



**CALIFORNIA**  
HEALTH BENEFITS REVIEW PROGRAM

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**Executive Summary**  
Analysis of Assembly Bill 2064:  
Immunizations for Children

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A Report to the 2011-2012 California Legislature  
April 23, 2012

# **A Report to the 2011-2012 California State Legislature**

## **Analysis of Assembly Bill 2064 Immunizations for Children**

**April 23, 2012**

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## EXECUTIVE SUMMARY

### California Health Benefits Review Program Analysis of Assembly Bill 2064

The California Assembly Committee on Health requested on February 28, 2012, that the California Health Benefits Review Program (CHBRP) conduct an evidence-based assessment of the medical, financial, and public health impacts of Assembly Bill (AB) 2064 (Perez), Immunizations for Children, a bill that would impose a health benefit mandate. In response to this request, CHBRP undertook this analysis pursuant to the provisions of the program’s authorizing statute.<sup>1</sup>

Only one of the several requirements in AB 2064—the requirement to be placed as Health and Safety Code Section 1367.36(g) and as Insurance Code Section 10123.56 (b)—is a health insurance benefit mandate. Therefore, this report analyzes *only the impact of the benefit mandate*.

Approximately 21.882 million Californians (59%) have health insurance that may be subject to a health benefit mandate law passed at the state level.<sup>2</sup> 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 law 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)<sup>3</sup> 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<sup>4</sup>, which offer benefit coverage to their enrollees through health insurance policies.

DMHC-regulated plans and CDI-regulated policies that provide coverage for childhood and adolescent immunizations would be subject to AB 2064. Coverage for “immunizations” includes coverage for both the vaccine itself (which is a prescription drug) and coverage for related procedures (including administration of the vaccine during a provider visit). CHBRP estimates that nearly all enrollees with health insurance subject to state-level benefit mandates have coverage for immunizations, so the mandate would affect the health insurance of approximately 21.873 of the 21.882 million Californians.

For DMHC-regulated plans and CDI-regulated policies that provide coverage for childhood and adolescent immunizations, the benefit mandate in AB 2064 would prohibit cost sharing (defined as including deductibles, copayments, and coinsurance, and “other cost-sharing mechanisms”)

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

<sup>2</sup> CHBRP’s estimates are available at: [http://www.chbrp.org/other\\_publications/index.php](http://www.chbrp.org/other_publications/index.php).

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

<sup>4</sup> 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.

for administration of a childhood or adolescent immunization or for procedures related to administration. The mandate would also prohibit dollar-limit provisions for childhood or adolescent immunization-related procedures. Dollar-limit provisions establish a limit (either an annual or a lifetime limit) beyond which benefit coverage is no longer provided.

AB 2064 references existing mandates<sup>5</sup> that require coverage for immunizations listed in the most current version of the “Recommended Childhood Immunization Schedule/United States, jointly adopted by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and the American Academy of Family Physicians.” Therefore, CHBRP has assumed for this analysis that AB 2064 would prohibit cost sharing for immunization-related procedures for all of the childhood and adolescent immunizations listed in the most currently recommended Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) immunization schedule, hereafter referred to as “ACIP recommendations.”

### Background on Immunization and Vaccine-Preventable Diseases

Evidence indicates that childhood and adolescent immunization are cost-effective (and, in many cases, cost-saving) medical procedures that prevent, reduce, or eliminate the incidence of numerous vaccine-preventable diseases and their associated morbidity, mortality, and health care costs. When a disease is transmitted from person to person or when humans are the reservoir for a disease, immunizations *directly* protect those who are immunized and *indirectly* protect unimmunized persons by reducing their risk of exposure to the disease. This indirect protection, or “herd immunity,” is relevant to most of the immunizations discussed in this report, including immunizations to prevent measles, pertussis, influenza, hepatitis A and B, polio, rubella, mumps, and diphtheria.

California implemented several school-based laws to promote immunization against 10 diseases: diphtheria, hepatitis b, *haemophilus influenzae* type b, measles, mumps, rubella, pertussis, polio, tetanus, and varicella<sup>6</sup>. These laws require a complete dose of these immunizations in children (aged 0-18 years) prior to admission into schools (public and private) or licensed childcare facilities (although exemptions for medical reasons or personal beliefs are permitted). These laws also require schools and licensed childcare facilities to collect and report immunization rates of their enrollees to the California Department of Public Health (CDPH).

