

California Health Benefits Review Program

Executive Summary

Analysis of Senate Bill 1239: Pupil Health Care: School Nurses

A Report to the 2013-2014 California Legislature

June 13, 2014



KEY FINDINGS

Analysis of California Senate Bill (SB) 1239: Pupil Health Care: School Nurses

SUMMARY TO THE 2013–2014 CALIFORNIA LEGISLATURE • JUNE 13, 2014



AT A GLANCE

SB 1239 (amended April 1, 2014) would require DMHC-regulated plans and CDI-regulated insurers to reimburse school districts for covered services delivered to a pupil by a school nurse, registered nurse (RN), or licensed vocational nurse (LVN) employed by or under contract with the school district. SB 1239 would also prohibit cost sharing for such services. SB 1239 was subsequently amended, but this analysis focuses on the April 1 version (which included a benefit mandate).

- **Enrollees.** An estimated 23.4 million Californians (60%) have health insurance that would be subject to SB 1239 (see Figure 1), including Medi-Cal beneficiaries enrolled in DMHC-regulated plans. Among this group are 5.7 million pupils (76% of California children aged 4–18 years).
- **Impact on expenditures.** In the initial year, CHBRP has made the simplifying assumption that school districts would bill health insurance as other providers do, which would increase expenditures (premiums) by \$150 million (0.117%).
- **EHBs.** SB 1239 requires reimbursement for services provided by school nurses that “would otherwise be covered by” a pupil’s plan or policy, so SB 1239 would not exceed EHBs.
- **Medical effectiveness.** Nursing services are effective in many settings. However, there is *insufficient evidence* to determine the effect of school nurse services on pupil health outcomes.
- **Benefit coverage.** For 100% of enrollees (an increase from 0%), SB 1239 would alter benefit coverage to include covered services when provided by a school nurse to a pupil.
- **Utilization.** For the initial year, CHBRP has made the simplifying assumption that SB 1239 would increase the number of school nurses and the use of reimbursable school nurse services by 10%.
- **Public health.** Although it is reasonable to assume that an increase of 10% services could positively affect pupil health, because there is insufficient evidence to determine effectiveness, the impact of the increase in school nurse services on pupil health outcomes is unknown.
- **Long-term impacts.** Due to the variety of possible responses to the mandate by a variety of actors (school districts, school nurses, health insurance plans and policies, parents, and students), simplifying assumptions made to estimate SB 1239’s initial impacts may not hold in the long term. Therefore, the long-term impacts on utilization, cost, and the public’s health are unknown.

BILL SUMMARY

SB 1239 would require DMHC-regulated plans and CDI-regulated insurers (including Medi-Cal Managed Care Plans) to reimburse school districts for covered services delivered to a pupil (if the pupil is a plan/policy enrollee) by a school nurse, registered nurse (RN), or licensed vocational nurse (LVN) employed by or under contract with the school district. SB 1239 would also prohibit plans and insurers from applying cost-sharing terms for covered services provided by school nurses.

In addition to the benefit mandate just described, SB 1239 would also require school districts eligible to receive concentration funding under the local control funding formula¹ to employ at least one school nurse as a “supervisor of health.”

BACKGROUND

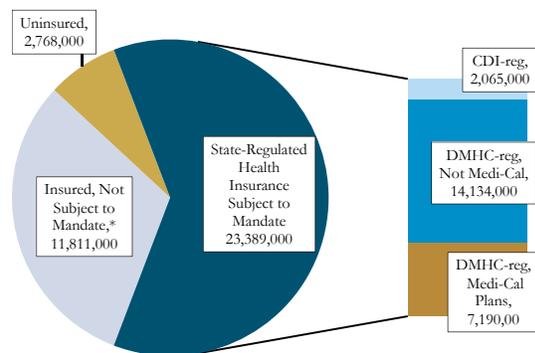
The National Association of School Nurses has identified seven core school nurse roles: (1) providing direct health care to students; (2) providing leadership for the provision of health services; (3) providing screening and referral for health conditions; (4) promoting healthy school environments; (5) promoting health; (6) serving as a leader in health policies and programs; and (7) acting as liaison between school, family, health care professionals, and community. These roles include, but are not limited to, the school nurse services SB 1239 would make reimbursable when provided to pupils by school nurses, registered nurses (RNs), or licensed vocational nurses (LVNs) (collectively referred to as “school nurses” in this report).

