individual and small-group market to provide a uniform health plan benefits and coverage matrix containing the major provisions of their health insurance products.<sup>22</sup> The uniform matrix, or benefit summary, includes 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,

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<sup>22</sup> Health and Safety Code Section 1363(a) and 1363(b); Insurance Code Section 10603 and 10604.

- mental health services,
- chemical dependency services, and
- home health services.

Health plans and carriers must also provide information to 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.<sup>23</sup> The first matrix compares individual conversion coverage plans (i.e., plans offered to individuals who have lost their employer-sponsored group health plan coverage) and plans offered to individuals with individually purchased coverage who chose to buy an individual product that is compliant with the Health Insurance Portability and Accountability Act (HIPAA) plan. DMHC provides an interactive Web site for consumers to compare these conversion and HIPAA products: [www.dmhc.ca.gov/coverage/conversion/hp\\_default.asp](http://www.dmhc.ca.gov/coverage/conversion/hp_default.asp).

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 products are separate from other individual health coverage that is available in the marketplace. DMHC provides a link on its Web site for consumers to compare rates between plans: [www.dmhc.ca.gov/coverage/mrmip/rates.pdf/](http://www.dmhc.ca.gov/coverage/mrmip/rates.pdf/)

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<sup>23</sup> Health and Safety Code Section 1363.06.

## **Impact of Standardizing Information and Standardizing Health Insurance Products**

The numerous health insurance options in California make choosing a health plan a highly complex task. At present, an informed choice would include an understanding of plans' provider networks, covered benefits, coinsurance rates, deductibles, formulary structure, and many other important health plan features. Research has found that many individuals in the U.S. have a limited understanding of health insurance plans and thus struggle with selecting a health plan (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 until they use health care services. A 2006 survey of Californian adults enrolled in HMOs (CHI, 2006) found that over 40% of HMO consumers 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 and employers often provide detailed health plan 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 health plan decisions since individuals can only process a limited number of factors when making a decision (Hibbard and Peters, 2003; 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 plans, minimize unexpected outcomes, and improve consumer satisfaction (Kirsch, 2002).

This informational approach was taken in the early 1990s when supplemental Medicare plans (Medigap policies) were required to adhere to one of 10 standardized benefit packages.<sup>24</sup> 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; 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).

The 2006 health reform in Massachusetts also included the provision of standardized health insurance information for consumers. The Commonwealth Health Insurance Connector Authority Web site ([www.mahealthconnector.org](http://www.mahealthconnector.org)) aims to assist individuals and employers in purchasing health insurance by classifying available health plans into three tiers according to the level of cost sharing (deductibles and copayments) and then providing information on costs and coverage. The Connector Authority grouped the privately insured plans that are relatively comparable in terms of actuarial value into one of three tiers: Gold (approximately 100% of actuarial value), Silver (approximately 80% of actuarial value), and Bronze (approximately 60% of actuarial value). Because the three-tiered system and standardized information provided by the Massachusetts Connector Web site on health plan decision-making was only implemented in

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<sup>24</sup> The details of the Medigap reform and SB 1522 differ substantially; although, both classify health plans into a tiered continuum with the aim to clarify confusion for individuals purchasing insurance.

2007, it is too early to expect any evaluations to have been completed. However, interviews with state officials in Massachusetts indicated a positive response from consumers and a damping of premiums as carriers aggressively priced their benefit product packages offered on the Connector Web site.<sup>25</sup>

Other organizations have also provided standardized information to their employees or to the general public in order 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 et al.'s (1996) study of organizations applying the consumer-choice model to their employees found that this approach could be successful as long as organizations limited the number of plans offered, provided standardized information through an objective third party, and supported employees with education.

As described previously, one of the aims of SB 1522 is to facilitate informed consumer choice of individual health insurance plans by creating a five-tiered system to categorize all health insurance products. Much of the success in achieving this aim depends on how SB 1522 is implemented; particularly in ensuring that the information provided is relevant, understandable, objective, and not overwhelming to the consumer (Hoy et al., 1996; Lubalin and Harris-Kojetin, 1999; Wroblewski, 2007).

## V. Other Policy Considerations Related to SB 1522

This section provides a brief overview of other policy considerations related to SB 1522. This section does not provide an exhaustive list of all the potential implications related to the current version of SB 1522 or the potential regulatory issues surrounding the implementation of SB 1522 if it were to be enacted.