Currently, about 71% of children in California, by age 35 months, receive the vaccine series 4:3:1:3:1:4<sup>7</sup>, with rates for immunizations against particular diseases ranging between 53% and 91% for children and adolescents. California appears to be meeting national targets for about half of the national ACIP-recommended immunizations (by age 35 months). The rates for the immunizations required for California daycare or school entrance are consistently close to the national targets with the exception of the pertussis (whooping cough) immunization.

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<sup>5</sup> Health and Safety Code Sections 1367.35, 1367.002 and Insurance Code Sections 10123.5, 10112.2

<sup>6</sup> California Code of Regulations Title 17, Div. 1, Chap. 4, Subchap. 8 Sections 6000-6075 and Health and Safety Code: Div. 105, Part 2, Chap. 1, Sections 120325-120380

<sup>7</sup> 4:3:1:3:1:4= the abbreviation for a grouping of individual vaccines per the CDC’s National Immunization Survey: ≥4DTaP; ≥3 polio; ≥1 MMR; ≥3 Hep B; ≥1 varicella (chickenpox); ≥4 PCV vaccines.

## Other Requirements

CHBRP is aware of several requirements that could overlap or interact with AB 2064.

California State Benefit Mandates:

- Comprehensive preventive care for children aged 16 years or younger<sup>8</sup>
- Comprehensive preventive care for children aged 17 or 18 years<sup>9</sup>
- Preventive services coverage without cost sharing<sup>10</sup>

The first state mandate requires coverage for immunization. The second requires that benefit coverage be offered. The third state mandate requires compliance with an existing federal mandate. The federal mandate is discussed below, under the heading “Effects of the Affordable Care Act.”

DMHC-regulated plans are also required to cover “basic health care services,” including a range of preventive care services. Regulations further specify that health plans are to cover preventive services, including recommended immunizations for children.<sup>11</sup> Laws and regulations related to CDI-regulated policies do not have a similar set of broad “basic health care services” requirements.

Although CHBRP is aware of well-child care coverage mandates in 35 states (BCBSA, 2011), CHBRP is unaware of benefit mandates in other states that prohibit cost sharing for immunization-related procedures.

## **Medical Effectiveness**

It is not feasible for CHBRP to review the large volume of literature on the medical effectiveness of the administration and efficacy of each of the ACIP-recommended vaccines and their immunization-related procedures within the 60-day time frame allotted for this analysis. Therefore, the medical effectiveness review utilized the information compiled by ACIP on immunization-related procedures and vaccine efficacy.

- ACIP has 38 current vaccine-specific recommendations, plus one report summarizing general recommendations on immunization. Of the 39 current recommendations, 14 were excluded because they were not relevant (i.e., not for pediatric population, not a routine immunization, etc.). The 25 remaining recommendations were retrieved and reviewed.

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<sup>8</sup> Health and Safety Code Section 1367.35 and Insurance Code Section 10123.5

<sup>9</sup> Health and Safety Code Section 1367.3 and Insurance Code Section 10123.55

<sup>10</sup> Health and Safety Code Section 1367.002 and Insurance Code Section 10112.2

<sup>11</sup> Personal communication, C. Hamilton, DMHC, April 2012.

- To ensure proper and safe administration of vaccines, ACIP issues recommendations regarding immunization-related procedures such as infection control, sterile immunization techniques, and the proper administration, storage, and handling of vaccines. Deviation from the recommended administration could lead to a reduction in the effectiveness of the vaccine or an increase in adverse reactions.

There are 12 vaccines recommended by ACIP for routine use in children and adolescents (aged 0-18 years):

- Diphtheria, tetanus, acellular pertussis (DTaP/Tdap);
  - *Haemophilus influenzae* type b (Hib);
  - Hepatitis A (HepA);
  - Hepatitis B (HepB);
  - Human papillomavirus (HPV);
  - Influenza;
  - Measles, mumps, rubella (MMR);
  - Meningococcal conjugate;
  - Pneumococcal conjugate (PCV);
  - Inactivated poliovirus (IPV);
  - Rotavirus; and
  - Varicella.
- Due to the rigor and thoroughness of the ACIP systematic review on the efficacy and safety of vaccines, for the purposes of this report, CHBRP concludes that any vaccine that has been recommended as part of the routine immunization schedule has *clear and convincing evidence* that it is effective in preventing disease.