¹ California Education Code 42238.02(f).

ANALYTIC APPROACH AND ASSUMPTIONS

To perform this analysis, CHBRP identified school nurse services that would be covered by pupils' plans and policies. This subset of the services included among school nurse roles are referred to in this report as "reimbursable services." CHBRP assumed the following: (1) the term "pupil" would include children aged 4–18 years attending K-12 public or private schools, or being home-schooled; (2) plans and insurers would be required to reimburse school districts for services provided by school nurses. However, plans and insurers would not be required to reimburse school districts for school nurses acting in other capacities (e.g., school nurses attached to school-based health clinics); and (3) "reimbursable services" would include covered services when provided by a school nurse (such as medication administration, screening, etc.), but would not include drugs or durable medical equipment.

Figure 1. SB 1239 Interaction With California Health Insurance: Enrollees/Persons, All Ages



Source: California Health Benefits Review Program, 2014.

Note: *Insured, Not Subject to Mandate = Federally regulated health insurance, such as Medicare, veterans, or self-insured plans.

Although the 5.7 million pupils enrolled in DMHC-regulated plans and CDI-regulated policies would be the potential users of reimbursable school nurse services, SB 1239's benefit coverage and premium impacts would affect the health insurance of all 23.4 million enrollees.

CHBRP KEY FINDINGS: INCREMENTAL IMPACT OF SB 1239 Medical Effectiveness

CHBRP's medical effectiveness analysis focused on the evidence of effectiveness of services delivered by a school nurse in a school setting. A limited number of studies addressed the effectiveness of school nurse services that SB 1239 would make reimbursable. These studies indicate: *insufficient evidence* to determine whether case management services delivered by a school nurse affect emergency department visits and/or hospital visits; *insufficient evidence* to determine whether immunization and surveillance efforts on the

part of school nurses affect vaccination rates; *insufficient evidence* to determine whether services delivered by a school nurse affect absenteeism. Although it stands to reason that the services provided by nurses may be as effective in school settings as in other settings, the medical effectiveness review found insufficient evidence to demonstrate the effectiveness in a school setting. Please note: insufficient evidence is not evidence of no effect, rather it indicates an unknown effect.

Benefit Coverage, Utilization, and Cost

If SB 1239 were enacted:

Benefit coverage impacts: Coverage for reimbursable services provided by school nurses would increase from 0% to 100% for all enrollees in DMHC-regulated plans and CDI-regulated policies.

Utilization impacts: For this analysis, CHBRP identified reimbursable services then averaged them all into a standard 15-minute visit increment. This reimbursable visit is the increment used throughout the analysis to calculate utilization and cost impacts. CHBRP has made the simplifying assumption that the number of school nurses would increase by 10% (due to SB 1239's impact on the education code and the economic incentive of reimbursable services), which would increase utilized reimbursable services from 3.6 to 3.9 million in the initial, postmandate year.

Cost impacts: For the initial, postmandate year, CHBRP has also made the simplifying assumption that school districts will bill for covered services provided by school nurses to pupils enrolled in DMHC-regulated plans and CDI-regulated policies, as other providers do. This would result in an increase in expenditures (premiums) of \$238 million (0.1851%).

CHBRP found no evidence in the literature that indicated cost shifting from pediatricians or other providers due to school nurse services; therefore, potential cost offsets are unknown.

Public Health Impacts

CHBRP estimates a 10% increase in services in the short term, and it stands to reason that nursing services found to be effective in other settings could be effective in school settings, which could positively impact pupil health. However, evidence is insufficient, so the degree to which increased services would improve pupil health and reduce pupil health disparities is unknown.