### **Some CDI Insurance Products That Pay Medical Benefits May Not be Subject to SB 1522**

SB 1522 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.”<sup>26</sup> This includes comprehensive health insurance products, such as a PPO or a fee-for-service indemnity plan, and limited health insurance products that reimburse for medical expenses incurred by plan participants.

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

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<sup>25</sup> Personal communication with Bob Carey, Director of Planning and Development, Commonwealth Health Insurance Connector Authority, May 28, 2008.

<sup>26</sup> Insurance Code Section 106(b).

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 SB 1522. 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 SB 1522. Scheduled benefit plans sold through associations would also fall outside the scope of SB 1522. Scheduled benefit plans are also known as “mini medical” plans.

## **Required Product Offerings**

SB1522 requires health care service plans and insurers to offer products in all five coverage choice categories. As discussed in Section I, individuals buying coverage segregate into small risk pools that reflect their expected risk of incurring medical expenses and are charged premiums accordingly. As a result of this adverse selection, SB1522 may lead to a widening gap in premiums among products because risk will not be widely shared. Premiums associated with plans 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 plans that attract high-risk individuals may be driven up to a point that causes individuals to drop health insurance entirely.

## **Provider Network Requirements**

The proposed legislation has provider network requirements but does not address network adequacy. Current law has access requirements to provider networks. DMHC-regulated health plans must ensure that services are “readily available and accessible to enrollees.” DMHC regulatory guidelines include specific physician-enrollee ratios and distance standards for the location of providers to enrollee residences and workplaces (i.e., one primary care physician for every 2,000 enrollees; primary care provider within 30 minutes or 15 miles of residence or work).<sup>27</sup> Plans are required to receive prior approval of networks in each geographic region. The CDI has accessibility regulations for exclusive provider organizations (EPO).<sup>28</sup>

SB 1522 requires that provider networks offered in one coverage choice category must be offered for at least one contract/policy in each category. Currently, health plans and carriers may offer a combination of broader coverage with narrower networks, relying on smaller networks to exercise control over the utilization of health care services, control that would otherwise be achieved by more restricted benefits. Such combinations of narrower networks and broader benefits may also be a way to limit the effects of adverse selection. By prohibiting such combinations, SB 1522 may reduce access if only the most restrictive categories of coverage are sustainable over time.

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<sup>27</sup> California Code of Regulations Title 28, Section 1300.51.

<sup>28</sup> Health and Safety Code Sections 1351(k) and 1367(e); Insurance Code Section 10133.5. EPOs are similar to HMOs except they are regulated by the CDI. EPOs require use of their network providers for coverage of services.

## **Product Pricing**

SB1522 is silent with respect to underwriting policies and procedures. Absent regulation, insurers use strategies to avoid enrolling a disproportionate share of low-cost enrollees. These strategies can take a variety of forms, including: excluding preexisting medical conditions from coverage for defined periods; engaging in 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 an applicant insurance (Blumberg, 2004). Although the five plan coverage choice categories would facilitate direct policy 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 tier.

## Attachments

### **Attachment A: Specifications of Health Care Coverage: Coverage Choice Categories SB 1522, as amended April 2, 2008**

#### Requirements on Regulatory Agencies to Provide Information on Health Insurance Products

The Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI) will develop 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.
- (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 health maintenance organization (HMO) and one standard preferred provider organization (PPO), each of which is the health care service plan contract or health insurance policy with the lowest benefit level in that category and for that type of contract or policy.

The Director of the Department of Managed Health Care and the Insurance Commissioner would 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, 2012, and every 3 years thereafter, the director and the commissioner would jointly determine whether the coverage choice categories should be revised to meet the needs of consumers.

#### Requirements on Health Plans and Carrier for Filing Prior to Offering Products

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

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

The Director of the Department of Managed Health Care and the Insurance Commissioner will categorize each individual health care plan contract and individual health insurance policy offer by a plan or carrier into the appropriate coverage choice category within 90 days of the date the contract is filed.

### Requirements on Health Plans and Health Insurers/Carriers for Product Offerings

Health care service plans and carriers are prohibited from offering or selling an individual health care service plan contract or policy until the director or insurance commissioner has categorized the contract.

Health care service plans and health insurers that offer coverage on an individual basis would offer at least one contract or policy in each coverage choice category.