## Benefit Coverage, Utilization, and Cost Impacts

AB 2064 has many requirements including but not limited to a health insurance benefit mandate. This report analyzes only the health benefit mandate contained in AB 2064, and makes no comment on the potential impacts of other requirements.

Table 1 and the following bullets summarize the expected benefit coverage, cost, and utilization impacts *only for the health benefit mandate* included in AB 2064.

### Benefit Coverage Impacts

- Of the population with health insurance subject to the mandate, nearly all (98.3%) enrollees have mandate-compliant benefit coverage for immunization-related procedures with no cost

sharing. The remaining 1.7% of enrollees (381,000) has benefit coverage not compliant with the mandate (Table 1). If AB 2064 were enacted, 100% of enrollees would have compliant benefit coverage for immunization-related procedures.

- DMHC-regulated Medi-Cal managed care plans already provide mandate-compliant coverage for immunization-related procedures with no cost sharing for enrollees. Therefore, CHBRP estimates that AB 2064 would have no impact on this subpopulation.
- DMHC-regulated CalPERS HMOs already provide mandate-compliant coverage for immunization-related procedures with no cost sharing for enrollees. Therefore, CHBRP estimates that AB 2064 would have no impact on this subpopulation.
- DMHC-regulated MRMIB plans (which enroll beneficiaries of the Healthy Families program, the Aid to Infants and Mothers (AIM) program, and the Major Risk Medical Insurance Program (MRMIP)) already provide mandate-compliant coverage for immunization-related procedures with no cost sharing. Therefore, CHBRP estimates that AB 2064 would have no impact on this subpopulation.
- CHBRP estimates no measurable impact of the mandate on the number of uninsured due to the estimated premium increases of less than 1%.

### Utilization Impacts

- Premandate, CHBRP estimates that the 1.46 million enrollees aged 0 to 4 years would obtain an average of 2.94 immunizations each (including both immunization-related procedures and vaccines) within a 12-month period, for a total of 4.285 million immunization-related procedures (Table 1). The 1.12 million enrolled children aged 5 to 7 would obtain an average of 0.64 immunizations each, for a total of 719,000 immunization-related procedures. Finally, the 5.19 million enrollee children aged 8 to 18 would obtain an average of 0.45 immunizations each, for a total of 2.33 million immunization-related procedures.
- Postmandate, CHBRP estimates that there will be some increase in utilization due to the change in cost sharing, but that the total increase in the number of immunizations will be less than 100 for all age groups (Table 1). However, approximately 89,000 immunization-related procedures would no longer be subject to cost-sharing.

### Cost Impacts

- Increases in per member per month (PMPM) premiums due to the prohibition on cost sharing for immunization-related procedures vary by regulator. There would be no impact on DMHC-regulated plans if AB 2064 were enacted, but there would be some impact for CDI-regulated policies.
- Increases as measured by percentage changes in PMPM premiums among CDI-regulated policies are estimated to range from a low of 0.0030% (for the large-group market segment)

to a high of 0.0101% (for the individual policies market segment). Increases as measured by PMPM premiums are estimated to be \$0.02 for CDI-regulated policies.

- Total net health expenditures are projected to increase by \$155,000 (0.0001%) (Table 1). This is due to a \$648,000 increase in health insurance premiums partially offset by reductions in enrollee out-of-pocket expenditures for covered benefits (\$493,000).

## **Public Health Impacts**

- CHBRP estimates that the health insurance benefit mandate in AB 2064 would result in fewer than 100 additional immunizations administered. Therefore, CHBRP estimates that AB 2064 would have no impact on California's rates of immunizations and vaccine-preventable diseases and their related mortality.
- Evidence shows that decreased cost sharing is associated with increased immunization rates, thus CHBRP projects that AB 2064 would remove the cost-sharing barrier. CHBRP estimates that approximately 89,000 immunization-related procedures would be no longer subject to cost-sharing postmandate. This would result in a savings of about \$493,000 in out-of-pocket expenses (coinsurance and deductibles) for those enrollees with newly compliant coverage who use immunizations. Those children whose parents abstained from or delayed immunization due to cost-sharing requirements for immunization-related procedures may benefit from AB 2064, as this cost barrier to completing recommended immunizations in a timely manner would be eliminated.
- CHBRP estimates that, to the extent that racial and ethnic disparities may exist in rates of immunization, vaccine-preventable disease incidence and related mortality, AB 2064 would have no statistically significant impact on those disparities due to the use of fewer than 100 additional immunizations postmandate. Furthermore, CHBRP found no evidence of gender disparities in rates of immunization, and vaccine-preventable disease incidence and related mortality. CHBRP estimates no statistically significant changes in these rates due to AB 2064.
- CHBRP expects AB 2064 would produce no statistically significant change in California's premature death rates for vaccine-preventable diseases because CHBRP estimates that the bill would increase utilization by fewer than 100 immunizations postmandate.
- Although vaccine-preventable diseases are known to cause economic loss, CHBRP expects AB 2064 would produce no statistically significant change in years of life saved or reductions in lost productivity due to less than an estimated 100 additional childhood and adolescent immunizations administered postmandate.
- CHBRP estimates that beyond 12 months postmandate, AB 2064 would have no statistically significant impact on California's rates of immunizations and vaccine-preventable diseases and mortality due to an estimated increase of less than 100 additional immunizations