Long-Term Impacts

Due to the many possibilities for implementation (and action on the part of school districts, school nurses, health insurance carriers, parents, and students), the short-term simplifying assumptions CHBRP has made to model the initial year may not hold. Therefore, the long-term impacts are unknown.

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EXECUTIVE SUMMARY

California Health Benefits Review Program Analysis of Senate Bill 1239

The California Senate Committee on Health requested on April 7, 2014, that the California Health Benefits Review Program (CHBRP) conduct an evidence-based assessment of the medical, financial, and public health impacts of the health insurance benefit mandate proposed by Senate Bill (SB) 1239, Pupil Health Care Services: School Nurses. In response to this request, CHBRP undertook this analysis pursuant to the provisions of the program's authorizing statute,¹ which allows for the review of benefit mandates affecting health insurance regulated by the state. SB 1239 was subsequently amended and the health insurance benefit mandate was removed from the bill. However, at the request of the Senate Committee on Health, CHBRP completed this analysis of the April 1, 2014, version of SB 1239 (the version that includes a health insurance benefit mandate).

State benefit mandates apply to a subset of health insurance in California, those regulated by one of California's two health insurance regulators:² the California Department of Managed Health Care (DMHC)³ and the California Department of Insurance (CDI).⁴ In 2015, CHBRP estimates that approximately 23.4 million Californians (60%) will have health insurance that may be subject to any state health benefit mandate law.⁵ Of the rest of the state's population, a portion will be uninsured (and therefore will have no health insurance subject to any benefit mandate), and another portion will have health insurance subject to other state laws or only to federal laws.

The mandate would affect the health insurance of approximately 23.4 million enrollees (60% of all Californians). Specifically, DMHC-regulated plans and/or CDI-regulated policies, including DMHC-regulated plans that enroll Medi-Cal beneficiaries, would be subject to SB 1239.

Bill-Specific Analysis of SB 1239

As of January 2015, SB 1239 would enact a health insurance benefit mandate. SB 1239 would require DMHC-regulated plans and CDI-regulated insurers (including Medi-Cal Managed Care Plans) to reimburse school districts for covered services when services are delivered to a pupil (if the pupil is a plan/policy enrollee) by a school nurse, registered nurse (RN), or licensed vocational nurse (LVN) employed by or under contract with the school district. SB 1239 would prohibit plans and insurers from applying cost-sharing terms for covered services provided by school nurses.

¹ Available at: www.chbrp.org/docs/authorizing_statute.pdf.

² California has a bifurcated system of regulation for health insurance. The Department of Managed Health Care (DMHC) 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, which offer benefit coverage to their enrollees through health insurance policies.

³ DMHC was established in 2000 to enforce the Knox-Keene Health Care Service Plan of 1975; see Health and Safety Code (H&SC) 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 (IC) Section 106(b) or subdivision (a) of Section 10198.6.

⁵ CHBRP's estimates are available at: www.chbrp.org/other_publications/index.php.

In addition to the health insurance benefit mandate just described, SB 1239 would also, at a later date (July 1, 2016), alter the California Education Code to require school districts eligible to receive concentration funding under the local control funding formula⁶ to employ at least one school nurse as a supervisor of health.

Just as only a portion of Californians are enrolled in DMHC-regulated plans or CDI-regulated policies, only a portion of California pupils (children aged 4–18 years) are plan/policy enrollees. Some pupils are enrolled in health insurance not subject to regulation by DMHC or CDI and some pupils have no health insurance. SB 1239 would not affect the health insurance of these pupils. CHBRP estimates that SB 1239 would affect the health insurance of 76% of California pupils.

Background on School Nurses

The National Association of School Nurses has identified 7 core roles of school nurses:

- Provide direct health care to students
- Provide leadership for the provision of health services
- Provide screening and referral for health conditions
- Promote healthy school environment
- Promote health
- Serve as a leader in health policies and programs
- Liaison between school, family, health care professionals, and community

These roles are inclusive of but not limited to the school nurse services SB 1239 would make reimbursable when provided by school nurses, registered nurses (RNs), or licensed vocational nurses (LVNs) collectively referred to as “school nurses” in this report.”

