



CALIFORNIA
HEALTH BENEFITS REVIEW PROGRAM

Executive Summary
Analysis of Senate Bill 255:
Breast Cancer

A Report to the 2011-2012 California Legislature
April 14, 2011

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EXECUTIVE SUMMARY

California Health Benefits Review Program Analysis of Senate Bill 255

The California Senate Committee on Health requested on February 11, 2011, that the California Health Benefits Review Program (CHBRP) conduct an evidence-based assessment of the medical, financial, and public health impacts of Senate Bill (SB) 255, a bill that would impose a health benefit mandate by revising and recasting the definition of mastectomy to include surgical treatment for breast cancer. In response to this request, CHBRP undertook this analysis pursuant to the provisions of the program's authorizing statute.¹

Analysis of SB 255

Approximately 21.9 million Californians (59%) have health insurance that may be subject to a health benefit mandate law passed at the state level.² Of the rest of the state's population, a portion is uninsured (and so has no health insurance subject to any benefit mandate), and another portion has health insurance subject to other state laws or only to federal laws.

Uniquely, California has a bifurcated system of regulation for health insurance subject to state-level benefit mandates. The California Department of Managed Health Care (DMHC)³ regulates health care service plans, which offer benefit coverage to their enrollees through health plan contracts. The California Department of Insurance (CDI) regulates health insurers,⁴ which offer benefit coverage to their enrollees through health insurance policies.

DMHC-regulated plans and CDI-regulated policies would be subject to SB 255. Therefore, the mandate would affect the health insurance of approximately 21.9 million Californians (59%).

Currently, California law requires health plans and insurers to cover breast cancer screening and treatment. SB 255 would amend existing California law by clarifying the definition of mastectomy to specify that partial removal of the breast includes, but is not limited to, lumpectomy. Lumpectomy includes surgical removal of the tumor with clear margins. The bill would require coverage of postsurgery consultation regarding the length of any hospital stay.

The Women's Health and Cancer Rights Act of 1998 (WHCRA) is a federal law that provides protections to patients who choose to have breast reconstruction in connection with a mastectomy.

¹ CHBRP's authorizing statute is available at: http://www.chbrp.org/documents/authorizing_statute.pdf.

² CHBRP's estimates are available at: http://www.chbrp.org/other_publications/index.php.

³ DMHC was established in 2000 to enforce the Knox-Keene Health Care Service Plan of 1975; see Health and Safety Code, Section 1340.

⁴ CDI licenses "disability insurers." Disability insurers may offer forms of insurance that are not health insurance. This report considers only the impact of the benefit mandate on health insurance policies, as defined in Insurance Code, Section 106(b) or subdivision (a) of Section 10198.6.

Currently, 20 states mandate minimum in-patient coverage after a patient undergoes a mastectomy, including California. Lumpectomy does not routinely require an overnight stay.

Medical Effectiveness

- Breast cancer is typically treated through a combination of surgery and/or radiation, chemotherapy, and hormone therapy.
- Women with early stage breast cancer (i.e., stage 0, I or, II) are often given two options for initial treatment: mastectomy or lumpectomy plus radiation.
- Factors that surgeons consider when determining whether to recommend lumpectomy plus radiation as a treatment option for women with breast cancer include size and extent of the tumor, the biology of the tumor, location of the tumor, pregnancy or another condition that would make radiation unsafe, and having a history of prior lumpectomy and/or radiation.

Lumpectomy With Radiation vs. Mastectomy

- There is clear and convincing evidence from multiple randomized controlled trials (RCTs) that rates of overall survival and local/regional recurrence of breast cancer are equivalent for women with stage I or II breast cancer who are treated with mastectomy or lumpectomy plus radiation.

Lumpectomy With Radiation vs. Lumpectomy Alone

- There is clear and convincing evidence from multiple RCTs that women with stage I or II breast cancer who receive lumpectomy with radiation have a lower rate of in-breast recurrence of breast cancer than women with stage I or II cancer who receive lumpectomy alone (i.e., without radiation). There is also a preponderance of evidence that they also have a lower rate of death from all causes.
- There is clear and convincing evidence that women with ductal carcinoma in situ (DCIS) who receive lumpectomy with radiation have lower rates of in-breast recurrence of DCIS and invasive breast cancer than women with DCIS who receive lumpectomy alone.

Benefit Coverage, Utilization, and Cost Impacts

- DHMC-regulated plans and CDI-regulated policies are estimated to be currently compliant with the provision in SB 255 of medically necessary lumpectomy upon provider referral. Therefore, no measurable change in coverage for these services is expected.
- DHMC-regulated plans and CDI-regulated policies are estimated to be currently compliant with the provision in SB 255 requiring coverage of postsurgery consultation regarding the length of any hospital stay.
- Approximately 4,000 women enrolled in DMHC-regulated plans and CDI-regulated policies receive lumpectomies in California each year. The average per-unit cost of lumpectomy is \$6,958. The \$6,958 average unit cost of lumpectomy is based on the average allowed charge per case in California for a hospital stay or outpatient procedure associated with lumpectomy.
- As no measurable change in benefit coverage is expected (100% of female enrollees in DMHC-regulated plans and CDI-regulated policies are estimated to be in compliant plans), no measurable change in utilization is projected.
- As no measurable change in benefit coverage is expected, no measurable changes in total premiums and total health care expenditures are expected.
- As no measurable change in benefit coverage or cost is expected, no measurable change in the number of uninsured persons is expected.