administered; however, those persons who abstained from or delayed immunization due to cost-sharing requirements for immunization-related procedures may benefit from AB 2064 by helping them complete their recommended immunization schedule.

## **Effects of 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. Together, these laws are referred to as the “Affordable Care Act (ACA).

Although AB 2064’s interaction with the essential health benefits (EHB) categories lists in the ACA is unclear, it seems likely that AB 2064’s prohibition on cost sharing for child and adolescent immunization-related procedures would be “within” EHBs due to use of a nongrandfathered<sup>12</sup> plan or policy (subject to the federal preventive services benefit mandate<sup>13</sup>) as the benchmark plan options to define EHBs. So it seems likely that passage of the benefit mandate contained in AB 2064 would not require the state to defray costs related to EHBs exceeding the selected benchmark in 2014 and 2015.

Potential interactions of the benefit mandate included in AB 2064 and the ACA are further discussed in *Addendum A* of this executive summary, under the heading “Effects of the Affordable Care Act.”

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<sup>12</sup> A grandfathered health plan is defined as “a group health plan that was created—or an individual health insurance policy that was purchased—on or before March 23, 2010. Grandfathered plans are exempted from many changes required under the Affordable Care Act. Plans or policies may lose their ‘grandfathered’ status if they make certain significant changes that reduce benefits or increase costs to consumers” (<http://www.healthcare.gov/glossary/g/grandfathered-health.html>).

<sup>13</sup> Affordable Care Act of 2010 Section 1001, modifying Section 2713 of the Public Health Services Act

**Table 1. AB 2064 (Benefit Mandate Only) Impacts on Benefit Coverage, Utilization, and Cost, 2012**

|   | Before Mandate           | After Mandate            | Increase/<br>Decrease | Change<br>After<br>Mandate |
|---|--------------------------|--------------------------|-----------------------|----------------------------|
| <b>Benefit coverage</b>   |                          |                          |                       |                            |
| Total enrollees with health insurance subject to state-level benefit mandates (a)                               | 21,882,000               | 21,882,000               | 0                     | 0%                         |
| Total enrollees with health insurance subject to AB 2064  | 21,873,000               | 21,873,000               | 0                     | 0%                         |
| Percentage of enrollees with coverage for immunization-related procedures                                       |                          |                          |                       |                            |
| Coverage not subject to cost sharing (b)  | 98.3%                    | 100.0%                   | 1.7%                  | 2%                         |
| Coverage subject to cost sharing  | 1.7%                     | 0.0%                     | -1.7%                 | -100%                      |
| Number of enrollees with coverage for immunization-related procedures   |                          |                          |                       |                            |
| Coverage not subject to cost sharing  | 21,492,000<br>(c)        | 21,873,000               | 381,000               | 2%                         |
| Coverage subject to cost sharing  | 381,000<br>(c)           | 0                        | -381,000              | -100%                      |
| <b>Utilization and cost</b>   |                          |                          |                       |                            |
| Number of immunization-related procedures: Ages 0-4   | 4,285,000                | 4,285,000<br>(d)         | 0<br>(d)              | 0%<br>(d)                  |
| Number of immunization-related procedures: Ages 5-7   | 719,000                  | 719,000<br>(d)           | 0<br>(d)              | 0%<br>(d)                  |
| Number of immunization-related procedures: Ages 8-18  | 2,335,000                | 2,335,000<br>(d)         | 0<br>(d)              | 0%<br>(d)                  |
| Average per-unit cost of immunization-related procedures only   | \$25                     | \$25                     | 0                     | 0%                         |
| <b>Expenditures</b>   |                          |                          |                       |                            |
| Premium expenditures by private employers for group insurance   | \$60,279,820,000         | \$60,280,020,000         | \$200,000             | 0.0003%                    |
| Premium expenditures for individually purchased insurance   | \$7,543,951,000          | \$7,544,340,000          | \$389,000             | 0.0052%                    |
| Premium expenditures by persons with group insurance, CalPERS HMOs, Healthy Families Program, AIM, or MRMIP (e) | \$14,706,245,000         | \$14,706,304,000         | \$59,000              | 0.0004%                    |
| CalPERS HMO employer expenditures (f)   | \$3,651,121,000          | \$3,651,121,000          | \$0                   | 0.0000%                    |
| Medi-Cal Managed Care Plan expenditures   | \$7,637,700,000          | \$7,637,700,000          | \$0                   | 0.0000%                    |
| MRMIB Plan expenditures (g)   | \$1,046,243,000          | \$1,046,243,000          | \$0                   | 0.0000%                    |
| Enrollee out-of-pocket expenses for covered benefits (deductibles, copayments, etc.)                            | \$8,521,470,000          | \$8,520,977,000          | -\$493,000            | -0.0058%                   |
| Enrollee expenses for noncovered benefits that would be covered postmandate (h)                                 | \$0                      | \$0                      | \$0                   | 0.000%                     |
| <b>Total expenditures</b>   | <b>\$103,386,550,000</b> | <b>\$103,386,705,000</b> | <b>\$155,000</b>      | <b>0.0001%</b>             |