Health care service plans and carriers offering a specific type of contract or insurance policy in one coverage choice category must offer that specific type of plan contract or health insurance policy in each coverage choice category. Types of plans or policies include a preferred provider organization, an exclusive provider organization model plan, a point of service model plan, and a health maintenance organization model plan.

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

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

### Requirements on Health Plans and Health Insurers/Carriers for Product Pricing

Health care service plans and health insurers would 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.

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.

### Requirements on Health Plans and Health Insurers/Carriers for Provider Networks

For health care service plan contracts and health insurance policies, the provider network offered for one health care service plan contract or one health benefit plan in one coverage choice category will be offered for at least one health care service plan contract in each coverage choice category.

## Attachment B: Mandates in Current Law that Apply to CDI-Regulated Policies Sold in the Individual Market

### Mandates for Coverage of Services for Specific Diseases or Conditions

Description of Benefit	California Insurance Code Section	Type of Requirement	Markets Affected <sup>a</sup>
AIDS vaccine	10145.2	Mandate	Individual and group
Diabetes management and treatment	10176.61	Mandate	No mention
Expanded alpha fetoprotein	10123.184	Mandate	Individual and group
Breast cancer benefits	10123.8	Mandate	No mention
Prostate cancer screening and diagnosis	10123.83	Mandate	Individual and group
Mammography	10123.81	Mandate	No mention
Cervical cancer screening	10123.18	Mandate	Individual and group
Osteoporosis	10123.185	Mandate	No mention
Jawbone or associated bone joints	10123.21	Mandate	No mention
Conditions associated with exposure to diethylstilbestrol	10119.7	Mandate	No mention
Phenylketonuria	10123.89	Mandate	No mention
Special footwear for persons suffering from foot disfigurement	10123.141	Mandated offering	No mention

<sup>a</sup>Statutes that do not specify a market apply to every insurance policy sold.

### Mandates for Coverage of Specific Types of Health Care Services

Description of Benefit	California Insurance Code Section	Type of Requirement	Markets Affected <sup>a</sup>
Contraceptive devices requiring a prescription	10123.196	Mandate	No mention
Screening children for blood lead levels	10119.8	Mandate	Individual and group
Prosthetic devices for laryngectomy	10123.82	Mandate	No mention
Reconstructive surgery <sup>29</sup>	10123.88	Mandate	Individual and group
Cancer screening tests	10123.2	Mandate	Individual and group
General anesthesia for dental procedures	10119.9	Mandate	No mention

<sup>a</sup>Statutes that do not specify a market apply to every insurance policy sold.

<sup>29</sup> The federal Women's Health and Cancer Rights Act of 1998 requires coverage for post-mastectomy reconstructive surgery.

## Mandates Regarding Terms and Conditions of Coverage

<b>Description of Benefit</b>	<b>California Insurance Code Section</b>	<b>Type of Requirement</b>	<b>Markets Affected<sup>a</sup></b>
Prescription drugs: coverage of "off-label" use	10123.195	Mandate	No mention
Maternity benefits—minimum length of stay <sup>30</sup>	10123.87	Mandate	Individual and group
Mastectomy and lymph node dissection—length of stay	10123.86	Mandate	Individual and group
Coverage and premiums for persons with physical or mental impairment	10122.1	Mandate	Individual and group
Transplantation services for persons with HIV	10123.21	Mandate	No mention

<sup>a</sup>Statutes that do not specify a market apply to every insurance policy sold.

## Provider Mandates

<b>Description of Benefit</b>	<b>California Insurance Code Section</b>	<b>Type of Requirement</b>	<b>Markets Affected<sup>a</sup></b>
Medical transportation services—direct reimbursement	10126.6	Mandate	No mention
OB-GYNs as primary care providers	10123.83	Mandate	No mention

<sup>a</sup>Statutes that do not specify a market apply to every insurance policy sold.

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<sup>30</sup> The federal Newborns' and Mothers' Health Protection Act of 1996 mandates this coverage if a plan covers maternity services.

### **Attachment C: Information Submitted by Outside Parties**

In accordance with CHBRP policy to analyze information submitted by outside parties during the first 2 weeks of the CHBRP review, the following parties chose to submit information.

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

For information on the processes for submitting information to CHBRP for review and consideration please visit: [www.chbrp.org/requests.html](http://www.chbrp.org/requests.html).

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