Analytic Approach and Key Assumptions

To perform this analysis, CHBRP identified school nurse services that would be covered by pupil’s plans and policies. This subset of the services included among school nurse roles are referred to in this report as “reimbursable services.” The roles of a school nurse include but are not limited to services covered under a pupil’s health insurance plan or policy. In this report, CHBRP will use the term “roles” to indicate the broad set of school nurse activities and “reimbursable services” to discuss school nurse actions for which a school district could bill a plan or policy.

The term “school nurse” is defined in law as a registered nurse (RN) who has a current credential in school nursing.⁷ However, because school districts utilize credentialed and noncredentialed RNs, as well as licensed vocational nurses (LVNs), to perform some or all school nursing roles, and because SB 1239 would make some services by all of these providers reimbursable, this

⁶ California Education Code 42238.02(f).

⁷ California Education Code 49426.

report uses term “school nurse” to include all RNs and LVNs performing some or all roles associated with school nursing.

In order to conduct this analysis, CHBRP assumed the following:

- The term “pupil” would include children aged 4–18 attending K-12 public or private schools, or being home-schooled.
- Plans and insurers would be required to reimburse school districts for services provided by school nurses. However, plans and insurers would not be required to reimburse school districts for school nurses acting in other capacities (e.g., school nurses attached to school-based health clinics).
- “Reimbursable services” would include covered services when provided by a school nurse (such as medication administration, screening, etc) but would not include drugs or durable medical equipment (DME).

Medical Effectiveness

The literature shows that nursing services are effective in many settings, including hospital-based care, primary care, community-based care, and home-based care. Although it stands to reason that the services provided by nurses may be as effective in school settings, the purpose of the Medical Effectiveness literature review and analysis was to find the evidence on the effectiveness of services provided by a school nurse in a school setting. The review of these studies indicate:

- There is *insufficient evidence* to determine whether case management services delivered by a school nurse affect emergency department visits and/or hospital visits. Insufficient evidence is not evidence of no effect, *rather it indicates an unknown effect*.
- There is *insufficient evidence* to determine whether immunization and surveillance efforts on the part of school nurses affect vaccination rates. Insufficient evidence is not evidence of no effect, *rather it indicates an unknown effect*.
- There is *insufficient evidence* to determine whether services delivered by a school nurse affect absenteeism. Insufficient evidence is not evidence of no effect, *rather it indicates an unknown effect*.
- The medical effectiveness review found no studies on the effects of other reimbursable services that SB 1239 would require coverage, such as medication administration and health education.

Taken collectively, although it stands to reason that the services provided by nurses may be as effective in school settings, the medical effectiveness review found insufficient evidence to demonstrate the effectiveness of services provided by a school nurse in a school setting. Insufficient evidence is not evidence of no effect, rather it indicates an unknown effect.

Benefit Coverage, Utilization, and Cost Impacts

The *Benefit Coverage, Utilization, and Cost Impacts* section only examines the services SB 1239 would make reimbursable (a sub-set of the full range included in the roles of school nurses).

Coverage impacts

- If SB 1239 were enacted, coverage for reimbursable services provided by school nurses would increase to 100% (from 0%) for all enrollees in DMHC-regulated plans and CDI-regulated policies.⁸

Utilization impacts

On the basis of existing literature and content expert input, CHBRP estimates that school nurse services are limited by the supply of school nurses; that demand far surpasses supply, so increasing the number of school nurses would increase utilization. To calculate reimbursable school nurse services, CHBRP averaged all reimbursable nursing services into a standard fifteen-minute visit increment. This reimbursable visit is the increment used throughout the calculations of utilization and cost impacts. CHBRP has also made a simplifying assumption: that the number of school nurses (due to SB 1239's legislative requirement for some school districts to employ school nurses, the economic incentives newly reimbursable services would provide, or a combination of both) will increase by 10% for the first year if SB 1239 were enacted.