Source: California Health Benefits Review Program, 2012.

Notes: (a) This population includes persons with privately funded and publicly funded (e.g., CalPERS HMOs, Medi-Cal Managed Care Plans, Healthy Families Program, AIM, MRMIP) health insurance products regulated by DMHC or CDI. Population includes enrollees aged 0 to 64 years and enrollees 65 years or older covered by employment-sponsored insurance.

- (b) “Cost sharing” includes copayments, coinsurance, deductibles, and dollar-limit provisions.
  - (c) Populations are calculated from unrounded numbers, and may not match precisely if percentages are multiplied by rounded population totals.
  - (d) CHBRP estimates that utilization will increase by less than 100 across all age groups. While this number is greater than 0, in this table it is included in the rounding.
  - (e) Premium expenditures by enrollees include employee contributions to employer-sponsored health insurance and enrollee contributions for publicly purchased insurance.
  - (f) Of the increase in CalPERS employer expenditures, about 58%, or \$0 would be state expenditures for CalPERS members who are state employees or their dependents.
  - (g) MRMIB Plan expenditures include expenditures for 874,000 enrollees of the Healthy Families Program, 7,000 enrollees of MRMIP, and 7,000 enrollees of the AIM program.
  - (h) Includes only those expenses that enrollees pay directly to providers for uncovered services related to the mandated benefit *and* that will be newly covered, postmandate. Other components of expenditures in this table include all health care services covered by insurance.
- Key:* AIM=Access for Infants and Mothers; CalPERS HMOs=California Public Employees’ Retirement System Health Maintenance Organizations; CDI=California Department of Insurance; DMHC=Department of Managed Health; MRMIB=Managed Risk Medical Insurance Board; MRMIP=Major Risk Medical Insurance Program.

## Addendum A

### Effects of 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 the 2014 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.

#### Current effects

Provisions of the ACA that go into effect during the transitional years (2010-2013) affect current (or baseline) enrollment, expenditures, and premiums. It is important to note that CHBRP’s analysis of specific mandate bills typically address 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. Each of the provisions that have gone into effect by January 2012 has been considered. Where data allow, CHBRP has made adjustments to reflect changes in enrollment and/or baseline premiums. These adjustments are discussed in further detail in Appendix D.

Some of the provisions of the ACA enacted federal health insurance benefit mandates.<sup>14</sup> The mandate relevant to AB 2064 is discussed below.