Public Health Impacts

- Although lumpectomy procedures are medically effective treatments for DCIS, stage I, and some stage II cancers, CHBRP finds that no change in enrollee coverage or utilization of this treatment would occur through SB 255. Therefore, CHBRP anticipates no public health impact on short- and long-term health outcomes, possible disparities, premature death, or economic loss related to breast cancer or its treatment through lumpectomy procedures.

Potential Effects of the Federal Affordable Care Act

The federal “Patient Protection and Affordable Care Act” (P.L.111-148) and the “Health Care and Education Reconciliation Act” (H.R.4872) were enacted in March 2010. These laws (together referred to as the “Affordable Care Act [ACA]”) are expected to dramatically affect the California health insurance market and its regulatory environment, with most changes becoming effective in 2014. How these provisions are implemented in California will largely depend on pending legal actions, funding decisions, regulations to be promulgated by federal agencies, and

statutory and regulatory actions to be taken by California state government. The provisions that go into effect during these transitional years would affect the baseline, or current enrollment, expenditures, and premiums. It is important to note that CHBRP's analysis of specific mandate bills typically addresses the marginal effects of the mandate bill—specifically, how the proposed mandate would impact benefit coverage, utilization, costs, and public health, holding all other factors constant. CHBRP's estimates of these marginal effects are presented in this report.

Essential health benefits offered by qualified health plans in the Exchange and potential interactions with SB 255

Essential health benefits (EHBs) are defined to include ambulatory patient services; hospitalization; and preventive and wellness services and chronic disease management. In addition, HHS when promulgating regulations on EHBs is to ensure that the EHB floor “is equal to the scope of benefits provided under a typical employer plan.” Virtually all employers provide coverage for lumpectomy services. Therefore, it is highly unlikely that there would be any impacts resulting from SB 255 in the longer term (beyond 2014).

The ACA requires, beginning 2014, for states to “make payments...to defray the cost of any additional benefits” required of QHPs sold in the Exchange.⁵ This potential liability would depend on three factors:

- Differences in the scope of “benefits in the final EHB package and the scope of mandated benefits in SB 255;
- The number of enrollees in QHPs; and
- The methods used to define and calculate the cost of additional benefits.

Again, because lumpectomy services as defined under SB 255 are considered standard coverage for employer-based plans, and because they are likely to be considered part of EHBs, it is unlikely that there would be any additional fiscal liability to the state for qualified health plans offered in the Exchange as a result of this mandate.

⁵ Affordable Care Act, 1311(d)(3)(B).

ACKNOWLEDGMENTS

This report provides an analysis of the medical, financial, and public health impacts of Senate Bill 255. In response to a request from the California Senate Committee on Health on February 11, 2011, the California Health Benefits Review Program (CHBRP) undertook this analysis pursuant to the program's authorizing statute.

Janet Coffman, MPP, PhD, and Margaret Fix, MPH, of the University of California, San Francisco, prepared the medical effectiveness analysis. Penny Coppernoll-Blach, MLIS, of the University of California, San Diego, conducted the literature search. Diana Cassady, ScD, Dominique Ritley, MPH, and Meghan Soulsby, MPH, all of the University of California, Davis, prepared the public health impact analysis. Todd Gilmer, PhD, of the University of California, San Diego, and Garen Corbett, MS, of CHBRP staff, prepared the cost impact analysis. Susan Pantely, FSA, MAAA, of Milliman, provided actuarial analysis. Laura Esserman, MD, MBA, of the University of California, San Francisco, provided technical assistance with the literature review and expert input on the analytic approach. Garen Corbett, MS, of CHBRP staff, prepared the introduction and synthesized the individual sections into a single report. A subcommittee of CHBRP's National Advisory Council (see final pages of this report) and a member of the CHBRP Faculty Task Force, Sylvia Guendelman, PhD, LCSW, of the University of California, Berkeley, reviewed the analysis for its accuracy, completeness, clarity, and responsiveness to the Legislature's request.

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

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California Health Benefits Review Program Committees and Staff

A group of faculty and staff undertakes most of the analysis that informs reports by the California Health Benefits Review Program (CHBRP). The CHBRP **Faculty Task Force** comprises rotating representatives from six University of California (UC) campuses 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 CHBRP's authorizing legislation, UC contracts with a certified actuary, Milliman Inc., to assist in assessing the financial impact of each legislative proposal mandating or repealing a health insurance benefit. Milliman also helped with the initial development of CHBRP methods for assessing that impact. The **National Advisory Council** provides expert reviews of draft analyses and offers general guidance on the program to CHBRP staff and the Faculty Task Force. CHBRP is grateful for the valuable assistance and thoughtful critiques provided by the members of the National Advisory Council. However, the Council does not necessarily approve or disapprove of or endorse this report. CHBRP assumes full responsibility for the report and the accuracy of its contents.

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