- CHBRP estimates that there are currently 1,218 reimbursable visits for health services provided per school nurse per year that would be reimbursable through DMHC-regulated plans or CDI-regulated policies if SB 1239 were enacted (Table 1).
- In total, CHBRP estimates that 3,554,070 school nurse visits that would be reimbursable under SB 1239 are currently provided to a pupil population of 5.7 million pupils with health insurance subject to SB 1239.
- CHBRP estimates that utilization of reimbursable visits will increase to 3.9 million in the first year, postmandate.

Cost impacts

CHBRP also assumes that school districts will, as other providers do, be able to bill state-regulated plans and policies for covered services provided to pupils by school nurses.

- SB 1239 would increase expenditures by \$150,272,000 or 0.117% on behalf of enrollees in DMHC-regulated plans and CDI-regulated policies (Table 1).
- CHBRP found no evidence in the literature that indicated cost-shifting from pediatricians or other providers due to school nurse services; therefore, potential cost offsets are unknown.

Public Health Impacts

- CHBRP estimates a 10% increase in services in the short term, and it stands to reason that if nursing services found to be effective in other settings are similarly effective in school settings, SB 1239 could have a positive health impact for pupils; however, the

⁸ Some enrollees have had coverage for CHDN, but this benefit coverage appears to have been limitedly accessed — and is not as broad as the set of services CHBRP is describing as reimbursable.

degree to which the increased access to school nurses would improve pupil health and reduce disparities in pupil health is unknown.

- Due to SB 1239 language that excludes enrollee cost-sharing, CHBRP projects that this mandate would pose no financial burden for enrollees who use school nurse services

Long-Term Impacts

As noted, above, CHBRP's short-term (first year) impact estimates are based on several assumptions regarding actions of school districts, school nurses, and health insurance. These assumptions may not be consistent over the long-term.

- In the long term, SB 1239 may produce unknown long-term impacts in utilization and costs due to the many possibilities for implementation that might occur after the first year, postmandate.
- Although disparities in health status exist by income, insurance status, and race/ethnicity, the long term impacts of SB 1239 on disparities in school-aged children are unknown due to a variety of indeterminate responses to the mandate by school districts, school nurses, and health insurance carriers and secondarily by parents and students.

Interaction With the Federal Affordable Care Act

The language of SB 1239 explicitly requires reimbursement for health care services provided by school nurses that "would otherwise be covered by" an enrollee's health plan contract or insurance policy. For this reason, CHBRP does not believe that the requirements in SB 1239 would interact with essential health benefits (EHBs) because such services are currently within the scope of EHBs.

Table 1. SB 1239 Impacts on Benefit Coverage, Utilization, and Cost, 2015

	Premandate	Postmandate	Increase/ Decrease	Change Postmandate
Benefit coverage				
Total enrollees with health insurance subject to state benefit mandates (a)	23,389,000	23,389,000	0%	0%
Total enrollees with health insurance subject to SB 1239	23,389,000	23,389,000	0%	0%
Percent of enrollees with coverage for reimbursable services provided by a school nurse	0%	100%	100%	100%
Number of enrollees with coverage for reimbursable services provided by a school nurse	—	23,389,000	23,389,000	100%
Utilization and cost				
Number of school nurses	2,918	3,210	292	10%
Number of reimbursable service visits per school nurse per year	1,218	1,218	—	0%
Number of unreimbursed school nurse visits	—	3,909,477	3,909,477	100%
Number of reimbursed school nurse visits	3,554,070	—	-3,554,070	-100%
Total number of school nurse visits	3,554,070	3,909,477	355,407	10%
Average per-unit cost of reimbursable services visit	\$45.00	\$45.00	\$0.00	0%
Expenditures				
<u>Premium expenditures by payer</u>				
Private employers for group insurance	\$54,590,722,000	\$54,649,043,000	\$58,321,000	0.1068%
CalPERS HMO employer expenditures (c)	\$4,297,494,000	\$4,301,715,000	\$4,221,000	0.0982%
Medi-Cal Managed Care Plan expenditures	\$17,504,711,000	\$17,557,088,000	\$52,377,000	0.2992%
Enrollees for individually purchased insurance	\$16,930,080,000	\$16,941,024,000	\$10,944,000	0.0646%