#### *Effective 2010: preventive services*

The ACA requires that nongrandfathered<sup>15</sup> health plans and policies cover certain preventive services with no cost sharing beginning September 23, 2010, including ACIP-recommended immunizations.<sup>16</sup> The federal mandate prohibits cost sharing for immunization-related procedures. Although grandfathered plans and policies are not subject to the federal mandate’s prohibition, plans and policies regulated by DMHC or CDI would be subject to the benefit mandate contained in AB 2064. Therefore, AB 2064 would broaden the mandated prohibition against cost sharing for immunization-related procedures. It is not clear how many DMHC-regulated plans

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<sup>14</sup> The benefit mandates enacted by the ACA and other federal benefit mandates appear in a list updated regularly by CHBRP. See *Current Mandates: Health Insurance Benefit Mandates in California State Law*, available at [http://www.chbrp.org/other\\_publications/index.php](http://www.chbrp.org/other_publications/index.php)

<sup>15</sup> A grandfathered health plan is defined as “a group health plan that was created—or an individual health insurance policy that was purchased—on or before March 23, 2010. Grandfathered plans are exempted from many changes required under the Affordable Care Act. Plans or policies may lose their ‘grandfathered’ status if they make certain significant changes that reduce benefits or increase costs to consumers” (<http://www.healthcare.gov/glossary/g/grandfathered-health.html>).

<sup>16</sup> Affordable Care Act of 2010 Section 1001, modifying Section 2713 of the Public Health Services Act

and CDI-regulated policies are grandfathered and therefore not subject to the mandate. The U.S. Departments of Labor and Treasury estimate that by 2013, between 39% and 69% of all employer group plans will have relinquished their grandfathered status.<sup>17</sup>

### *Effective in 2014: essential health benefits*

The ACA requires nongrandfathered small-group and individual health insurance, including but not limited to qualified health plans (QHPs) sold through the California Exchange, to cover specified categories of benefits called essential health benefits (EHBs)<sup>18</sup> beginning January 1, 2014. The ACA defines EHBs as including these categories: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services, including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care. The Secretary of Health and Human Services (HHS) is charged with defining these categories through regulation and ensuring that the EHB floor “is equal to the scope of benefits provided under a typical employer plan.”

The ACA allows a state to require QHPs sold through an exchange to provide benefits that are “in addition to” EHBs. However, if the state does so, the state must defray the cost of those additionally mandated benefits that exceed EHBs, either by paying the purchaser directly, or by paying the QHP.

HHS has proposed<sup>19</sup> that each state define its own EHBs for 2014 and 2015 by selecting one of a set of specified benchmark plan options. The choice of benchmark plan is expected to dictate which state benefit mandates, if any, will be included in the state’s EHBs.

Any state-mandated benefit enacted after December 31, 2011, may not be part of the EHBs for 2014 and 2015.<sup>20</sup> If passed, AB 2064 would be effective January 1, 2013. Therefore, if any proposed benefit coverage mandates included in AB 2064 exceed EHBs, as defined in 2014 and 2015, California may be required to defray the cost for QHPs sold through an Exchange.

HHS has not released final guidance on defining the EHBs or final guidance on how states will defray the costs of state benefit mandates that require QHPs to exceed EHBs. However, it seems likely that states would be required to defray the marginal cost impact associated with the state benefit mandates’ exceeding EHBs. Such a marginal cost may be calculated in a fashion similar

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<sup>17</sup> For small employers (3 to 99 employees), the estimated percentage relinquishing grandfathered status is between 49% and 80%; for large employers (more than 100 employees), the estimate is 34% to 64%. U.S. Department of Labor and Department of Treasury, *Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act*, (June 17, 2010), available at <https://www.federalregister.gov/articles/2010/06/17/2010-14488/interim-final-rules-for-group-health-plans-and-health-insurance-coverage-relating-to-status-as-a>

<sup>18</sup> Affordable Care Act of 2010 Section 1302(b)

<sup>19</sup> CCIIO, *Essential Health Benefits Bulletin* (December 2011). Available at:

[http://cciio.cms.gov/resources/files/Files2/12162011/essential\\_health\\_benefits\\_bulletin.pdf](http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf).

<sup>20</sup> CCIIO, *Frequently Asked Questions on Essential Health Benefit Bulletin*, (February 2012)). Available at: <http://cciio.cms.gov/resources/files/Files2/02172012/ehb-faq-508.pdf>.

to the manner in which CHBRP estimates marginal cost impacts when assessing benefit mandate bills on behalf of the California Legislature. For further discussion on how state benefit mandates may interact with the EHBs and the benchmark plan regulatory approach, please see CHBRP issue brief *Interaction between California's State Benefit Mandates and the Affordable Care Act's "Essential Health Benefits."*<sup>21</sup>

*Effects beginning in 2014: interactions between essential health benefits and AB 2064*

Because of the potential fiscal responsibility for the state, CHBRP is providing the following consideration of how the benefit mandate in AB 2064 might interact with EHBs.

As mentioned, the 10 EHB categories in the ACA explicitly include prevention and wellness services. Although definitions of the EHB categories are not yet available, it seems likely that childhood and adolescent immunizations recommended by ACIP will be included in the final definition of "prevention services." However, it is unclear whether AB 2064's prohibition on cost sharing for immunization-related procedures for ACIP-recommended childhood and adolescent immunizations would be part of the final definition to be issued by HHS.

Also as mentioned, HHS has suggested that states will begin defining EHBs for 2014 and 2015 by selecting a benchmark plan option. Older mandates may effectively become part of the definition of EHBs because the plan or policy selected as the benchmark plan option is already compliant with them. Because AB 2064 would not be in effect until after a benchmark plan option is selected, it seems unlikely that the benefit mandate in AB 2064 would become part of the EHBs for 2014 and 2015. However, many of the benchmark plan options may already be compliant with AB 2064 (applying no cost sharing for immunization-related procedures). Furthermore, of the possible benchmark plan options, few would be grandfathered plans or policies, so it seems likely that selected benchmark plan option would be subject to the previously discussed federal preventive services health insurance benefit mandate, which prohibits cost sharing for immunization-related procedures when associated with ACIP-recommended childhood and adolescent immunizations.

Although interaction with the EHB categories listed in the ACA is unclear, it seems likely that AB 2064's prohibition on cost sharing for child and adolescent immunization-related procedures would be "within" EHBs due to use of a nongrandfathered plan or policy as the benchmark plan option to define EHBs (see Table 2). So it seems likely that passage of the benefit mandate contained in AB 2064 would not require the state to defray costs related to EHBs exceeding the selected benchmark in 2014 and 2015.

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<sup>21</sup> Available at: [http://www.chbrp.org/other\\_publications/index.php](http://www.chbrp.org/other_publications/index.php)

**Table 2.** Potential Interaction of Essential Health Benefits (EHBs) in 2014-2015 with the Benefit Mandate Included in AB 2064

| Affordable Care Act (ACA) Essential Health Benefits (EHBs)                             | AB 2064’s Prohibition on Cost Sharing for Immunization-Related Procedures for ACIP-Recommended Childhood and Adolescent Immunizations |
|--|---|
| <b>10 ACA EHB categories</b>   | Unclear   |
| <b>Proposed approach for defining EHBs in 2014-2015</b>                                |   |
| Benchmark plan option 1: small group insurance product*                                | Within  |
| Benchmark plan option 2: state employee health benefits plan—CalPERS HMO*              | Within  |
| Benchmark plan option 2: state employee health benefits plan—CalPERS self-insured PPO* | Within  |
| Benchmark plan option 3: Federal Employees Health Benefits Program (FEHBP)*            | Within  |
| Benchmark plan option 4: largest commercial HMO*                                       | Within  |

Source: CHBRP, 2012.

Notes: (\*) Assumes a nongrandfathered plan or policy (therefore subject to the federal preventive services health benefit mandate)<sup>22</sup>

Key: ACIP=Centers for Disease Control and Prevention Advisory Committee on Immunization Practices CalPERS HMO=California Public Employees’ Retirement System Health Maintenance Organization; CalPERS HMO=California Public Employees’ Retirement System Preferred Provider Organization.

<sup>22</sup> Affordable Care Act of 2010 Section 1001, modifying Section 2713 of the Public Health Services Act

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Theodore Ganiats, MD, and Sara McMenamain, PhD, of the University of California, San Diego, prepared the medical effectiveness analysis. Stephen L. Clancy, MLS, AHIP, of the University of California, Irvine, conducted the literature search. Diana Cassady, DrPH, and Dominique Ritley, MPH, of the University of California, Davis, prepared the public health impact analysis. Shana Lavarreda, PhD, MPP, prepared the cost impact analysis. Susan Pantely, FSA, MAAA, of Milliman, provided actuarial analysis. Byung-Kwang Yoo, MD, MSc, PhD, of the University of California, Davis, provided technical assistance with the literature review and expert input on the analytic approach. John Lewis, MPA, 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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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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