Table 1. SB 1239 Impacts on Benefit Coverage, Utilization, and Cost, 2015 (Cont'd)

	Premandate	Postmandate	Increase/ Decrease	Change Postmandate
Expenditures (cont'd)				
Enrollees with group insurance, CalPERS HMOs, Covered California, and Medi-Cal Managed Care (a) (b)	\$22,232,708,000	\$22,257,117,000	\$24,409,000	0.1098%
<u>Enrollee expenses</u>				
Enrollee out-of-pocket expenses for covered benefits (deductibles, copayments, etc.)	\$12,867,143,000	\$12,867,143,000	\$0	0.0000%
Enrollee expenses for noncovered benefits (d)	\$0	\$0	\$0	0.000%
Total Expenditures	\$128,422,858,000	\$128,573,130,000	\$150,272,000	0.1170%

Source: California Health Benefits Review Program, 2014.

Note: (a) This population includes persons with privately funded (including Covered California) and publicly funded (e.g., CalPERS HMOs, Medi-Cal Managed Care Plans) health insurance products regulated by DMHC or CDI.

Population includes enrollees aged 0 to 64 years and enrollees 65 years or older covered by employer-sponsored health insurance.

(b) Of the increase in CalPERS employer expenditures, about 57% or \$3,327,000, would be state expenditures for CalPERS members who are state employees, state retirees, or their dependents. This percentage reflects the share of enrollees in CalPERS HMOs as of September 30, 2013. CHBRP assumes the same ratio in 2015.

(c) Enrollee premium expenditures include contributions to employer-sponsored health insurance, health insurance purchased through Covered California, and contributions for Medi-Cal Managed Care.

(d) Includes only those expenses that are paid directly by enrollees or other sources to providers for services related to the mandated benefit that are not currently covered by insurance. This only includes those expenses that will be newly covered postmandate. Other components of expenditures in this table include all health care services covered by insurance.

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

ACKNOWLEDGMENTS

This report provides an analysis of the medical, financial, and public health impacts of Senate Bill 1239. In response to a request from the California Senate Committee on Health on April 7, 2014, the California Health Benefits Review Program (CHBRP) undertook this analysis pursuant to the program's authorizing statute, which established CHBRP provide independent and impartial analysis of proposed health insurance benefit mandates and repeals.

Margaret Fix, MPH, Chris Tonner, MPH, and Gina Evans-Young, all of the University of California, San Francisco, prepared the medical effectiveness analysis. Bruce Abbott, MLS, of the University of California, Davis, conducted the literature search. Ronald Fong, MD, MPH, Dominique Ritley, MPH, and Patricia Zrelak, PhD, RN, CNRN, NEA-BC, all of the University of California, Davis, prepared the public health impact analysis. Shana Lavarreda, PhD, MPP, Jack Needleman, PhD, and AJ Scheitler, MEd, all of the University of California, Los Angeles, prepared the cost impact analysis. Robert Cosway, FSA, MAAA, and John Rogers, MS, of Milliman, provided actuarial analysis. Dian Baker, PhD, APRN-BC, PNP, of California State University, Sacramento, and Joanne Spetz, PhD, of the University of California, San Francisco, provided technical assistance with the literature review and expert input on the analytic approach. John Lewis, MPA, and Nimit Ruparel, MPP, 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 for a full list of members) 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, researchers, and staff complete the analysis that informs California Health Benefits Review Program (CHBRP) reports. The CHBRP **Faculty Task Force** comprises rotating senior faculty from University of California (UC) campuses. In addition to these representatives, there are other ongoing contributors to CHBRP from UC that conduct 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 manages all external communications, including those with the California Legislature. 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.

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 of its National Advisory Council. CHBRP assumes full responsibility for the report and the accuracy of its contents.

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